

C Medicare A CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

July 2011



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National version 5010 testing week

Monday, August 22 through Friday, August 26

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, announce a national 5010 testing week to be held Monday, August 22 through Friday, August 26. National 5010 testing week is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs.

CMS encourages all trading partners to participate in the national 5010 testing week, including:

- Providers
- Clearinghouses
- Vendors

More details concerning transactions to be tested are forthcoming from your local MAC. There are several state Medicaid agencies who will also be participating in the national 5010 testing week; more details on Medicaid testing will become available soon.

Again, CMS national 5010 testing week does not preclude trading partners from testing transactions immediately with their MAC. Don't wait until August. CMS encourages you 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 take advantage of this great opportunity to ensure testing and transition efforts are on track.

For more information on HIPAA version 5010, visit the CMS dedicated 5010 website at <http://www.CMS.gov/Versions5010andD0>.

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Source: CMS PERL 201107-27



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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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Partnership for Patients meets goal of over 2,000 hospitals participating

Obama Administration's initiative aims to improve patient safety and lower costs

U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced on Friday, July 8, that nearly 4,500 organizations – including more than 2,000 hospitals – have pledged their support for the Partnership for Patients, the Obama Administration's new nationwide patient safety initiative. In less than three months, the Administration has met its goal of having 2,000 hospitals pledge their support.

On a conference call with leaders of major hospitals, employers, health plans, physicians, nurses, patient advocates, and state government officials, the Secretary reported on the progress of the Partnership for Patients, encouraging them to reach out to colleagues and to get started on the challenging but critical work of making care safer, more reliable, and less costly for all Americans.

The Partnership for Patients also has the potential to save up to \$35 billion in health care costs, including up to \$10 billion for Medicare. Over the next ten years, the Partnership for Patients could reduce costs to Medicare by about \$50 billion and result in billions more in Medicaid savings.

The Partnership for Patients has announced two funding opportunities created by the Affordable Care Act:

- The Community-Based Care Transitions Program provides up to \$500 million in funding for community based organizations in partnership with hospitals to help patients safely transition between settings of care. To read more about this program and how to apply, visit http://www.Healthcare.gov/center/programs/partnership/safer/transitions_.html. Applications will be accepted on a rolling basis.
- The Centers for Medicare & Medicaid Services (CMS) Innovation Center has posted a request for bids for state, regional, national, or hospital system organizations to manage improvement projects that affiliated hospitals may join. To read the solicitation, visit <https://www.FBO.gov/spg/HHS/HCFA/AGG/APP111513/listing.html>.



For more information on the Partnership for Patients initiative and success stories, or to join, visit <http://www.Healthcare.gov/partnershipforpatients>.

The full text of this excerpted press release can be found on the CMS website at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4019>.

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

Source: CMS PERL 201107-28

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at <http://www.cms.gov/QuarterlyProviderUpdates/>. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Medicare data to calculate your primary service areas

The Centers for Medicare & Medicaid Services (CMS) has posted to its website Medicare data that allows applicants of the Medicare Shared Savings Program to calculate their share of services in each applicable primary service area (PSA), as described in the Federal Trade Commission/Department of Justice (FTC/DOJ) Proposed Antitrust Enforcement Policy Statement Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program at <http://www.ftc.gov/opp/aco/>. Data sets available include:

- Physician file – all physician fee-for-service claims for calendar year 2010 (1/1/2010-12/31/2010)
- Inpatient facility file – all Inpatient fee for service claims for Federal fiscal year (FY) 2010 (10/1/2009-9/30/2010)
- Outpatient facility file – all outpatient fee for service claims for calendar year 2010 (1/1/2010-12/31/2010)

Crosswalk files of inpatient and outpatient services treatment codes include:

- Crosswalk from ambulatory surgical center (ASC) Healthcare Common Procedure Coding System (HCPCS) codes to outpatient categories
- Crosswalk from ambulatory payment classifications (APCs) to outpatient categories
- Crosswalk from diagnosis-related groups (DRGs) to major diagnostic categories (MDCs)

To access this data, visit the CMS Shared Savings Program website at www.cms.gov/sharedsavingsprogram, select the “Medicare Data to Calculate Your Primary Service Area” tab, and scroll to the bottom of the page to the “Downloads” section.

For detailed instructions on how to use this data to calculate PSA shares, applicants should refer to the FTC/DOJ Policy Statement at <http://www.ftc.gov/opp/aco/>.

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Source: CMS PERL 201106-56

First quarter health outcomes results for DMEPOS competitive bidding

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program in nine different areas of the country.

Since program implementation, CMS has been conducting real-time claims analysis for groups of Medicare beneficiaries potentially affected by the program. CMS has now issued the 2011 first quarter DMEPOS Competitive Bidding Program health outcomes results, which show no significant changes in health outcomes for these groups. To view the results, please visit http://www.cms.gov/DMEPOSCompetitiveBid/01A3_Monitoring.asp.

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

Source: CMS PERL 201106-55

Letter from the CMS administrator posted to website

The Centers for Medicare & Medicaid Services (CMS) has posted online the Monday, June 20, letter from CMS Administrator, Donald M. Berwick, M.D., that highlights opportunities for providers, Medicare beneficiaries, and patients not covered by Medicare as a result of the Affordable Care Act. The letter was sent to Medicare fee-for-service providers by the Medicare administrative contractors (MACs) during the week of Monday, June 20, and can now be found at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp.

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

Source: CMS PERL 201106-51

Incentive Programs

Save the date: National provider call on Medicare and Medicaid EHR incentive programs

“Understanding Meaningful Use”

Thursday, August 18, 1:30-3:00 p.m. ET

Providers have received more than \$273 million in Medicare and Medicaid EHR incentive payments. You may be eligible for a payment, too. Join the Centers for Medicare & Medicaid Services (CMS) for a national provider call on the Medicare and Medicaid EHR incentive program meaningful use requirements.

Agenda:

- Defining “meaningful use”
- The requirements for stage 1 of meaningful use (2011 and 2012)
- Attestation for meaningful use
- Goals of the *Meaningful Use Objectives Specification Sheets*
 - [Stage 1 EHR Meaningful Use Specification Sheets for Eligible Professionals](#)
 - [Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals](#)
- A question and answer session

Registration information will be made available soon, and will be shared via Listserv announcement and the [Spotlight and Upcoming Events Page](#) of the EHR incentive programs website.

Source: CMS PERL 201107-40

Four new state Medicaid EHR incentive programs launched in July

On Monday, July 4, the Medicaid electronic health record (EHR) incentive program launched in Arizona, Connecticut, Rhode Island, and West Virginia. This means that eligible professionals and eligible hospitals in these four states will be able to complete their EHR incentive program registration at the state level and receive incentive payments. More information about the Medicaid EHR incentive program can be found on the [Medicare and Medicaid EHR incentive program basics](#) page of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you are a resident of Arizona, Connecticut, Rhode Island, or West Virginia and are eligible to participate in the Medicaid EHR incentive program, visit your state Medicaid agency website for more information on your state’s participation in the Medicaid EHR incentive program:

- [Arizona](#)
- [Connecticut](#)
- [Rhode Island](#)
- [West Virginia](#)

Twenty-one states have launched Medicaid EHR incentive programs, and 14 states have issued incentive payments to Medicaid-eligible professionals and eligible hospitals that have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launch of additional states’ programs in the coming months. For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the [Medicaid State Information](#) page on the CMS EHR website.

Want more information about the EHR incentive programs? Visit the [CMS EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs; also sign up for the [EHR incentive programs email update Listserv](#).

Source: CMS PERL 201107-26

CMS' attestation resources for electronic health records

Are you an eligible professional (EP) or eligible hospital participating in the Medicare electronic health record (EHR) incentive program? The Centers for Medicare & Medicaid Services (CMS) has resources to help you attest to having met meaningful use requirements in order to receive your EHR incentive payment.

Attestation resources located on the CMS EHR website include:

- An [Attestation page](#) on the CMS EHR website, where participants in the Medicare EHR incentive program can find important information on attestation.
- The [Meaningful Use Attestation Calculator](#) allows EPs and eligible hospitals to check whether they have met meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary.
- The [Attestation User Guide for Medicare Eligible Professionals](#) and the [Attestation User Guide for Eligible Hospitals](#) provide step-by-step guidance for EPs and eligible hospitals participating in the Medicare EHR incentive program on navigating the attestation system.
- Attestation worksheets for [EPs](#) and [eligible hospitals](#) allow users to fill out their meaningful use measure values, so they have a quick reference tool to use while attesting.
- An [Eligible Professional Medicare EHR Incentive Program Attestation Webinar](#), which is a video version of the user guides for EPs and walks viewers through how to complete the attestation process.

Attestation is currently open for all participants in the Medicare EHR incentive program. You can attest via [CMS' Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#).

Want more information about the EHR incentive programs?

Make sure to visit the [EHR incentive programs website](#) for the latest news and updates.

Source: CMS PERL 201107-46

Medscape modules available on CMS EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that through Medscape education, providers now have the opportunity to earn continuing medical education (CME) credits by learning more about the electronic health records (EHR) incentive programs.

On [Medscape's EHR Learning Center website](#), leading physician experts in medical informatics provide information, resources, and tools to help providers determine eligibility for the EHR incentive programs, understand the requirements for participating, take steps to participate, and recognize the immediate benefits of participation and future consequences of not participating.

By completing the module "From Meaningful Use to Meaningful Care," providers can earn CME credit while gaining a better understanding about the purpose of the EHR Incentive Programs, the stages of meaningful use, a timeline of key dates, and, most importantly, how patients will benefit.

Providers can also use the Medscape Learning Center to determine their comprehension of the EHR incentive programs by taking the "Medicare and Medicaid EHR Incentives: What Do You Know and Do You Know Enough?" participant self-assessment. By completing the assessment, providers can help to shape the

content of future CME activities to best address the educational and clinical performance gaps identified.

The site also offers interviews, in which physician EHR experts explain why it's important to register for the programs and the significance of EHRs to health care overall. Expert interviews include:

- Registering for the EHR Incentive Program – Ready, Set, Go: An Expert Interview With Jason M. Mitchell, M.D., and Richard Paula, M.D.
- Are You an Eligible Professional Who Hasn't Registered for the EHR Incentive Program? What Are You Waiting For? – An Expert Interview With William F. Bria II, M.D.

In the next few weeks, new CME modules on meaningful use will also be made available; look out for a message to announce these new learning resources. Membership on Medscape is free, but you must register to view content; you do not have to be a health professional.

Want more information about the EHR incentive programs?

Visit the [CMS EHR Incentive Programs website](#) for the latest news and updates; also sign up for the [EHR Incentive Programs email update Listserv](#).

Source: CMS PERL 201107-17

New FAQs posted to the EHR website

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with the latest information about the Medicare and Medicaid electronic health record (EHR) incentive programs. Fifteen new frequently asked questions (FAQs) on meaningful use, payment information for eligible hospitals, eligibility, and additional information for eligible hospitals have been added to the CMS website. Take a minute and review these new FAQs.

Payment information for critical access hospitals

- What cost report data elements are used in the EHR incentive payment calculation for Medicare subsection (d) hospitals? [Read the answer.](#)
- How are Medicare EHR incentive payments calculated for critical access hospitals (CAHs)? [Read the answer.](#)
- What costs can be included in the CAH's Medicare EHR incentive payment? [Read the answer.](#)

More new FAQs for critical access hospitals:

- [FAQ # 10716](#)
- [FAQ # 10719](#)
- [FAQ # 10721](#)
- [FAQ # 10722](#)
- [FAQ # 10723](#)
- [FAQ # 10724](#)
- [FAQ # 10725](#)
- [FAQ # 10726](#)
- [FAQ # 10727](#)



Meaningful use

- If my certified EHR technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Meaningful Use objective “submit electronic data to immunization registries” for the Medicare and Medicaid EHR incentive programs? [Read the answer.](#)
- If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion? [Read the answer.](#)

Eligibility

- How does CMS define pediatrician for purposes of the Medicaid EHR incentive program? [Read the answer.](#)

Want more information about the EHR incentive programs?

Make sure to visit the [CMS EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201107-33

New FAQ on payment for the Medicare EHR incentive program

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with information on the Medicare and Medicaid electronic health record (EHR) incentive programs. Take a minute and review CMS' new frequently asked question (FAQ) on receiving an incentive payment in the Medicare EHR incentive program.

Question: I am an eligible professional (EP) who has successfully attested for the Medicare EHR incentive program, so why haven't I received my incentive payment yet?

Answer: For EPs, incentive payments for the Medicare EHR incentive program will be made approximately four to eight weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year.

The Medicare EHR incentive payments to EPs are based on 75 percent of the estimated allowed charges for covered professional services furnished by the EP during the entire payment year. Therefore, to receive the maximum incentive payment of \$18,000 for the first year of participation in 2011 or 2012, the EP must accumulate \$24,000 in allowed charges. If the EP has not met the \$24,000 threshold in allowed charges at the time of attestation, CMS will hold the incentive payment until the EP meets the \$24,000 threshold in order to maximize the amount of the EHR incentive payment the EP receives. If the EP still has not met the \$24,000 threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March 2012 (allowing 60 days after the end of the 2011 calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic health professional shortage area (HPSA) will be made as separate lump-sum payments no later than 120 days after the end of the calendar year for which the EP was eligible for the bonus payment.

Want more information about the EHR incentive programs?

Make sure to visit the [CMS EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201106-47

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>

Important reminders about advanced diagnostic imaging accreditation requirements

Provider types affected

Physicians, non-physician practitioners, and independent diagnostic testing facilities (IDTF) who are suppliers of imaging services and submitting claims for the technical component (TC) of advanced diagnostic imaging (ADI) procedures to Medicare contractors [carriers and A/B Medicare administrative contractors (MACs)] are affected by this article.

What you need to know

Stop – impact to you

This article provides suppliers who furnish the technical component (TC) of ADI services assistance in meeting the accreditation requirements established in Section 135 (a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Caution – what you need to know

In order to furnish the TC of ADI services for Medicare beneficiaries, you must be accredited by January 1, 2012, to submit claims with a date of service on or after January 1, 2012.

Go – what you need to do

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

Background

What are the requirements for ADI accreditation?

The MIPPA required the Secretary of the Department of Health and Human Services to designate organizations to accredit suppliers that furnish the TC of ADI services.

- ADI procedures include magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, including positron emission tomography.
- The MIPPA expressly excludes X-ray, ultrasound, and fluoroscopy procedures.
- Suppliers of imaging services include, but are not limited to, physicians, non-physician practitioners, and IDTFs.

Who do the requirements affect?

The accreditation requirements apply only to the suppliers of the images themselves (TC) and not the physician's interpretation (professional component) of the image.

- The accreditation requirement applies to all suppliers of the TC who submit claims to Medicare.

- The accreditation requirement applies only to those suppliers of ADI paid under the Medicare physician fee schedule (MPFS).
- The accreditation requirements do not apply to ADI services furnished in a hospital outpatient setting.

When are the requirements mandatory?

In order to furnish the TC of ADI services for Medicare beneficiaries, you must be accredited by January 1, 2012, to submit claims with a date of service on or after January 1, 2012.

How do I comply with the requirements?

You should apply for accreditation now if you are not already accredited. Visit the "Advanced Diagnostic Imaging Accreditation Enrollment Procedures," available at <http://www.cms.gov/medicareprovidersupenroll> on the Centers for Medicare & Medicaid Services (CMS) website, and review each of the three designated accreditation organizations. Then,

- Call or email each of the accreditation organizations to determine the one that best fits your business needs. The accreditation organizations each have their own published standards.
- Follow all of the application requirements so that your application is not delayed. It may take up to five months to be accredited. So, you really must start now to be sure in meeting the January 1, 2012, date.

Who are the three national accreditation organizations approved by CMS?

The approved accreditation organizations are:

- The American College of Radiology;
- The Intersocietal Accreditation Commission; and
- The Joint Commission.

What are the quality standards that I must meet?

There are many quality standards, for which you must be in compliance, and you will need to show that compliance to the accreditation organization. The quality standards at a minimum address:

- Qualifications of medical personnel who are not physicians;
- Qualifications and responsibilities of medical directors and supervising physicians;

continued on next page

Imaging...continued

- Procedures to ensure that equipment used meets performance specifications;
- Procedures to ensure the safety of personnel who furnish the imaging;
- Procedures to ensure the safety of beneficiaries; and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity, and accuracy of the technical quality of the image.



What does the accreditation process consist of?

First, you are expected to complete the entire application prior to the accreditation organization commencing the review process. The length of the approval process depends on the completeness and readiness of the supplier.

- Make certain that you understand how to comply with each of the accreditation organizations quality standards.
- If you are non-compliant with any of the standards, you may be required to complete a corrective action plan, which will need to be approved and possibly require another site visit.

Make certain to review all of your ADI procedures to determine if you will need to be accredited.

- Accreditation is given at the facility for each modality that is supplied.
- The accreditation is not attached to the machine. If you purchase another machine within the same modality, it most likely will not require another accreditation decision.
- You must notify the accreditation organization after the initial accreditation decision of any changes to your facility.

The accreditation process may include:

- An un-announced site visit;
- Random site visits;

- Review of phantom images;
- Review of staff credentialing records;
- Review of maintenance records;
- Review of beneficiary complaints;
- Review of patient records;
- Review of quality data;
- Ongoing data monitoring; and
- Triennial surveys.

What else do I need to know?

Here are some helpful facts about the ADI accreditation:

- Hospitals are exempt from this requirement, since hospitals generally are not paid under the MPFS.
- The accreditation requirement does not apply to the radiologists, per se. However, the interpreting physicians must meet the accreditation organization's published standards for training and residency
- If you are accredited before January 1, 2012, by one of the designated accreditation organizations, you are considered to have met the accreditation requirement. However,
 - You must apply for reaccreditation if your accreditation is due to expire before this date, and
 - You must remain in good standing.
- The accreditation organization will transmit all necessary data to CMS on an ongoing basis. Your Medicare billing contractor will receive these data from CMS.
- The *Current Procedural Terminology (CPT)* codes that are affected by this requirement are published on the CMS website.
- **No suppliers are exempt.**
 - Oral surgeons and dentists must be accredited if they perform the TC of MRI, CT or nuclear medicine for the technical component of the codes that require ADI accreditation.
 - If your facility uses an accredited mobile facility, you, as a Medicare supplier billing for the TC of ADI, must also be accredited. The accreditation requirement is attached to the biller of the services.

What does it cost to be accredited?

The accreditation costs vary by accreditation organization. The average cost for one location and one modality is approximately \$3,500 every 3 years.

continued on next page

Imaging...continued

When will claims for Medicare services be affected?

Medicare contractors will begin denying claims for services on or after January 1, 2012, for modalities that are not accredited.

- Denial code N290 will be used (“Missing/incomplete/invalid rendering provider primary identifier.”)
- Contractors will deny codes submitted for the TC if the code is not listed as “accredited.”

Additional information

For more information about the enrollment procedures, see the *Medicare Learning Network*® (MLN) article MM7177, “Advanced Diagnostic Imaging Accreditation Enrollment Procedures,” available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7177.pdf>.

If you are a physician or non-physician practitioner supplying the TC of ADI, see the MLN article MM7176, “Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) Service,” available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7176.pdf>.

To obtain additional information about the accreditation process, please contact the accreditation organizations listed on the Medicare Provider-Supplier Enrollment page, Advanced Diagnostic Imaging Accreditation, available at http://www.cms.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp.

If you have any questions, please contact your 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: SE1122

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: Accreditation Date, January 1, 2012

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 proposes coverage of screening/counseling for alcohol misuse and screening for depression

The Centers for Medicare & Medicaid Services (CMS) has proposed to add alcohol screening and behavioral counseling, and screening for depression, to the comprehensive package of preventive services now covered by Medicare. These proposed national coverage determinations (NCDs) are issued under authority granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which allows CMS to add coverage of new preventive benefits that are recommended by the U.S. Preventive Services Task Force and are appropriate for Medicare beneficiaries.

Under the new proposals, Medicare would cover an annual alcohol misuse screening by a beneficiary’s primary care provider. The benefit would also include four behavioral counseling sessions per year if a beneficiary screens positive for alcohol misuse. Medicare would also cover an annual screening for depression in primary care settings that offer staff-assisted depression care, so beneficiaries can receive an accurate diagnosis, effective treatment, and follow-up.

Public comments are invited on today’s proposed decisions for 30 days. CMS will issue final coverage decisions later this year.

- The proposal for screening and counseling for alcohol misuse is available on the CMS website at: <https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%20and%20Behavioral%20Counseling%20Interventions%20in%20Primary%20Care%20to%20Reduce%20Alcohol%20Misuse&bc=ACAAAAAIAAA&NCAId=249&>
- The proposal for screening and counseling for depression is available on the CMS website at: <https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%20for%20Depression%20in%20Adults&bc=ACAAAAAIAAA&NCAId=251&>

Source: CMS PERL 201107-42

Autologous cellular immunotherapy treatment of metastatic prostate cancer

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 metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7431 regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. It is therefore reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)) effective for services performed on or after June 30, 2011.

Go – what you need to do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

Change request (CR) 7431 instructs that, effective for services performed on or after June 30, 2011, CMS concludes that the evidence is adequate to support the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

Medicare contractors will continue to process claims for PROVENGE® with dates of service on June 30, 2011, as they do currently when providers submit Not Otherwise Classified Healthcare Common Procedure Coding System (HCPCS) code(s) J3590, J3490 or C9273. HCPCS code C9273 will be deleted on June 30, 2011.

The new HCPCS code Q2043 will:

- Replace C9273 (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion);
- Be implemented in the July 2011 Update of Quarterly HCPCS Drug/Biological Code Changes (CR 7303 Transmittal R2227CP); see <http://www.cms.gov/transmittals/downloads/R2227CP.pdf>; and
- Have an effective date of July 1, 2011.



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Immunotherapy...continued

The ambulatory surgical center (ASC) payment system will be updated to reflect these coding changes, and these changes will be announced in the ASC quarterly update CR for July 2011.

Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one (1) treatment regimen in a patient’s lifetime, consisting of three (3) doses with each dose administered approximately two (2) weeks apart for a total treatment period not to exceed 30 weeks from the first administration.

The language given in the long descriptor of Provenge® that states “all other preparatory procedures” refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs associated with its administration. Thus contractors will not pay separately for any claims of routine costs associated with PROVENGE®, such as *Common Procedure Terminology (CPT) code 96365, “intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.”*

Note: For a local coverage determination by an individual MAC to cover PROVENGE® “off-label” for the treatment of prostate cancer, the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code must be either 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate). ICD-9 diagnosis code 233.4 may not be used for “on-label” coverage claims.

Coding and billing information

ICD-9 diagnosis coding

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9 code	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - the spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung – cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.
197.7	Malignant neoplasm of liver secondary – cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney - the spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow – cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland
198.82	Secondary malignant neoplasm of genital organs

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Immunotherapy...continued

Coding for off-label PROVENGE® services

At the discretion of the local Medicare administrative contractors, claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE® services must be billed with either ICD-10 code D075 (carcinoma in situ of prostate) or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 diagnosis coding

The appropriate ICD-10 code(s) that are listed below are for future implementation.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

Types of bill (TOB) and revenue codes

The applicable TOBs for PROVENGE® are: 12x, 13x, 22x, 23x, 71x, 77x, and 85x.

On institutional claims, TOBs 12x, 13x, 22x, 23x, and 85x, use revenue code 0636 – drugs requiring detailed coding.

Payment methods

Payment for PROVENGE® is as follows:

- TOBs 12x, 13x, 22x and 23x - based on the average sales price (ASP) + 6 percent,
- TOB 85x – based on reasonable cost,
- TOBs 71x and 77x – based on all-inclusive rate (drugs/supplies are not reimbursed separately).
- For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6 percent.

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Immunotherapy...continued

Note: Medicare contractors will not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.

Remittance advice remark codes (RARCs), claim adjustment reason codes (CARCs), and group codes

Medicare will use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table shown above:

- RARC 167 – this (these) diagnosis(es) are not covered. **Note:** Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code – contractual obligation (CO)

Medicare will use the following messages when denying line items on claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4 or 185:

- RARC 167 – this (these) diagnosis(es) are not covered. **Note:** Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code – CO.

When denying claims for PROVENGE®, HCPCS Q2043 that exceed three (3) payments in a patient's lifetime, contractors shall use the following messages:

- RARC N362 – the number of Days or Units of Service exceeds our acceptable maximum.
- CARC 149 – lifetime benefit maximum has been reached for this service/benefit category.
- Group code – CO.

When denying claims for PROVENGE®, HCPCS Q2043 that are provided more than 30 weeks from the date of the first PROVENGE® administration, contractors shall use the following messages:

- CARC B5 – coverage/program guidelines were not met or were exceeded.
- Group code – CO.

Additional information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the *National Coverage Determinations Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R133NCD.pdf>. The second updates the Medicare Claims Processing Manual and it is at <http://www.cms.gov/Transmittals/downloads/R2254CP.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>.

MLN Matters® Number: MM7431

Related Change Request (CR) #: CR 7431

Related CR Release Date: July 8, 2011

Effective Date: June 30, 2011

Related CR Transmittal #: R2254CP and R133NCD

Implementation Date: August 8, 2011

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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.

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Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **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

A70544: Magnetic resonance angiography (MRA) – revision to the LCD

LCD ID number: L28903 (Florida)

LCD ID number: L28925 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was most recently revised on October 1, 2010. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to add a “Limitations” section. The “CPT/HCPCS Codes” section of the LCD has also been revised to add a section, “HCPCS Codes that Do Not Support Medical Necessity.” This notification serves as a 45-day notice that the procedures represented by the HCPCS codes listed in this section (i.e., C8931 – C8936) are not considered medically reasonable and necessary.

Effective date

This LCD revision is effective for services provided **on or after September 12, 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.

Additional Information

J3095: Vibativ (telavancin) – clarification on billing

Vibativ is a lipoglycopeptide antibacterial indicated for the treatment of adult patients with complicated skin and skin structure infections caused by susceptible Gram-positive bacteria. The Food and Drug Administration (FDA) label lists the following Gram-positive microorganisms that are susceptible isolates of vibativ: staphylococcus aureus (including methicillin-susceptible and resistant isolates), streptococcus pyogenes, streptococcus agalactiae, streptococcus anginosus group (includes s. anginosus, s. intermedius, and s. constellatus), or enterococcus faecalis (vancomycin-susceptible isolates only). In the absence of local coverage determinations, national coverage determinations or specific Medicare manual language, coverage of drugs is generally limited to the indications outlined on the FDA approved label. The MAC J9 considers the following ICD-9-CM diagnosis codes as consistent with the FDA approved indications. The medical record must support that the service is reasonable and necessary for the given patient.

ICD-9-CM codes to be considered for complicated skin or wound infection: 680.0-682.9, 707.00-707.09, 707.10-707.19, 707.8, 707.9, 872.10-872.11, 873.1, 873.50-873.59, 873.9, 875.1, 876.1, 877.1, 879.1, 879.3, 879.5, 879.7, 879.9, 880.10-880.13, 880.19, 881.10-881.12, 882.1, 883.1, 884.1, 890.1, 891.1, 892.1, 893.1, or 894.1

ICD-9-CM codes to report the Gram-positive microorganism: 041.01, 041.02, 041.04, 041.05, 041.10, 041.11, 041.12, or 041.19

According to the 2011 ICD-9-CM book, the disease being treated should be reported first, then the bacterium. It is expected that these diagnosis codes are reported on the same claim and in the situation where they are not billed together on the same claim, the claim will be denied. Per ICD-9-CM guidelines, diagnosis codes are to be used to their highest number of digits available, and can be clearly supported in review of the medical record. As a reminder, medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration.

Delayed implementation of X12N version 5010 paperwork segment

The Centers for Medicare & Medicaid Services (CMS) is delaying the implementation of the paperwork (PWK) segment associated with the X12N version 5010 837 professional and institutional electronic claim transaction originally scheduled for July and October 2011. This means Medicare billers will continue to submit additional documentation needed for claims adjudication following the existing process established by their Medicare claims administration contractor.

CMS will give Medicare billers ample notice before implementing change requests (CR) 7041 and 7306, which change how additional documentation for claims adjudication is submitted. For additional information related to CR 7041 and 7306, please refer to the *MLN Matters* articles associated with these CRs:

- <http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf>
- <http://www.cms.gov/MLNMattersArticles/downloads/MM7306.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 201107-09

Act now to prepare for transition to version 5010

The version 5010 transition is less than six months away for all HIPAA covered entities. This means that to submit transactions electronically, all covered entities must upgrade from version 4010/4010A to version 5010. Unlike version 4010, version 5010 accommodates the new ICD-10 medical code sets and the transition to 5010 is a required preliminary step for the use of ICD-10 codes.

You should conduct internal and external 5010 transaction testing within your organization and with your billing partners – including payers, vendors, clearinghouses, and providers – before the January 1, 2012, compliance deadline. External testing should take place now in order to make sure that you are able to send and receive compliant transactions effectively. Testing now will help identify any potential issues that may arise and allow the necessary time to address them.

The [ICD-10 page](#), located on CMS' website, has resources to support providers, payers, and vendors as they make the transition to version 5010 and ICD-10.

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 201107-47

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>.

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

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



Announcements

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

Reminders

[Versions 5010 & D.0 FAQs Now Available!](#)
[National Testing Day Message Now Available!](#)
[5010/D.0 Errata requirements and testing schedule can be found here](#)
[Contact your MAC for their testing schedule](#)

Readiness assessment

[Have you done the following to be ready for 5010/D.0.?](#)
[What do you need to have in place to test with your Medicare administrative contactor \(MAC\)?](#)
[Do you know the implications of not being ready?](#)

Implementation calendar

Current events

July 2011

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

Upcoming events

August 2011

August 24: National MAC testing day

August 31: CMS-hosted Medicare fee-for-service national call – MAC panel questions & answers

September 2011

September 14: CMS-hosted Medicare fee-for-service national call – question & answer session

October 2011

October 5: MAC hosted outreach and education session – last push for implementation

October 24-27: [WEDI 2011 fall conference](#) *

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](#)

June 30: [5010 national call – 837 institutional claim transaction](#)

July 2010

July 28: [5010 national call – 276/277 claim status inquiry and response transaction set](#)

August 2010

August 25: [5010 national call – 835 remittance advice transaction](#)

September 2010

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

continued on next page

Calendar...continued

October 2010

October 13: [5010/D.O. errata requirements and testing schedule released](#)

October 27: [5010 national call – NCPDP version D.O. transaction](#)

November 2010

November 4: [Version 5010 resource card published](#)

November 8: [WEDI 2010 fall conference *](#)

November 17: [5010 national call – coordination of benefits \(COB\)](#)

December 2010

December 8: [5010 national call – MAC outreach and education activities and transaction-specific testing protocols](#)

January 2011

January 1: Beginning of transition year

January 11: [HIMSS 5010 industry readiness update *](#)

January 19: [5010 national call – errata/companion guides](#)

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

February 2011

February 20-24: [Healthcare Information and Management Systems Society \(HIMSS\) 11th Annual Conference & Exhibition *](#)

March 2011

March 1: New readiness assessment – [Do you know the implications of not being ready?](#)

March 30: [CMS-hosted 5010 national call – provider testing and readiness .](#)

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 *](#)

May 25: [Medicare fee-for-service national call – call to action -- test](#)

June 2011

June 15: National MAC Testing Day

June 29: CMS-hosted Medicare fee-for-service national call – question & answer session

For older national call information, visit the [5010 National Calls section of CMS' versions 5010 & D.O. Web page](#)

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

Source: CMS PERL 201107-10

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.

Ordering physician spinal orthotic comparative billing report released

In July, the Centers for Medicare & Medicaid Services (CMS) released a national provider comparative billing report (CBR) centered on physicians ordering spinal orthotic devices billed to Medicare. The CBRs was released to approximately 5,000 ordering physicians nationwide.

The CBRs, produced by SafeGuard Services under contract with CMS, provide comparative data on how an individual health care provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

These reports are not available to anyone but the provider who receives them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients.

For more information and to review a sample of the spinal orthotic CBR, please visit the CBR Services website at <http://www.CBRservices.com> or call the SafeGuard Services provider help desk, CBR support team at 530-896-7080.

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

Source: CMS PERL 201107-24

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

Note: This article was revised on July 5, 2011, to reflect the revised change request (CR) 7397 issued on July 1. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same.

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 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

continued on next page

Pharmacy...continued

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 on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Transmittals/downloads/R2251CP.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 Revised
 Related Change Request (CR) #: 7397
 Related CR Release Date: July 1, 2011
 Effective Date: August 15, 2011
 Related CR Transmittal #: R2251CP
 Implementation Date: August 15, 2011

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“Place of Service Codes” on the CMS website

A new section for the *Place of Service Codes* is now available on the Centers for Medicare & Medicaid Services (CMS) website. This section is located under the “Coding” category on the Medicare tab of the CMS website at <http://www.cms.gov/place-of-service-codes/>. From that section, you can access a print-friendly version of the “*Place of Service Codes for Professional Claims*” document. This document is also available in the Downloads section on the following two Web pages: *HCPSC General Information* and *Physician Fee Schedule - Overview*. This *Place of Service Codes* section was formerly located on the Medicaid website.

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

Source: CMS PERL 201107-34

Annual update of ICD-9-CM effective October 1

Provider types affected

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

Provider action needed

This article, based on change request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) update that is effective for the dates of service on and after October 1, 2011 (effective for discharges on or after October 1, 2011, for institutional providers). Please be sure to inform your staffs of these updates.

Background

ICD-9 information

The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised and discontinued ICD-9-CM diagnosis codes annually at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd.htm> on the Internet. The NCHS will post the new ICD-9-CM Addendum on their website in June. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

International Classification of Diseases, Tenth Revision (ICD-10) information

CMS has posted a list of 2011 ICD-10-CM code descriptions in tabular order (the order they appear in the code book) at http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp on the CMS website. The 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. In addition, a list of 2012 ICD-10-PCS codes is at http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp on the CMS site. The 2012 ICD-10-CM list should be posted later this year and its posting will be conveyed via Listserv notices.



Additional information

The official instruction, CR 7454, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2246CP.pdf>.

If you have any questions, please contact your FI, RHHI, 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: MM7454
Related Change Request (CR) #: 7454
Related CR Release Date: June 24, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2246CP
Implementation Date: October 3, 2011

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Now available – presentations from May ICD-10 national provider call

The Centers for Medicare & Medicaid Services (CMS) has released four podcasts and a video slideshow presentation of the May 18, 2011, national provider call on “CMS ICD-10 Conversion Activities, Including a Lab Case Study.”

Did you miss the May 18 ICD-10 national provider call? The entire presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio and captioning.

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone.

- Podcast 1 of 4: Welcome and ICD-10 Overview
- Podcast 2 of 4: Case Study on Translating the Lab NCDs
- Podcast 3 of 4: ICD-10 Updates from CMS Subject Matter Experts
- Podcast 4 of 4: Question and Answer Session

The podcasts, slideshow presentation, and written transcripts are now available on the CMS website at <http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998>.

The four audio podcasts with corresponding written transcripts, as well as the full written transcript of the call can be accessed by scrolling to the “Downloads” section at the bottom of the page. To access the video slideshow presentation, select the link in the “Related Links Outside CMS” 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 201107-20

Learn the secrets to billing Medicare correctly

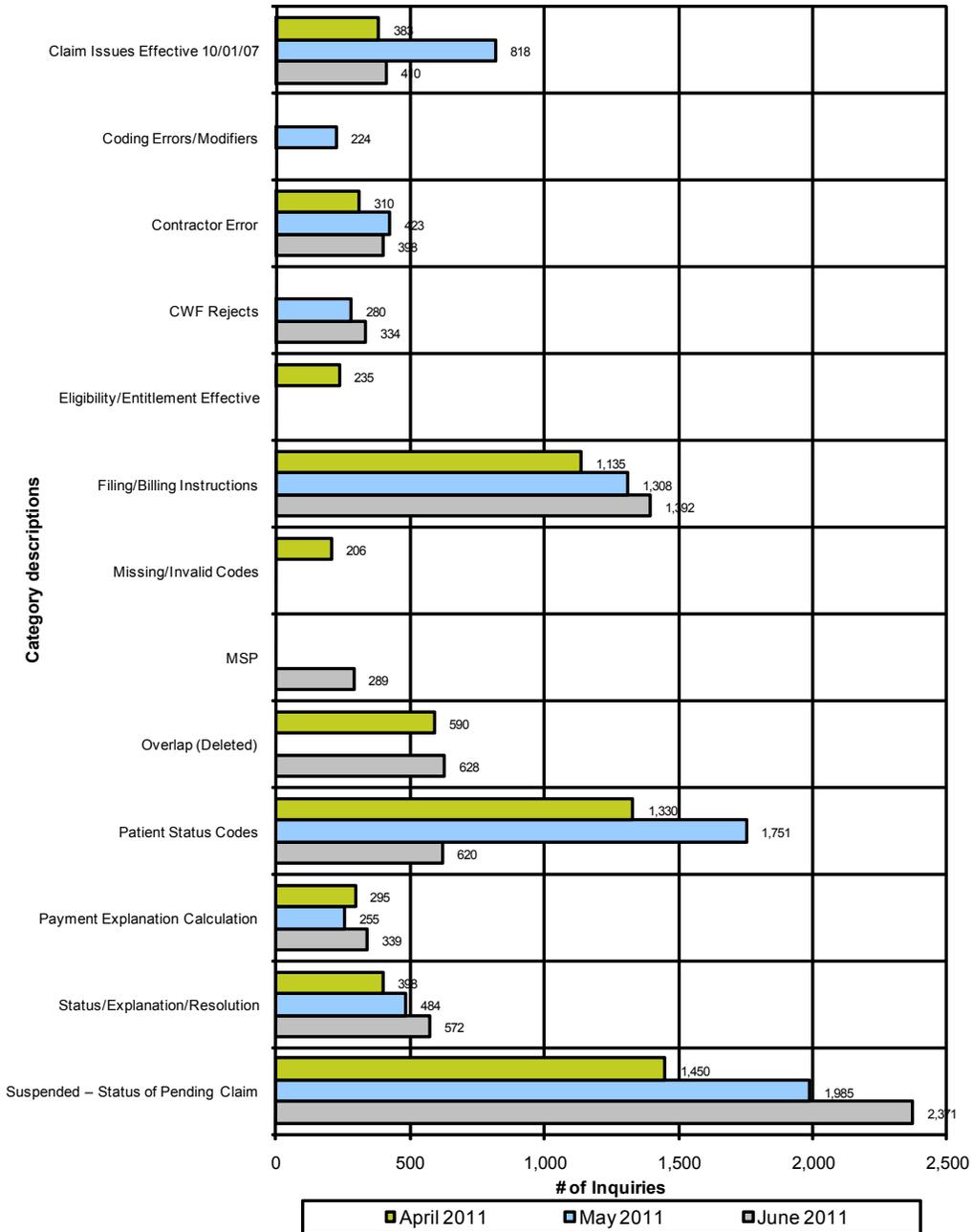
Who has the power to improve your billing accuracy and efficiency? You do -- visit the *Provider self-audit resources* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly -- the first time. You'll find FCSO's most popular self-audit resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

Top inquiries, rejects, and return to provider claims – April-June 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 April-June 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.

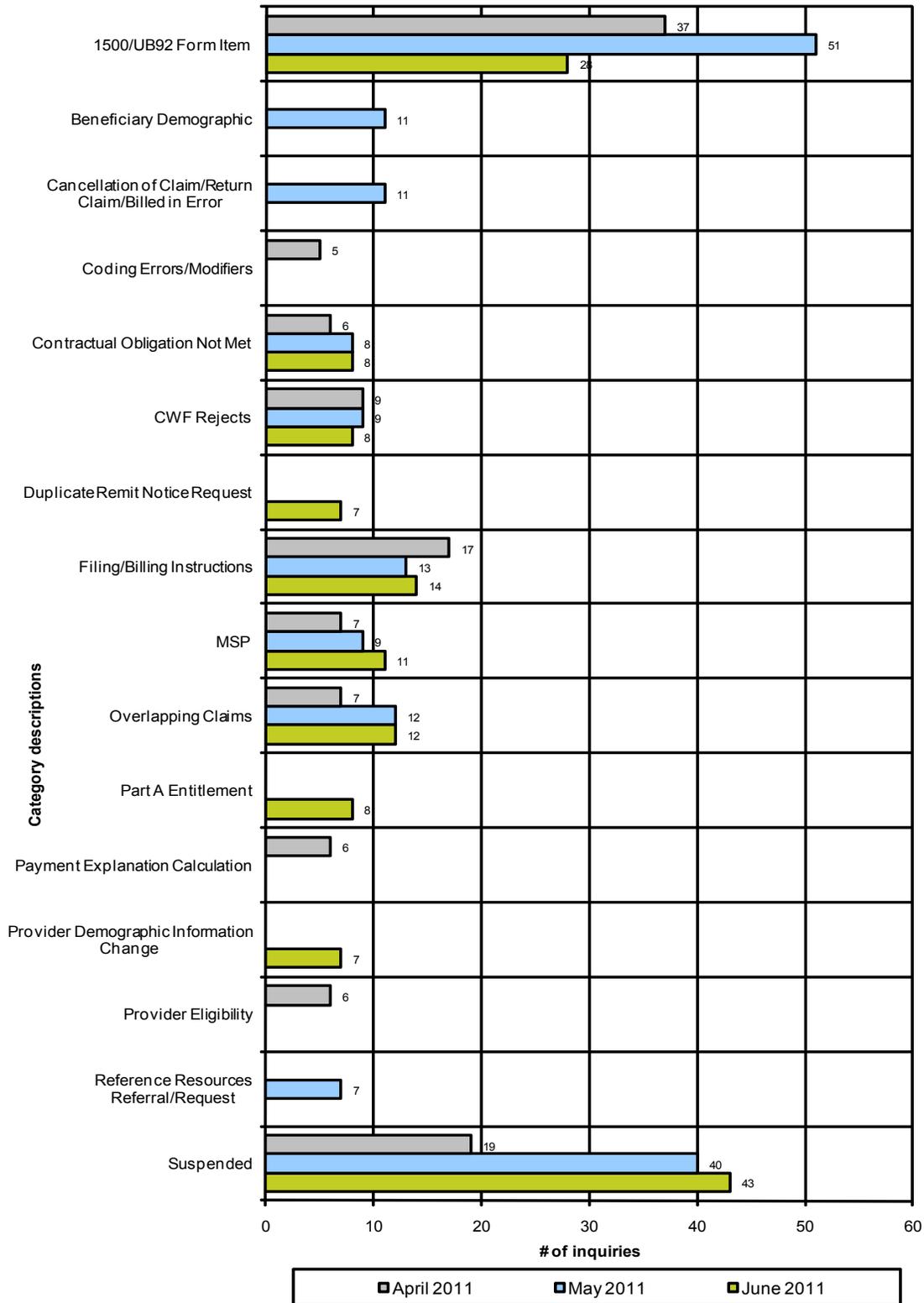
Florida Part A top inquiries for April-June 2011



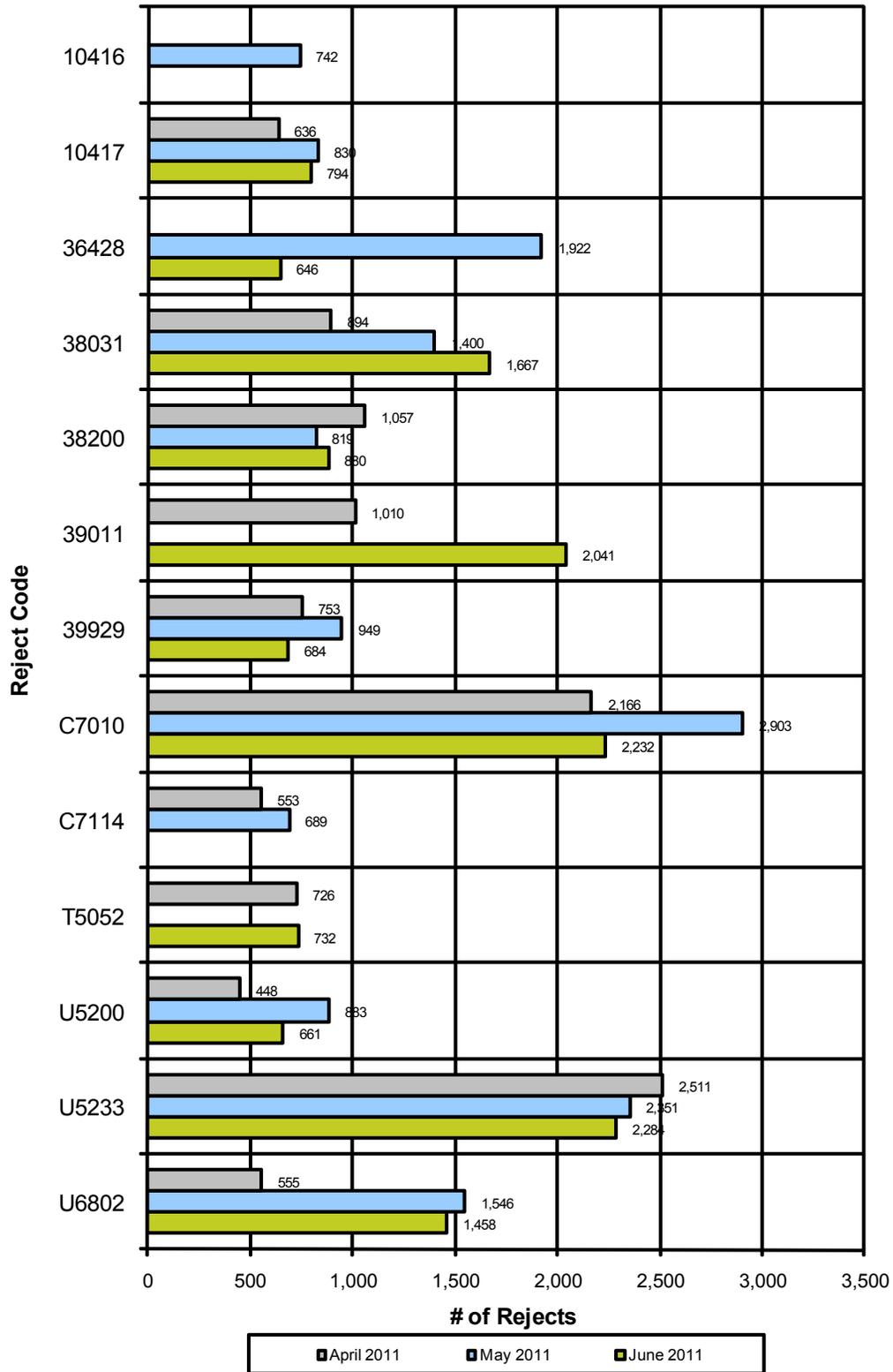
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Inquiries...continued

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



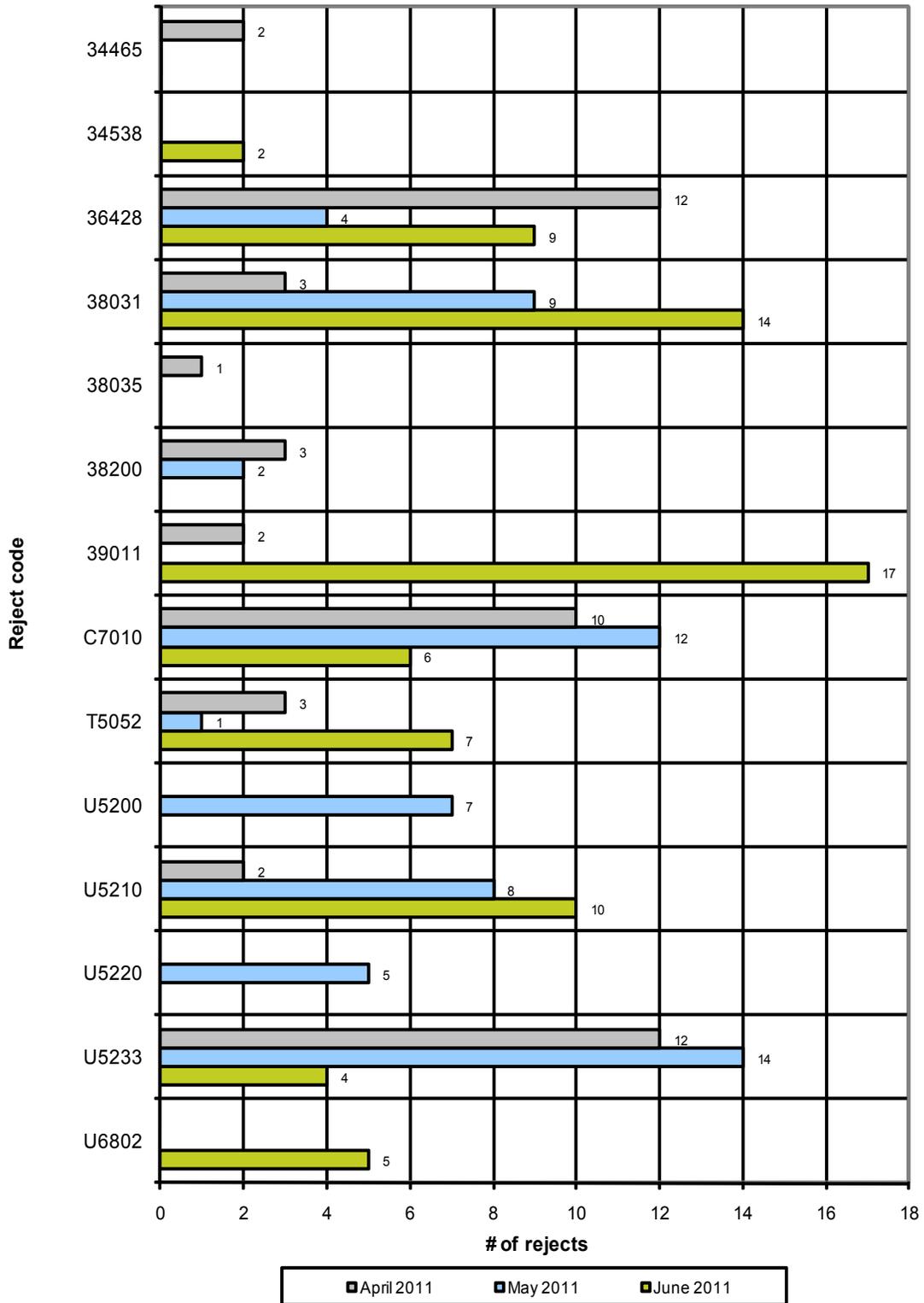
Florida Part A top rejects for April-June 2011



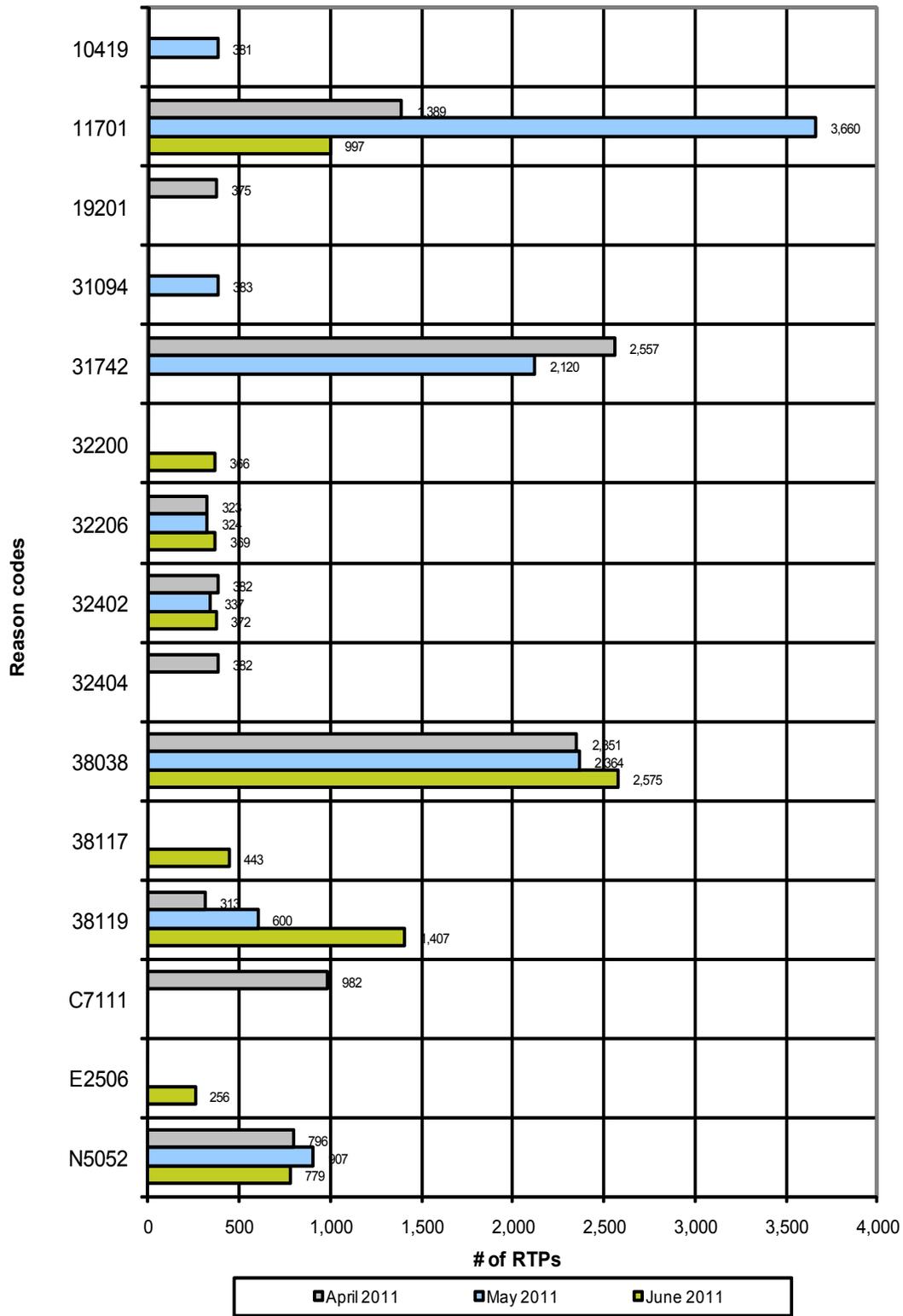
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Rejects...continued

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



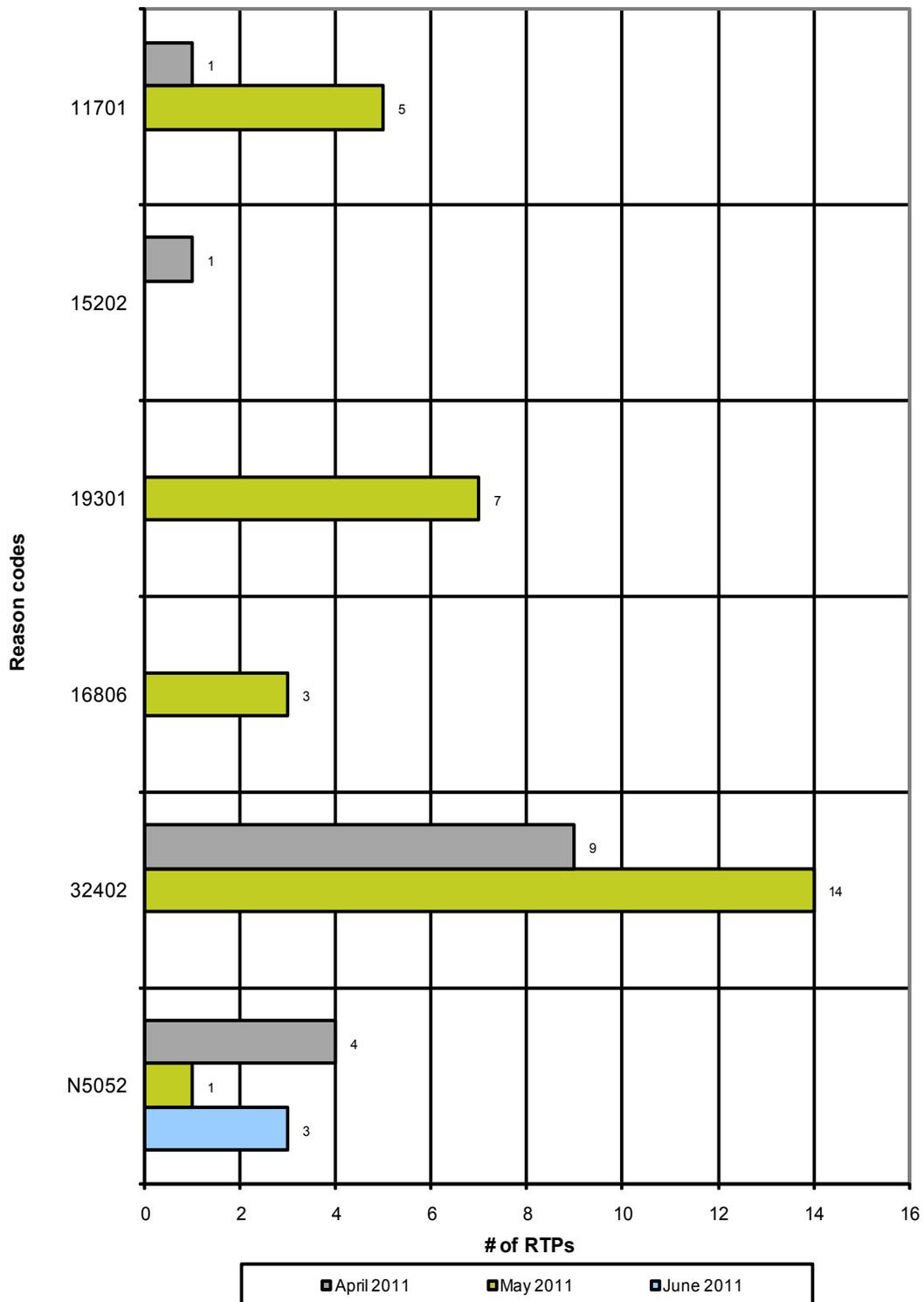
Florida Part A top return to providers (RTPs) for April-June 2011



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RTPs...continued

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



Proposed policy and payment changes for outpatient care in hospitals and ambulatory surgical centers

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2012. The proposed rule would continue to emphasize the importance of ensuring that beneficiaries receive high quality care without regard to the setting in which that care is provided.

The proposed rule also contains proposals that would strengthen the Hospital Value-Based Purchasing (HVBP) Program. The HVBP program, which was required by the Affordable Care Act of 2010, will tie a portion of a hospital's payment for inpatient stays under the inpatient prospective payment system in fiscal year (FY) 2014 to its performance score on a set of quality measures. CMS issued a final rule establishing this program in April of this year.

CMS is also proposing changes to the Medicare Electronic Health Record Incentive Program that would allow eligible hospitals and critical access hospitals (CAHs) to report clinical quality measures for 2012 by participating in an electronic reporting pilot.

The proposed rule would continue to strengthen the Hospital Outpatient Quality Reporting Program and for the first time establish a quality reporting program for ASCs.

Finally, the proposed rule would implement certain provisions in the Affordable Care Act affecting the expansion of physician-owned hospitals. The Affordable Care Act narrows access to the "rural provider" and "whole hospital" exceptions, in part by limiting the ability of existing physician-owned hospitals to expand their capacity. However, the Affordable Care Act also requires CMS to create a process for certain

physician-owned hospitals to apply for an exception to the prohibition on expansion of facility capacity. The proposed exception process for expanding a physician-owned hospital's facility capacity mirrors the statutory criteria.

Read the entire CMS press release at http://www.cms.gov/apps/media/press_releases.asp.

Also, for additional information please see the CMS fact sheets at http://www.cms.gov/apps/media/fact_sheets.asp and the OPPTS/ASC Rule at *Federal Register* at http://www.ofr.gov/OFRUpload/OFRData/2011-16949_PI.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 201107-04



2011 OPPTS Pricer file update now available

The July 2011 update for outpatient provider data is now available for download from the outpatient prospective payment system (OPPTS) Pricer Web page. Users may now access the July provider data update at <http://www.cms.gov/PCPricer/OutPPS/list.asp> by selecting 2011, and then downloading "3rd Quarter 2011 Files" from the OPPTS Pricer Web page.

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

Source: CMS PERL 201107-43

Adjustment of therapy claims subject to 2010 Medicare physician fee schedule changes

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

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims are being reprocessed. We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

We have previously advised providers that, in the majority of cases, they will not have to request adjustments because Medicare claims administration contractors will automatically reprocess claims, and that remains the case. However, there have been situations where the original claim for a service subject to the therapy cap as per *Internet Only Manual* 100-04, Chapter 5, Section 10.2 (<http://www.CMS.gov/manuals/downloads/clm104c05.pdf>) was processed without a KX modifier, presumably because the beneficiary had not yet reached the therapy cap and, therefore, no KX modifier was necessary. When processing adjustments for such claims, Medicare contractors have found that the therapy cap was often subsequently reached, causing the adjustment claim to be rejected, and in some cases for the original claim to be subject to overpayment recovery.

In order to prevent this, contractors will not be automatically processing Affordable Care Act adjustments on claims for services subject to the therapy cap. If you performed services subject to the therapy cap between Friday, January 1 and Monday, May 31, 2010, and if you believe you are entitled to an additional payment as a result of the change to the fee schedule in that year, then you will need to request that your Medicare contractor reopen those claims in order to receive the adjustment. When doing so, you should also indicate which of those services would have been subject to the KX modifier if the therapy

cap had been reached when the original claim was processed. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, CMS believes that these circumstances fall under the “good cause” criteria described in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 34, Section 10.11 (<http://www.CMS.gov/manuals/downloads/clm104c34.pdf>). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Contractors will not be automatically processing adjustments on claims for services subject to the therapy cap; you must request an adjustment.

In some cases the Medicare contractor may generate an adjustment claim without the provider requesting it and either return it to the provider (RTP) or deny it. If you receive such a notice, believe you are entitled to an adjustment, and want to pursue the matter, you should contact the Medicare contractor and request it be reopened. You should also indicate whether the service would have qualified for the KX modifier.

The Centers for Medicare and Medicaid Services wants to remind physicians, practitioners, and other providers impacted by the retroactive increases in payment rates by the Affordable Care Act and the 2010 MPFS changes of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. The policy may be found by visiting http://oig.HHS.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf.

Please contact your Medicare claims administration contractor with any questions about this information.

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

Source: CMS PERL 201107-19

July 2011 quarterly provider specific file update

The July 2011 quarterly provider specific files (PSF), which include SAS data files and text data files, are now available on the Centers for Medicare & Medicaid Services website.

- The SAS data files are available at http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp in the Downloads section.
- The text data files are available on the CMS website at http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp in the Downloads section.

If you use the provider specific text or SAS file data, please go to the respective page above and download the latest version of the PSF files.

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

Source: CMS PERL 201107-29

Inpatient Psychiatric Facility Prospective Payment System fact sheet revised

The *Inpatient Psychiatric Facility Prospective Payment System* fact sheet has been revised (June 2011) and is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/InpatientPsychFac.pdf>. This fact sheet is designed to provide education on the inpatient psychiatric facility prospective payment system (IPF PPS), including background, coverage requirements, how payment rates are set, and the rate year 2012 update to the IPF PPS.

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

Source: CMS PERL 201106-49

CMS proposes 2012 Medicare home health payment changes

Separate *Federal Register* filing for Medicaid home health services proposed to unify Affordable Care Act provisions

The Centers for Medicare & Medicaid Services (CMS) announced a number of proposed changes to Medicare home health payments for 2012 that, if finalized, will promote greater efficiency and payment accuracy.

A proposed rule was displayed at the *Federal Register* on July 5, 2011, proposing a 3.35 percent decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2012. This would be an estimated net decrease of \$640 million compared to HHA payments in CY 2011. It would include the combined effects of market basket and wage index updates (a \$310 million increase) and reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are largely related to billing practices and not related to changes in the health status of patients (a \$950 million decrease).

Provisions of the Affordable Care Act (ACA) mandate that CMS apply a one (1) percentage point reduction to the CY 2012 home health market basket amount; this would equate to a proposed 1.5 percent update for HHAs next year. As part of the HH PPS rate update, CMS also proposes to reduce HH PPS rates by 5.06 percent in CY 2012 to account for the increase in the case-mix that is unrelated to changes in patient acuity.

The Medicare HHA proposed rule would also make structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

“CMS’s proposal reflects our commitment to ensure that we pay accurately for Medicare home health services as we improve the structure of our payment system and decrease incentives for upcoding,” said Jonathan Blum, Deputy Administrator and Director of the Center for Medicare.

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Home health...continued

Medicare pays home health agencies through a prospective payment system (PPS), which pays at higher rates to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians; such data are currently required from all Medicare-participating home health agencies (HHAs).

Home health payment rates have been updated annually by either the full home health market basket percentage increase, or by the home health market basket percentage increase as adjusted by Congress. CMS uses the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services. The Deficit Reduction Act of 2005 requires an adjustment to the home health market basket percentage update depending on HHAs submission of quality data. The proposed home health market basket increase for CY 2012 is 1.5 percent. HHAs that submit the required quality data would receive payments based on this full home health market basket update. If an HHA does not submit quality data, the home health market basket percentage increase would be reduced by 2 percentage points to -0.5 percent for CY 2012.

The proposed home health market basket increase for CY 2012 is 1.5 percent.

Under current Medicare policy a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. In the proposed rule filing, Medicare has proposed to add flexibility to allow physicians who attended to a home health patient in an acute or post-acute setting to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

In a separate proposed rulemaking filed (CMS-2348-P), CMS would require comparable face-to-face (F2F) encounters for people receiving Medicaid home health services to adhere to the unifying nature of these provisions made under the ACA.

To qualify for the Medicare home health benefits, a beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical or speech therapy, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare-approved home health agency. Beneficiaries receiving Medicaid home health do not need to be homebound or require skilled care. Home health agencies participating in the Medicaid program must also adhere to Medicare conditions of participation.

Cindy Mann, director of CMS' Center for Medicaid, CHIP and Survey & Certification, said the alignment of F2F encounter requirements between the two CMS programs fulfills Section 6407 of the Affordable Care Act. "We established the Medicaid implementation of this requirement to align with Medicare's guidance to better facilitate home health services provided to individuals that are eligible for Medicare and Medicaid and to lessen the administrative burden on providers participating in both programs" Mann said.

This Medicaid regulation also clarifies long-standing CMS policy on locations and facilities in which home health services may be provided, in order for states to remain in compliance with the Olmstead Supreme Court decision.

The proposed rules went on display at 4:00 p.m. on July 5, 2011, at the *Federal Register*. The rule can be located at <http://federalregister.gov/inspection.aspx>.

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

Source: CMS PERL 201107-08

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Laboratory demonstration for certain complex diagnostic tests

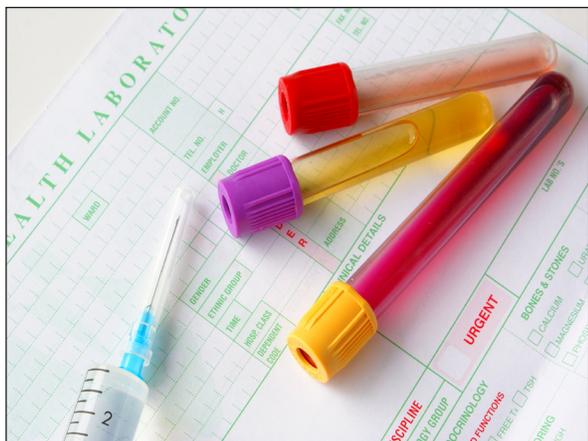
Note: This article fully rescinds and replaces MM7413. This information was previously published in the June 2011 *Medicare A Connection*, pages 56-57.

Provider types affected

Clinical laboratories and hospitals 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) 7516 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

Section 3113 of the Affordable Care Act requires CMS to conduct a demonstration under Part B, title XVIII of the Social Security Act (the Act) for 2 years subject to a \$100 million total payment limit. This demonstration will allow a separate payment to laboratories performing certain complex laboratory tests billed with a date of service that would, under standard Medicare rules (at 42 CFR 414.510(b)(2)(i)(A)), be bundled into the payment to the hospital or critical access hospital (CAH). Payment under the demonstration begins January 1, 2012. Once the demonstration has ended, payment for these tests will be made under the existing non-demonstration process.

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).

Section 3113(a)(3) defines separate payment as “direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act [(the Act)] by reason of Sections 1862(a)(14) and 1866(a)(1)(H) (i)” of the Act. In general terms, Sections 1862(a)(14) and 1866(a)(1)(H) of the Act state that no Medicare payment will be made for non-physician services, such as diagnostic laboratory tests, furnished to a hospital or CAH patient unless the tests are furnished by the hospital or CAH, either directly or under arrangement.

The Date of Service (DOS) rule at 42 CFR 414.510(b)(2)(i)(A) defines the date of service of a clinical laboratory test as the date the test was performed only if a test is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital or CAH. When a test is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital, the hospital or CAH must bill Medicare for a clinical laboratory test provided by a laboratory and the hospital or CAH would in turn pay the laboratory if the test was furnished under arrangement. Under the demonstration, a laboratory may bill Medicare directly for a complex clinical laboratory test which is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital or CAH.

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Laboratory...continued

Laboratories choosing to directly bill Medicare under this demonstration must submit a claim with a Project Identifier 56. 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. 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.

Laboratories shall 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. Claims billed for this demonstration cannot include non-demonstration services on the same claim/bill.

All test codes included in this demonstration will be on the “Section 3113 Demonstration Fee Schedule (also referred to or known as the Demonstration Test List).” This fee schedule will be used to pay for test codes included in the demonstration and billed using the demonstration project identifier 56. Participation in this demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule (or Test List). 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.

All other Medicare rules for adjudicating laboratory claims continue to apply. For the purpose of CR 7516, the period of the two-year demonstration period is effective for dates of service between January 1, 2012 and December 31, 2013.

Additional information

The official instruction, CR 7516, was issued in two transmittals to your FI, carrier and/or A/B MAC. The first transmittal updates the *Demonstrations Manual* and is at <http://www.cms.gov/Transmittals/downloads/R78DEMO.pdf>. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R2261CP.pdf>.

If you have any questions, please contact your FI, carrier 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: MM7516

Related Change Request (CR) #: 7516

Related CR Release Date: July 29, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R78 DEMO and R2261CP
Implementation Date: January 3, 2012

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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.

Prompt payment interest rate revision

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

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

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

Interest is not paid on:

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

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

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



Reopening requests for certain claims to be reprocessed under the Affordable Care Act no longer being accepted

In May 2011, First Coast Service Options (FCSO) began accepting fax requests for reopenings of claims with dates of service in January-May 2010 to be reprocessed under the Affordable Care Act (ACA). Since that time, mass adjustments have been executed that automatically reprocess claims where the billed amount was greater than the new (post-ACA) allowances. To reduce workloads and costs associated with manually reprocessing faxed requests, the Centers for Medicare & Medicaid Services (CMS) has authorized contractors to stop performing manual reopening of those claims that are scheduled to be mass-adjusted.

Therefore, **effective July 15, 2011**, FCSO will no longer accept fax reopenings of claims where the original amount submitted was sufficient to allow mass adjustments to provide additional moneys due as a result of the ACA changes.

Providers continue to be required to request a reopening for claims containing services where the original amount submitted was less than the new ACA allowance, indicating that the billed amount should be increased to at least the new payment rate.

For additional information concerning the ACA fee changes and the national reprocessing effort, see [Claims reprocessing questions and answers](#).

Source: TDL 11371

Payment update and CWF editing for influenza and pneumococcal vaccines codes

Note: This article was revised on July 1, 2011, to reflect the revised change request (CR) 7128 issued on May 5, 2011. The article was revised to reflect the new CR transmittal number and release date. Also, the Web address for accessing CR 7128 was revised. All other information is the same. This information was previously published in the March 2011, *Medicare A Bulletin*, page 18.

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs) for Medicare beneficiaries receiving influenza vaccines or pneumococcal vaccines (PPVs) are affected.

What you need to know

The influenza virus vaccine Healthcare Common Procedure Coding System (HCPCS) code 90662 (*influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*) and PPV HCPCS code 90670 (*pneumococcal conjugate vaccine, 13 valent, for intramuscular use*) are being added to existing edits to prevent payment duplication for claims processed on or after July 5, 2011. Make sure your coding and billing staff is aware of this change.

Background

In order to prevent duplicate payments for influenza virus vaccine and PPV claims by the same contractor, the Centers for Medicare & Medicaid Services (CMS) has implemented a number of edits that were effective for claims received on or after July 1, 2002.

CR 7128 provides instructions for payment and common working file (CWF) edits to be updated to include influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 for claims processed on or after July 5, 2011.

Basis for influenza vaccine and PPV payments

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to hospitals (types of bill (TOB) 12x and 13x), skilled nursing facilities (SNFs) (TOBs 22x and

23x), home health agencies (HHAs) (TOB 34x), hospital-based renal dialysis facilities (RDFs) (TOB 72x), and critical access hospitals (CAHs) (TOB 85x) is based on reasonable cost;

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to Indian Health Service (IHS) hospitals (TOB 12x, 13x) and HIS CAHs (TOB 85x) is based on 95 percent of the average wholesale price (AWP); and
- The payment for influenza virus vaccine HCPCS code 90662 and PPV code 90670 to comprehensive outpatient rehabilitation facilities (TOB 75x) and independent RDFs (TOB 72x) is based on the lower of the actual charge or 95 percent of the average wholesale price.

Contractors will not search their files to either retract payment for claims already paid or retroactively pay claims. However, they will adjust claims brought to their attention.

Additional information

The official instruction, CR 7128 issued to your carrier, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2212CP.pdf>.

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

MLN Matters® Number: MM7128 Revised
 Related Change Request (CR) #: 7128
 Related CR Release Date: May 5, 2011
 Effective Date: October 1, 2010
 Related CR Transmittal #: R2212CP Implementation Date: July 5, 2011

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

Fiscal year 2012 IPPS proposed rule wage index and outmigration adjustment corrections

The Centers for Medicare & Medicaid Services (CMS) has become aware that an error was made in the calculation of the wage index outmigration adjustment in Table 4J of the fiscal year (FY) 2012 IPPS-LTCH PPS proposed rule (CMS-1518-P), posted on the CMS Web site at <http://www.cms.gov/AcuteInpatientPPS/IPPS2012/list.asp>. The correction of this error results in an additional 104 providers being eligible for the outmigration adjustment in the FY 2012 proposed wage index. For a provider that is newly eligible for the adjustment and is not reclassified in the proposed wage index (under Sections 1886(d)(8) or (d)(10) of the Social Security Act (the Act)), the correction to the outmigration adjustment also changes the provider's FY 2012 wage index value listed on Table 2.

Since these changes could affect hospitals' geographic reclassification decisions for FY 2012, CMS is providing immediate notification of the corrections to Tables 2 and 4J of the FY 2012 IPPS/LTCH PPS proposed rule and a brief extension of the 45-day deadline of §412.273 (referenced at 75 FR 25881) for hospitals to terminate or withdraw 1886(d)(10) reclassifications as well as the 45-day deadline (referenced at 75 FR 25887) for a hospital to receive the out-migration adjustment rather than their Section 1886(d)(8)(B) redesignation. A discussion of the corrections will be included in a [correction notice to the FY 2012 IPPS/LTCH proposed rule \(CMS-1518-CN2\)](#), which was put on display July 13, 2011, in the *Federal Register*. The corrections to Tables 2 and 4J are posted at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp. Hospitals that wish to request (or to revise a previous request) to terminate or withdraw a Section 1886(d)(10) reclassification, or to receive the out-migration adjustment rather than their Section 1886(d)(8)(B) redesignation, **must submit their request no later than seven days from the actual date of display of the *Federal Register* correction notice.**

A [detailed instructional letter \(TDL-11384, 6-28-11, attachment\)](#) has also been distributed to (and posted for) hospitals through their Medicare contractors and is available on CMS's website at http://www.cms.gov/AcuteInpatientPPS/01_overview.asp, in the Downloads section. For questions, contact Brian Slater (410-786-5229) or Valerie Miller (410-786-4535).

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

Source: CMS PERL 201107-11

Fiscal year 2011 INP PPS PC Pricer update

An error was discovered and fixed in the hospital "floor" logic for the fiscal year (FY) 2011 inpatient prospective payment system (INP PPS) PC Pricer. If you use the FY 2011 INP PPS PC Pricers, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at http://www.cms.gov/PCPricer/03_inpatient.asp, and download the latest version of the FY 2011 PC Pricer. The update is for claims dated from October 1, 2010, through September 30, 2011. The update is dated July 15, 2011.

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

Source: CMS PERL 201107-37

Find out first: Subscribe to FCSO eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Minimum data set 3.0 training materials update

This following is an update to *Minimum Data Set (MDS) 3.0 Resident Assessment Instrument Manual* (Chapter 3) V1.06 July 2011:

Appendix A and Section M have been updated to clarify the definition of “worsening.” The clarification is as follows: Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

Source: CMS PERL 201107-31

Skilled nursing facility/swing bed billing clarification

The following is a clarification for usage of the occurrence code 16, date of last therapy, on inpatient skilled nursing facility (SNF)/swing bed (SB) claims. Please note that only one occurrence code may be billed on a single claim, therefore, you would use the final date therapy was provided in relation to the latest end of therapy (EOT) – other Medicare required assessment (OMRA) applicable for the claim being billed.

Source: CMS PERL 201106-48

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 bottom line.

Medicare proposes revisions to the ESRD prospective payment system

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update Medicare policies and payment rates for dialysis facilities, while strengthening incentives for improved quality of care and better outcomes for beneficiaries diagnosed with end-stage renal disease (ESRD). The proposals would affect payments for dialysis treatments furnished on or after January 1, 2012, under the new bundled ESRD prospective payment system (PPS) that was implemented in calendar year (CY) 2011.

CMS is projecting that payment rates for dialysis treatments will increase by 1.8 percent, representing a projected inflation (or ESRD market basket) increase of 3.0 percent, less a projected productivity adjustment of 1.2 percent. CMS estimates that payments to ESRD facilities in 2012 will total \$8.3 billion.

CMS is also proposing to strengthen the Quality Incentive Program (QIP) that will adjust payment rates to individual facilities based on how well they meet specified performance standards. Please refer to the OCSQ Web page for more information.

The proposed rule also includes several proposals that are not related to the ESRD PPS and QIP. These include proposing a one-year extension of certain payment rate increases for both ground and air ambulance services, and proposing to establish a three-year minimum lifetime for equipment to be considered durable for purposes of payment under the benefit category for durable medical equipment, prosthetics, orthotics, and supplies.

For more information, please go to <http://www.cms.gov/ESRDPayment/PAY/list.asp>.

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

Source: CMS PERL 201107-03

End-stage renal disease 2011 PC Pricer

The Centers for Medicare & Medicaid Services (CMS) would like to announce the publication of the 2011 end-stage renal disease prospective payment system PC Pricer. The PC Pricer and user guide is available at http://www.cms.gov/PCPricer/02e_ESRD_Pricer.asp.

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

Source: CMS PERL 201107-36

Presentation materials for ESRD special open door forum now available

The presentation materials for the July 14, 2011, special open door forum webcast: "End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) – Reviewing your Facility's Performance Data," can be found in the Downloads section at http://www.cms.gov/OpenDoorForums/15_ODF_ESRD.asp.

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

Source: CMS PERL 201107-35

Your feedback matters

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

Educational Events

Upcoming provider outreach and educational events – August 2011

Transition to HIPAA version 5010 technical seminar

When: Monday, August 15

Time: 10:00 – 11:30 a.m. ET or 2:00 – 3:30 p.m. ET **Delivery language:** English

Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Medifest Tampa 2011

When: August 16-18

Time: 8:00 a.m. – 4:30 p.m. ET **Delivery language:** English

Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

National 5010 Testing Day

When: Wednesday, August 24

Time: 10:00 – 11:00 a.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit our provider training website at www.fcsouniversity.com, logon to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

First-time user? Set up an account by completing “Request a New Account” online. Providers who do not have a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcsso.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 <http://medicare.fcsso.com/Events/160889.asp>, 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. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at www.fcsouniversity.com.

Other Educational Resources

Provider-supplier enrollment fact sheets revised

The fact sheets below provide education to specific provider types on how to enroll in the Medicare program and maintain their enrollment information using internet-based Provider Enrollment, Chain, and Ownership System (PECOS). They have been recently updated and are available in downloadable format from the *Medicare Learning Network*[®]:

- *Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record* advises FFS physicians and non-physician practitioners on how to ensure their enrollment records are secure and up-to-date. (http://www.CMS.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf)
- *The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers* explains general Medicare enrollment information relevant to physicians and other Part B suppliers. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf)
- *The Basics of Internet-Based PECOS for DMEPOS Suppliers* describes general Medicare enrollment information relevant to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf)
- *The Basics of Medicare Enrollment for Institutional Providers* explains general Medicare enrollment information relevant to institutional providers. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf)
- *The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement* describes general Medicare

enrollment information relevant to those physicians required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_Phys_Infreq_Reimb_FactSheet_ICN006881.pdf)

- *The Basics of Internet-Based PECOS for Physicians and Non-Physician Practitioners* provides an overview of how physician and non-physician practitioners can enroll in Medicare using Internet-based PECOS. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf)
- *The Basics of Internet-Based PECOS for Provider and Supplier Organizations* describes how provider and supplier organizations can enroll in Medicare using internet-based PECOS. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf)
- *Internet-Based PECOS Contact Information* provides contact information for technical assistance with internet-based PECOS. (http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf)

Please visit http://www.CMS.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf for a complete list of all MLN products related to Medicare provider-supplier enrollment.

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

Source: CMS PERL 201106-49

Rehabilitation Therapy Information Resource for Medicare fact sheet revised

The *Rehabilitation Therapy Information Resource for Medicare* fact sheet has been revised and is now available in downloadable format from the *Medicare Learning Network*[®] at http://www.CMS.gov/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf. This fact sheet is designed to provide education on rehabilitation therapy services and includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

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

Source: CMS PERL 201107-18

Revised fact sheet and brochures from the *Medicare Learning Network*[®]

Medicare Billing for Speech-Language Pathologists in Private Practice fact sheet revised

The *Medicare Billing for Speech-Language Pathologists in Private Practice* fact sheet has been revised and is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/SpeechLangPathfctsh.pdf>. This fact sheet is designed to provide education on enrollment and billing procedures specific to speech-language pathologists (SLPs) and includes general billing and enrollment information and what services can be billed directly by an SLP.



Glaucoma Screening brochure revised

The *Glaucoma Screening* brochure, which is designed to provide education on Medicare-covered glaucoma screening, has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network*[®]. To view, download, or print the brochure, visit <http://www.CMS.gov/MLNProducts/downloads/glaucoma.pdf>.

Expanded Benefits brochure revised

The revised publication titled *Expanded Benefits* is now available in downloadable format from the *Medicare Learning Network*[®] at http://www.CMS.gov/MLNProducts/downloads/Expanded_Benefits.pdf. This brochure is designed to provide education on three preventive services: the initial preventive physical examination (IPPE) (also known as the “Welcome to Medicare” physical exam or the “Welcome to Medicare” visit), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.

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

Source: CMS PERL 201106-49

New podcasts released on avoiding Medicare billing errors

The *Medicare Learning Network*[®] has released the next in a series of podcasts designed to provide education to fee-for-service (FFS) providers on how to avoid common billing errors and other improper activities when dealing with the Medicare program:

- “[Power Mobility Device Face-to-Face Examination Checklist](#)” discusses the documentation requirements for the face-to-face examination that occurs before ordering a power mobility device for Medicare beneficiaries.
- “[Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements](#)” discusses the documentation and coverage requirements needed to submit Medicare claims for oxygen therapy supplies.

To download these and other MLN podcasts, please visit the [MLN Multimedia Web page](#) and select the topic of the podcast. Also visit the [MLN Provider Compliance Web page](#), which contains educational FFS provider materials to help providers understand – and avoid – common billing errors and other improper activities identified through claim review programs.

Source: CMS PERL 201107-18

New Medicare Ambulance Services booklet

A new publication titled *Medicare Ambulance Services* (released May 2011), which is designed to provide education on Medicare ambulance services, is now available in downloadable format at http://www.CMS.gov/MLNProducts/downloads/Medicare_Ambulance_Services_ICN903194.pdf. This booklet includes information about the ambulance service benefit, ambulance transports, ground and air ambulance providers and suppliers, ground and air ambulance vehicles and personnel requirements, covered destinations, ambulance transport coverage requirements, and ambulance services payments.

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

Source: CMS PERL 201107-23

DMEPOS fact sheets and booklet available in hard copy

Basics of DMEPOS Accreditation fact sheet

The *Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation* fact sheet is now available in hard copy format from the *Medicare Learning Network*[®]; this fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. To place your order, visit the *MLN Product Ordering* page at http://CMS.meridianksi.com/kc/pfs/pfs_Inkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

DMEPOS Quality Standards fact sheet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards* fact sheet is now available in a hard copy format from the *Medicare Learning Network*[®]; this fact sheet is designed to provide education on DMEPOS quality standards for Medicare-deemed Accreditation Organizations (AOs) for DMEPOS suppliers. To place your order, visit the *MLN Product Ordering* page at http://CMS.meridianksi.com/kc/pfs/pfs_Inkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

DMEPOS New Information for Pharmacies booklet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies* booklet is now available in hard copy format from the *Medicare Learning Network*[®]; this booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by CMS-approved independent national Accreditation Organization (AO) or must obtain an accreditation exemption. To place your order, visit the *MLN Product Ordering* page at http://CMS.meridianksi.com/kc/pfs/pfs_Inkfrm_fl.asp?lgnfrm=reqprod&function=pfs.

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

Source: CMS PERL 201107-39

Medicare Learning Network[®] provider exhibit program

Would you like to have the Centers for Medicare & Medicaid Services (CMS) present at your next national and/or regional provider association meeting or conference? If so, visit the brand new *Medicare Learning Network* provider exhibit program Web page to contact us directly. We can provide your conference attendees with access to relevant *MLN* educational products and resources that have been developed especially for their use; your members/attendees will also be provided with an opportunity to provide feedback and exchange ideas with CMS on the relevance of our *MLN* program materials. For more information on the exhibit program selection process and the current schedule, please visit the *MLN* provider exhibit program Web page at <http://www.CMS.gov/MLN-Provider-Exhibit-Program>.

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

Source: CMS PERL 201107-23

Advance Beneficiary Notice of Noncoverage – Part A and Part B booklet revised

The *Advance Beneficiary Notice of Noncoverage (ABN) – Part A and Part B* booklet, which is designed to provide education on the ABN, has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network*[®] (MLN). To view, download, or print the brochure, visit http://www.CMS.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf. A hard copy version of this product will be made available at a later date.

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

Source: CMS PERL 201106-49

Preventive services resources updated

The *Medicare Learning Network*® (MLN) has recently updated several educational tools related to Medicare-covered preventive services:

- The *Quick Reference Information: Preventive Services* offers coverage, coding, and payment information on the wide variety of preventive services Medicare covers; view, download, or print at http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- The *Quick Reference Information: The ABCS of Providing the Initial Preventive Physical Examination (IPPE)* offers a list of the elements included in the IPPE, along with some frequently asked questions; view, download, or print at http://www.CMS.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf.
- The *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (AWV)* offers a list of the elements included in the AWV, along with some frequently asked questions; view, download, or print at http://www.CMS.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.
- The *Quick Reference Information: Medicare Immunization Billing* offers coverage, coding, and payment information for the seasonal influenza, pneumococcal, and hepatitis B vaccines; view, download, or print at http://www.CMS.gov/MLNProducts/downloads/qr_immun_bill.pdf.



The MLN® also offers these charts in a laminated, ring-bound booklet titled *Quick Reference Information Resources: Medicare Preventive Services*. This booklet contains all four of the preventive services charts listed above in a single, easy-to-use format. To order your free copy, visit the Preventive Services MLN page at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp, then scroll to MLN Product Ordering Page in the Related Links Inside CMS section. Please note that, aside from the *Medicare Immunization Billing* chart, these charts are no longer offered individually in hard copy.

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

Source: CMS PERL 201107-23

Preventive Immunizations brochure updated

The *Preventive Immunizations* brochure – which is designed to provide education on Medicare’s influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine benefits – has been updated and is now available in downloadable format, free of charge at http://www.CMS.gov/MLNProducts/downloads/adult_immunization.pdf. This brochure will also be made available in print at a later date.

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

Source: CMS PERL 201107-18

Tobacco-Use Cessation Counseling Services brochure revised

The *Tobacco-Use Cessation Counseling Services* brochure – which is designed to provide education on tobacco-use cessation counseling services – has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network*®. To view, download, or print the brochure, please visit <http://www.CMS.gov/MLNproducts/downloads/smoking.pdf>. This brochure is suggested for all Medicare providers, and will also be made available in print at a later date.

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

Source: CMS PERL 201107-23

Annual Wellness Visit brochure and Medicare Preventive Services booklet available

New Annual Wellness Visit brochure

The new publication titled *Annual Wellness Visit* is now available in downloadable format from the *Medicare Learning Network*® at http://www.CMS.gov/MLNProducts/downloads/Annual_Wellness_Visit.pdf.

This brochure is designed to provide education on the annual wellness visit and providing personalized prevention plan services, at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update their personalized prevention plan.

Quick Reference Information Resources: Medicare Preventive Services booklet available in hard copy

The *Quick Reference Information Resources: Medicare Preventive Services* booklet, which is designed to provide education on coverage, coding, and billing criteria for Medicare-covered preventive services, is now available in print, free of charge, from the *Medicare Learning Network*® (MLN). It includes the following four quick reference information charts: *Preventive Services*, *Medicare Immunization Billing*, *The ABCs of Providing the Initial Preventive Physical Examination*, and *The ABCs of Providing the Annual Wellness Visit*.

To order your copy, visit the *MLN* General Information page at <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS,” and choose “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 201106-49



Cancer Screenings brochure revised

The *Cancer Screenings* brochure has been updated and is now available, free of charge, from the Medicare Learning Network. This brochure is designed to provide education on Medicare’s mammography screening, screening Pap test, pelvic screening examination, and prostate cancer screening benefits. To view, download, or print the brochure, visit http://www.CMS.gov/MLNProducts/downloads/cancer_screening.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 201107-23

Bone Mass Measurement brochure revised

The *Bone Mass Measurement* brochure is designed to provide education on the bone mass measurement benefit, and includes information on methods of bone measurement (bone density), coverage information, and risk factors. This brochure has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network* at http://www.CMS.gov/MLNproducts/downloads/bone_mass.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 201107-39

Addresses

First Coast Service Options

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
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 (PAR)
Attn: FOIA PAR – 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 (PAR)

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

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)

Durable medical equipment, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

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

Railroad Medicare

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

Regional home health and hospice intermediary

Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR

Providers:

888-664-4112

Speech and hearing impaired

877-660-1759

Beneficiaries:

800-MEDICARE (800-633-4227)

Speech and hearing impaired

800-754-7820

Credit balance report

Debt recovery

904-791-6281

Fax

904-361-0359

Electronic data interchange

888-670-0940

Provider audit and reimbursement

904-791-8430

Provider education and outreach

Seminar registration hotline

904-791-8103

Seminar registration fax

904-361-0407

Provider enrollment

877-602-8816

Websites

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

medicare.fcso.com

Centers for Medicare & Medicaid Services

Providers:

www.cms.gov

Beneficiaries:

www.medicare.gov

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