Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

August 2011

In this issue

Medicare providers must revalidate enrollment by March 2013

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (section 6401a). (Providers/suppliers who enrolled on or after Friday, March 25, 2011, have already been subject to this screening, and do not need to revalidate at this time.)

In the continued effort to reduce fraud, waste, and abuse, the Centers for Medicare & Medicaid Services (CMS) implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare administrative contractor (MAC) processing the enrollment application.

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS), at *https://pecos.CMS.hhs.gov*.

Section 6401a of the Affordable Care Act requires institutional providers and suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via *www.Pay.gov*.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including *Internet-based PECOS*. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the *Medicare Learning Network's* *Special Edition Article #SE1126*, titled "Further Details on the Revalidation of Provider Enrollment Information."

Source: CMS PERL 201108-19

Contents

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Publication staff:
Cindi Fox
Terri Drury
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

Details on the revalidation of provider enrollment information

Provider types affected

This *Medicare Learning Network* (*MLN*) Matters® special edition article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's contractors [Fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC)]. These contractors are collectively referred to as MACs in this article.

Provider action needed

Stop – impact to you

In change request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*. A related *MLN* Matters® Article is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

Caution – what you need to know

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee thru pay.gov; and
- Mail your supporting documents and certification statement to your MAC.

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

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are not impacted. Between now and March 23, 2013, MACs will send out notices on a regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must wait to submit the revalidation only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov* on the CMS website. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, **you must** print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC **immediately**.

The most efficient way to submit revalidation information is by using Internet-based PECOS.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for Calendar Year (CY) 2011. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers and suppliers who respond to a revalidation request must submit an enrollment fee via Pay.Gov (reference 42 CFR 424.514). You may submit your fee by electronic check, debit, or credit card. Revalidations are processed only when fees

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Revalidation...*continued*

have cleared. To pay your application fee, go to *http://www.pay.gov* and type "CMS" in the search box under Find Public Forms, and click the Go button. Click on the CMS Medicare Application Fee link. Complete the form and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid.

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.

Additional information

More information about the enrollment process and required fees can be found in *MLN* Matters® Article MM7350, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*.

The *MLN*® fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare program and can be found at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

To access PECOS, your authorized official must register with the PECOS Identification and Authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment web page at *http://www.cms.gov/MedicareProviderSupEnroll*.

If you have questions, contact your Medicare contractor. Medicare provider enrollment contact information for each State can be found at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

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Provider enrollment revalidation – wait until you hear from your MAC

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to submit their enrollment information so they can be revalidated under new risk screening criteria required by the Affordable Care Act (section 6401a). Providers and suppliers that enrolled on or after Friday, March 25, 2011, have already been subjected to this screening, and they are not required to revalidate at this time.

Do not submit your revalidation until you are notified to do so by your Medicare administrative contractor (MAC). You will receive a notice to revalidate between now and March 2013.

This will allow MACs to process revalidations in a timely fashion and allow providers to take advantage of innovative technologies and streamlined enrollment processes now under development. Updates will be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the *Medicare Learning Network's special edition article #SE1126*, titled "Further Details on the Revalidation of Provider Enrollment Information."

Source: CMS PERL 201108-38

New information to improve patient safety at America's hospitals

Provider types affected

This article is informational in nature and of interest to all providers who serve Medicare beneficiaries.

What you need to know

This article alerts providers that they may review and share data about hospital acquired conditions (HACs) with their Medicare patients. The Centers for Medicare & Medicaid Services (CMS) is making this important new data about the safety of care in America's hospitals available on the "Hospital Compare" website at *http://www.healthcare.gov/compare*. This site contains information on more than 4,700 hospitals across the nation.

Background

HACs are serious conditions that often result from improper procedures during inpatient care.

The data released on the "Hospital Compare" website shows the number of times an HAC occurred for Medicare fee-for-service patients between October 2008 and June 2010. The numbers are reported as number of HACs per 1,000 discharges, and are not adjusted for hospitals' patient populations or case-mix.

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

- Blood infections from a catheter placed incorrectly in a patient or from a catheter that is not kept clean properly;
- Urinary tract infections caused by a urinary catheter;
- Falls and injuries during a hospital stay;
- Transfusions through mismatched blood types;
- Severe pressure ulcers (or bed sores that develop while a patient is in the hospital;
- Air bubbles in the bloodstream;
- Objects accidentally left in the body after surgery (such as a sponge, gauze, or a surgical instrument); and
- Signs of uncontrolled blood sugar for patients with diabetes.

Data shows that as many as 98,000 people die in hospitals each year from preventable medical errors.

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

CMS has gathered data on HAC rates from hospitals since 2007. Since 2008, Medicare has denied additional reimbursement for cases for which HACs were presented as secondary diagnoses during a patient's hospital stay.

Rates for the eight HAC rates reported on "Hospital Compare" vary among hospitals. The most common HAC reported was injury from a fall or some other type of trauma. Over 70 percent of hospitals reported at least one fall or trauma, and more than 50 percent reported at least two occurrences. The rarest HACs reported were transfusions through mismatched blood types and air bubbles in the bloodstream. More than 95 percent of the hospitals had no occurrences of these HACs.

Rates for infection were also relatively common, with more than 45 percent of hospitals reporting at least one occurrence of blood or urinary tract infection developed during a hospital stay.

Although HACs were rare, there is still room for improvement. While 19 percent of hospitals had no occurrences of HACs, 81 percent had at least one HAC; 62 percent had two different types of HACs.

In addition to information about HACs, "Hospital Compare" reports 25 inpatient and five outpatient

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Safety...*continued*

process of care measures, readmission and mortality rates for certain conditions, three children's asthma care measures, and 10 measures that gauge patient satisfaction with hospital care. The site also features information about the volume of certain hospital procedures and conditions treated for Medicare patients and what Medicare pays for those services.

Additional information

- To review the HAC data please visit *http://www.healthcare.gov/compare*. Select "Visit the Website" next to "Compare Hospitals". Then click the link in the "Hospital Spotlight" section.
- CMS is working with the members of the Hospital Quality Alliance—a national private-public partnership of hospitals, consumers, providers, employers, payers, and government agencies—to make HAC data accessible to the public in meaningful, relevant, and easily understood ways to encourage healthcare quality improvement. CMS is working with the Alliance and consumers about how to include HAC data in the main report of "Hospital Compare". For now, HAC data are available through a downloadable file linked to the "Hospital Compare" website and on data.medicare.gov (*http://data.medicare.gov/dataset/Hospital-Acquired-Condition-Calculations/sjdk-f65s*).
- You can also view archived data on the CMS Hospital Compare website at *http://www.cms.gov/HospitalQualityInits/11_HospitalCompare.asp*.
- CMS is also working with its Quality Improvement Organization (QIO) contractors to give hospitals the resources to eliminate HACs as much as possible. QIOs have been working with providers across the country since 2008 to reduce rates of hospital-associated infections, slow rates of pressure ulcers in nursing homes and hospitals, and improve safety and reduce infections for surgical patients. More information about QIOs' efforts is online at *http://www.cms.gov/qualityimprovementorgs*.

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Fraud prevention initiative

If you help people with Medicare, Medicaid and the Children's Health Insurance Program (CHIP), you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

Significant progress in the fight against health care fraud has already been made as shown by the federal government's recovery of a record $4 billion last year from people who attempted to defraud seniors and taxpayers. The Affordable Care Act provides additional resources and tools to enable the Centers for Medicare & Medicaid Services (CMS) to expand efforts to prevent and fight fraud, waste and abuse. The CMS fraud prevention initiative aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former "pay and chase" recovery operations to a more proactive "prevention and detection" model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Yet, as important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available in the CMS fraud prevention toolkit on the Web at *https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp#TopOfPage*.

The website contains materials to help you inform Medicare beneficiaries about how to protect themselves from becoming a victim of fraud and how to report it.

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

Source: CMS PERL 201108-27

August is National Immunization Awareness Month

This national health observance presents a great opportunity to educate seniors and other people with Medicare on the importance of disease control and prevention through immunization. Vaccine-preventable disease levels are at or near record lows, yet many adults remain under-immunized, missing opportunities to protect themselves against diseases such as hepatitis B, seasonal influenza, and pneumococcal disease.

What can you do?

The Centers for Medicare & Medicaid Services (CMS) asks health care providers who provide care to seniors and others with Medicare to join it during National Immunization Awareness Month to help protect your Medicare patients from vaccine-preventable diseases. This can be done by ensuring their immunizations are up-to-date, educating them on risk factors, and encouraging their use of appropriate Medicare-covered immunizations.

Note: If you provide the Medicare annual wellness visit to your eligible Medicare patients, please ensure that a written screening schedule for immunizations is reflected on their personalized preventive service plan.

Medicare Part B immunization benefits

Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration for qualified beneficiaries as preventive immunizations. Providers who accept the Medicare-approved payment amount for the following services are paid under Medicare Part B:

- Seasonal influenza immunization – Medicare provides payment for the seasonal influenza vaccine and its administration for all people with Medicare, once per influenza season. Medicare may cover additional influenza vaccinations, if medically necessary. You may visit the *Centers for Disease Control and Prevention (CDC) website* for the latest 2011-2012 seasonal flu recommendations and alerts.
- Pneumococcal immunization – Medicare provides payment for the pneumococcal vaccine and its administration for all beneficiaries, generally once in a lifetime. Medicare may cover additional vaccinations based on risk.
- Hepatitis B immunization – Medicare provides payment for the hepatitis B vaccine and its administration for beneficiaries at medium to high risk of contracting hepatitis B.

For more information

- *The CMS Guide to Medicare Preventive Services*
- *Medicare Immunizations Billing Quick Reference Chart*
- *CMS Adult Immunizations Brochure*
- *CMS Adult Immunizations Web page*
- *CMS Medicare Learning Network® (MLN) Preventive Services Educational Products Web page* – this site provides access to *MLN* educational resources developed by CMS for fee-for-service providers and suppliers related to preventive services covered by Medicare, including immunizations covered by Part B
- *The CDC Vaccines and Immunizations Web page*
- *National Immunization Awareness Month 2011 Toolkit*
- *Annual Wellness Visit Brochure* – a brochure for health care professionals.
- *The ABCs of Providing the Annual Wellness Visit Quick Reference Chart*

Source: CMS PERL 201108-11

Hold of claims related to CR 7133 – counseling to prevent tobacco use

Beginning April 7, 2011, the Centers for Medicare & Medicaid Services (CMS) instructed fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) to hold claims with the following criteria, until change request (CR) 7133R2 was installed into production on May 9, 2011:

- HCPCS G0436 and/or G0437
- Revenue code 0942, 096x, 097x or 098x
- Dates of service on or after January 1, 2011
- Diagnosis code 305.1 or V15.82
- Occurrence code 32 is not present

When CR 7133R2 was installed, FIs and A/B MACs were instructed to release the held claims and enter condition code "15," to indicate they were clean claims in which payment was delayed due to the CMS's processing delay and therefore, not subject to claims processing timeliness standards.

Source: CMS PERL 201108-16

Reprocessing of customized prosthetic devices

Part-B payment can be made for items of prosthetics, orthotics, and supplies (POS) when they are furnished to a beneficiary who is in a non-covered Part-A stay at a hospital or skilled nursing facility (SNF). If these items are furnished to beneficiaries residing in a covered Part-A hospital or SNF stay, under inpatient prospective payment system or SNF consolidated billing (CB) payment rules, the items would be bundled into the global Part-A payment for the covered stay itself. An exception to this policy is when certain customized prosthetic devices are furnished to beneficiaries residing in a covered Part A SNF stay as these items were carved out of the SNF CB provision by the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F, Section 103).

Since Monday, April 4, the claims processing system has been erroneously denying claims for certain custom prosthetic devices.

The Centers for Medicare & Medicaid Services (CMS) is issuing instructions to correct this processing error but the correction will not be implemented until Sunday, January 1, 2012. In the interim, the durable medical equipment Medicare administrative contractors (DME MACs) will reprocess any claims for custom prosthetic devices (identified by the "L" series of HCPCS codes) that were inappropriately denied when such claims are brought to their attention.

Source: CMS PERL 201107-52

Chiropractors not eligible to order and refer

In recent announcements and materials, the Centers for Medicare & Medicaid Services (CMS) incorrectly included chiropractors in the list of physician and practitioner types that may order and refer items or services to Medicare beneficiaries. In accordance with section 1877(a)(1) and (5)(A), and section 1861(r)(5) of the Social Security Act, and 42 CFR 410.21(b)(1) and (2), doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation; all other services furnished or ordered by chiropractors are not covered.

CMS is in the process of revising documents (including change requests) to reflect this correction.

Source: CMS PERL 201108-34

Registration now open for second ACO accelerated development learning session

September 15-16, 2011
San Francisco, CA

The *Center for Medicare and Medicaid Innovation* is offering free *accelerated development learning sessions* for providers interested in learning more about how to coordinate patient care through accountable care organizations (ACOs). The second of four accelerated development learning sessions in 2011, will be held in San Francisco, CA on Thursday, September 15, through Friday, September 16. Registration is free and open for teams of between two and four senior leaders from health care delivery organizations interested in forming an ACO or from an existing ACO.

The accelerated development learning sessions are designed to help existing or emerging ACOs understand the steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care. The content at each ACO learning session is repetitive and is not part of an ongoing series

For more information, to register, or to view the plenary sessions from the first learning session, please visit *http://ACOregister.rti.org*. For more information, please visit the *Frequently Asked Questions 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 201108-37

Incentive Programs

Certified EHR technology and the EHR incentive programs

Eligible professionals (EPs) and eligible hospitals participating in the Medicare and Medicaid electronic health record (EHR) incentive programs are required to use certified EHR technology in order to receive incentive payments. To get an incentive payment, you must use an EHR that is certified specifically for the EHR incentive programs. EHRs certified or qualified for other Medicare or Medicaid incentive programs may not be certified for this program.

To qualify as certified EHR technology for the EHR incentive programs, an EHR needs to be tested by one of the Office of the National Coordinator for Health Information Technology-Authorized Testing and Certification Bodies (otherwise known as the ONC-ATCBs). If an EHR technology has been certified by an ONC-ATCB, it indicates to EPs and eligible hospitals that it has the capacities necessary to support their efforts to meet meaningful use goals and objectives.

Note that you do not need to already have certified EHR technology in place when you register for the EHR incentive programs. However, you will need to have meaningfully used your certified EHR technology to receive your first year Medicare incentive payment. Under the Medicaid EHR incentive program, you will need to have at least adopted (i.e., purchased or acquired) certified EHR technology in order to receive your first year incentive payment.

For more details on certified EHR technology, visit the *EHR section* of the Centers for Medicare & Medicaid Services (CMS) website. For a list of certified EHR technologies, visit the *ONC's Certified Health IT Product List*.

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 201108-21

Differences between the Medicare and Medicaid EHR incentive programs

With the exception of dually-eligible hospitals, providers can only participate in one of the Medicare and Medicaid Electronic Health Records (EHR) incentive programs (Medicare or Medicaid) each year. The Centers for Medicare & Medicaid Services (CMS) outlines key differences between the Medicare and Medicaid EHR incentive programs to help you determine which EHR incentive program is right for you.

Who is eligible?

For the Medicare EHR incentive program, eligible participants include:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Chiropractors
- "Subsection (d) hospitals" in the 50 states or District of Columbia (D.C.) that are paid under the inpatient prospective payment system (IPPS)
- Critical access hospitals (CAHs)
- Medicare advantage (MA-affiliated) hospitals

For the Medicaid EHR incentive program, eligible participants include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a federally qualified health center or rural health clinic that is led by a physician assistant
- Acute care hospitals (including CAHs and cancer hospitals) with at least 10 percent Medicaid patient volume
- Children's hospitals (no Medicaid patient volume requirements)

Dually-eligible hospitals

If you represent a hospital that **meets all of the following qualifications**, you are dually-eligible for the Medicare and Medicaid EHR incentive programs:

- You are a subsection (d) hospital in the 50 states or D.C., or you are a CAH
- You have a CMS certification number ending in 0001-0879 or 1300-1399
- You have 10 percent of your patient volume derived from Medicaid encounters

We encourage potential participants to review *CMS's comparison chart* to learn more about the differences between the two EHR incentive programs, and use the *eligibility wizard application* (i.e., *EHR EP Decision Tool*) to determine for which program they may be eligible.

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 201108-09

2010 Medicare eRx incentive program payment update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2010 Medicare electronic prescribing (eRx) incentive program has begun for eligible professionals who met the criteria for successful reporting. Distribution of 2010 Medicare eRx incentive payments is scheduled to be completed by August 31, 2011.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of "LE" to indicate incentive payments instead of "LS." LE will appear on the electronic remit. In an effort to further clarify the type of incentive payment issued (either physician quality reporting system or eRx incentive), CMS created a 4-digit code to indicate the type of incentive and reporting year. For the 2010 eRx incentive payments, the 4-digit code is "RX10." This code will be displayed on the electronic remittance advice along with the LE indicator. For example, eligible professionals will see LE to indicate an incentive payment, along with RX10 to identify that payment as the 2010 eRx incentive payment. Additionally, the paper remittance advice will read, "This is an eRx incentive payment." The year will not be included in the paper remittance.

Who to contact for questions?

If you have questions about the status of your eRx incentive payment (during the distribution timeframe), contact your provider contact center. The contact center directory is available at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

The QualityNet help desk is available Monday through Friday from 7 a.m. – 7 p.m. CST at 866-288-8912 or via *qnetsupport@sdps.org*. The help desk can also assist with program and measure-specific questions.

The following CMS resource is available to help eligible professionals understand the 2010 eRx Incentive Payments; view *A Guide for Understanding the 2010 eRx Incentive Payment [PDF 57 KB]*.

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

Source: CMS PERL 201108-17

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*

2012 annual update for the HPSA bonus payments

Provider types affected

This article is for physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries in Health Professional Shortage Areas (HPSAs).

What you need to know

Change request (CR) 7517, from which this article is taken, alerts providers that the annual HPSA bonus payment file for 2012 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2012, through December 31, 2012. These files will be posted to the internet on or about December 1, 2011. Physician and other providers should review *http://www.cms.gov/hpsapsaphysicianbonuses* each year to determine whether they need to add the AQ modifier to their claim in order to receive the bonus payment, or to see if the ZIP code area in which they rendered services will automatically receive the HPSA bonus payment.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors each year.

Additional information

The official instruction, CR 7517 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2274CP.pdf*.

You will find annual HPSA files (as they become available) and other important HPSA information at *http://www.cms.gov/hpsapsaphysicianbonuses*.

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

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Related CR Transmittal #: R2274CP
Implementation Date: January 3, 2012

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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*.

Submission of rural air ambulance service protocol for contractor review

According to Section 415 of the Medicare Modernization Act of 2003, the reasonable and necessary requirement for rural air ambulance transport may be "deemed" to be met when the service is provided pursuant to an established state or regional emergency medical services (EMS) agency protocol. The protocol must be recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through the Centers for Medicare & Medicaid Services (CMS).

CMS defines "established" to mean those protocols that have been reviewed and approved by the state EMS agencies or have been developed according to state EMS umbrella guidelines. Submission of protocols for review and subsequent approval will "deem" that the reasonable and necessary requirement for rural air ambulance transport has been met by the provider.

Providers that anticipate rural air ambulance transports pursuant to such a protocol may submit their written protocol to their fiscal intermediary for review and approval in advance. Providers may submit protocols for review as follow:

By email: *medicalpolicy@fcso.com* (Please include "Air Ambulance Protocol" in the subject line.)

By U.S. Postal Service:

First Coast Service Options Inc.
Medical Policy and Procedures ROC 19T
Attn: Manager of Medical Policy and Procedures
P.O. Box 2078
Jacksonville, FL 32231-0048

By fax: 904-791-8006

Providers will be notified of all protocol review decisions in writing within 30 days of receipt by FCSO.

Please include a contact name, telephone number and address with your submissions. Review decisions will be mailed to this address.

CMS has issued a "MLN Matters" article pertaining to this requirement, which may be viewed at *http://www.cms.gov/mlnmattersarticles/downloads/MM3571.pdf*.

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

Source: Pub. 100-09, Chapter 6, Section 6.4.2

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

Revisions to LCDs

AJ0881: Erythropoiesis stimulating agents – revision to LCD

LCD ID number: L28836 (Florida)
LCD ID number: L28869 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for erythropoiesis stimulating agents was most recently revised on October 1, 2010. Since that time, the LCD has been revised. On June 24, 2011, the Food and Drug Administration (FDA) issued a revised drug label for epoetin alfa (Procrit® and Epogen®) and darbepoetin alfa (Aranesp®). These revisions required that the LCD be updated to reflect the new language surrounding the indications, black box warning, and dosage and administration for these drugs. Therefore, the "Indications and Limitations of Coverage and/or Medical Necessity," "Utilization Guidelines," "Documentation Requirements," and "Sources of Information and Basis for Decision" sections of the LCD have been revised accordingly to read in-line with the revised drugs labels.

This LCD revision is effective for claims processed **on or after August 23, 2011,** for services provided **on or after June 24, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

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

Get news about LCDs delivered to your inbox

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

First National Version 5010 Testing Day results now available

The Centers for Medicare & Medicaid Services (CMS) version 5010 team held its first National Testing Day on June 15, 2011. On National Testing Day, 349 Medicare fee-for-service (FFS) trading partners conducted testing using the version 5010 format that all covered entities are required to use starting January 1, 2012.

From those 349 trading partners, 974 files were submitted, and there were no significant error scenarios reported. Sixty-eight trading partners responded to a follow-up survey about National Testing Day. Of those who responded to the survey, 32 percent stated that they feel ready to process version 5010 production transactions. In addition, 39 percent of the respondents stated that they were able to receive and process a 277CA while testing on National Testing Day.

The following metrics represent 5010 **production** transactions:

- Part B claims processed (May and June) – 59,778
- Coordination of benefits (COB) Part B claims (May and June) – 4,041
- Trading partners for Part B claims and COB (as of June) – Part A - 43, Part B - 84, COB - 24
- Eligibility inquiries (May and June) – 305,884 inquiries

CMS and the Medicare FFS program have scheduled a National 5010 Testing Week for August 22-26, 2011. National 5010 Testing Week provides an opportunity for trading partners to test compliance efforts that are already underway, with the support of a real-time help desk and access to Medicare administrative contractors. Check the *version 5010* section of the CMS website for more information about the transition to version 5010.

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 201108-15

MREP and PC Print user guides updated for implementation of version 5010A1

Provider types affected

This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors [carriers, fiscal intermediaries (FIs), DME Medicare administrative contractors (DME MACs) and/or Part A/B Medicare administrative contractors (MACs)] for services provided to Medicare beneficiaries.

What you need to know

MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for transaction 835 – Health Care Claim Payment/Advice. Specifically:

- The *MREP User Guide* is being updated to reflect the changes in the software related to the HIPAA 5010A1; and
- The *PC Print User Guide* is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 transaction 835.

If you use MREP or PC Print, be sure to download the updated user guides for 835 version 5010A1 when they are available.

Background

The Centers for Medicare & Medicaid Services (CMS) is implementing the new standard for transaction 835 (Health Care Claim Payment/Advice) version 5010A1 adopted under the Health Insurance Portability and Accountability Act (HIPAA). Providers/suppliers must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/

continued on next page

Guides...*continued*

print/download the electronic remittance advice in version 5010A1 in a human readable format.

Additional Information

The official instruction, CR 7466 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R926OTN.pdf*. For more information on the Version 5010 transition and implementation, visit *http://www.cms.gov/Versions5010andD0/*.

If you have any questions, contact your carrier, FI, 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:MM7466
Related Change Request (CR) #: 7466
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R926OTN
Implementation Date: January 3, 2012

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Subset of HIPAA 837 institutional version 5010 errata production claims not crossing over

Description of the problem

As part of the Tuesday, July 5, 2011, Medicare Part A quarterly systems release, the Part A shared system (FISS) inadvertently included an invalid character ('{') within a line of code for Health Insurance Portability & Accountability Act (HIPAA) 837 institutional version 5010 errata claims that it sends to the coordination of benefits contractor (COBC) for crossover purposes. The issue appears to only be affecting claims that our Part A system must force balance in accordance with HIPAA 5010 claim transaction requirements (roughly an average of 200 per day, out of the entire universe of claims crossed over on a daily basis).

Currently, when the COBC receives claims with the invalid character, it rejects them and returns edit H10041 to the A/B Medicare administrative contractor (MAC) or fiscal intermediary (FI). That entity, in turn, would normally issue and mail supplemental notices to the affected provider(s) that:

- List the affected claims, by document control number (DCN) and patient, that cannot be crossed over; and
- Include the error message (in this case H10041), along with error description, to explain why Medicare cannot cross over the affected claims.

On Friday, July 8, 2011, the Centers for Medicare & Medicaid Services (CMS) asked its A/B MAC and FI crossover staffs to temporarily suspend issuance of the letters containing error code H10041 while a resolution to the current problem was sought. CMS, the Part A shared system maintainer, and the A/B MACs and FIs have now determined that efforts to complete repairs/corrections to affected claims that received error H10041 may take several weeks beyond Monday, August 8, 2011, the projected date on which the fix the correct the current problem will be elevated to production.

What this means to you

When providers receive special notification letters containing error code H10041 from their servicing A/B MAC or FI, they will need to bill their affected patients' supplemental payers. The claims denoted within the letters cannot be crossed over.

Current status

The Part A shared system has projected August 8, 2011, as the fix date for the described problem. Therefore, any claims that A/B MACs or FIs send to the COBC on and after that date should no longer receive error code H10041.

Additional questions can be directed to your local servicing A/B MAC or FI.

Source: CMS PERL 201108-02

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

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

Announcements

The HIPAA 5010 compliance date is fast-approaching. There are only five months left until full implementation on January 1, 2012. Please contact your local Medicare administrative contractor (MAC) and test now.

Reminders

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

Upcoming events

September 2011
September 8: FCSO-hosted webcast – 5010 testing support
September 9: FCSO-hosted webcast – 5010 testing support
September 12: FCSO-hosted – transition to HIPAA version 5010 technical seminar
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)*

October 2010
October 13: *5010/D.0. errata requirements and testing schedule released*
October 27: *5010 national call – NCPDP version D.0. transaction*

continued on next page

Calendar...*continued*

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

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

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

For older national call information, please visit the *5010 National Calls section of CMS' versions 5010 & D.0. 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.

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

Source: CMS PERL 201108-07

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.

Comparative billing report on outpatient physical therapy services with modifier KX

On Tuesday, August 2, 2011, CMS released a national provider comparative billing report (CBR) centered on independent physical therapy providers who practice in the outpatient setting and bill Medicare with modifier KX. The CBR is similar to the original study distributed last summer except this current study will focus on 2010 billing data and is being sent to 5000 additional or different providers.

The CBRs are produced by Safeguard Services under contract with CMS and contain actual data-driven tables and graphs with an explanation of findings that compare a provider's billing and payment patterns to those of their peers located in the state and across the nation. 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.

These reports are not available to anyone but the providers who receive 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 outpatient physical therapy services 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 201108-10

Instructions to accept and process all ambulance transportation HCPCS codes

Provider types affected

This article is for ambulance providers and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for ambulance transportation services and transportation related services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 1, 2012, you will be able to submit "no-pay claims" to Medicare for statutorily excluded ambulance transportation services and transportation related services, in order to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

Caution – what you need to know

Change request (CR) 7489, from which this article is taken, announces that (effective January 1, 2012) Medicare FIs, carriers, and A/B MACs will revise their claims processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily excluded ambulance transportation services and transportation related services. Medicare will then deny claims containing these codes as "non-covered," which will allow you to submit the denied claim to a beneficiary's secondary insurance for coordination of benefits purposes.

Go – what you need to do

You should ensure that your billing staffs are aware of this change and the need to include the "GY" modifier to the HCPCS code identifying the excluded ambulance transportation service and transportation related services.

Background

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare Physician Fee Schedule

continued on next page

Ambulance...*continued*

Database (MPFSDB), a status indicator of "I" or "X" is associated with these codes. The "I" shows the HCPCS code is "Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services." The "X" indicates a (Statutory Exclusion" of the code. [See the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), which you can find at *http://www.cms.gov/manuals/downloads/clm104c23.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.]

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation related services (HCPCS codes A0021 through A0424 and A0998) which are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit "no-pay claims" to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. Doing so will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

If you wish to bill for statutorily excluded ambulance transportation services and transportation related services in order to obtain a "Medicare denial," you should bill for such services by attaching the "GY" modifier to the HCPCS code identifying the service according to long-standing CMS policy.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

- Claim adjustment reason code - 96 – "Non-covered charge(s);"
- Remittance advice remark code - N425 – "Statutorily excluded service(s);" and
- Group code - PR – "Patient responsibility."

Note: Make sure that you include the HCPCS code that accurately identifies the excluded ambulance transportation service and transportation related services that the beneficiary was furnished.

Additional information

You can find more information about instructions given to your carrier, FI, or A/B MAC to accept and process all ambulance transportation HCPCS Codes by going to CR 7489, located at *http://www.cms.gov/Transmittals/downloads/R942OTN.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: MM7489 Revised
Related Change Request (CR) #: CR 7489
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R942OTN
Implementation Date: January 3, 2012

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

Note: This article was revised on August 9, 2011, to reflect the revised change request (CR) 7397 issued on August 5. The effective and implementation dates, CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same. This information was published in the July 2011 *Medicare A Connection*, pages 21-22.

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 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 may be viewed at *http://www.cms.gov/Transmittals/downloads/R2271CP.pdf*.

If you have any questions, 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: August 5, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2271CP
Implementation Date: October 1, 2011

Changes to the laboratory NCD edit software for October 2011

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at *http://www.cms.gov/manuals/downloads/clm104c16.pdf* on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

- For codes that are denied by Medicare for all 23 lab NCDs:
  - Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.
  - Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.
- For codes that do not support medical necessity for the blood counts
  - Add ICD-9-CM code V54.82 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.
- For partial thromboplastin time
  - Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- For prothrombin time
  - Delete ICD-9-CM codes 286.5, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, 286.59, 415.13, 444.01, 444.09, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- For serum iron studies
  - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.
  - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

continued on next page

Lab...*continued*

- For blood glucose testing
  - Add ICD-9-CM codes V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the blood glucose testing (190.20) NCD.
- For glycated hemoglobin/glycated protein
  - Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
  - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- For thyroid testing
  - Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.
  - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.
- For lipids testing
  - Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
  - Add ICD-9-CM codes 444.01 and 444.09 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
- For human chorionic gonadotropin
  - Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
  - Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
- For gamma glutamyl transferase
  - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.
  - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, and 173.99 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD
- For fecal occult blood test
  - Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.

Additional information

The official instruction, CR 7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2257CP.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: MM7507
Related Change Request (CR) #: 7507
Related CR Release Date: July 22, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2257CP
Implementation Date: October 3, 2011

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FY 2012 ICD-9-CM code titles available

The full and abbreviated fiscal year (FY) 2012 ICD-9-CM code titles effective Saturday, October 1, 2011 (version 29), are now available in both Microsoft Excel and text formats at *http://www.CMS.gov/ICD9ProviderDiagnosticCodes/06_codes.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 201108-06

New podcasts available from four CMS ICD-10 national provider calls

Limited on time? The Centers for Medicare & Medicaid Services (CMS) has created podcasts from four popular national provider calls on ICD-10. These podcasts are perfect for use in the office, on the go in your car, or on your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs.

- *"CMS ICD-10 Conversion Activities"* – Wednesday, May 18, 2011
- *"Preparing for ICD-10 Implementation in 2011"* – Wednesday, January 12, 2011
- *"Basic Introduction to ICD-10-CM"* – Tuesday, March 23, 2010
- *"ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks)"* – Tuesday, May 19, 2009

To access these podcasts, select the links above or visit the CMS-sponsored ICD-10 teleconferences Web page at *http://www.CMS.gov/ICD10/Tel10/list.asp*; select a call date from the list of previous national provider calls to access related presentation materials, audio recordings, and written transcripts.

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

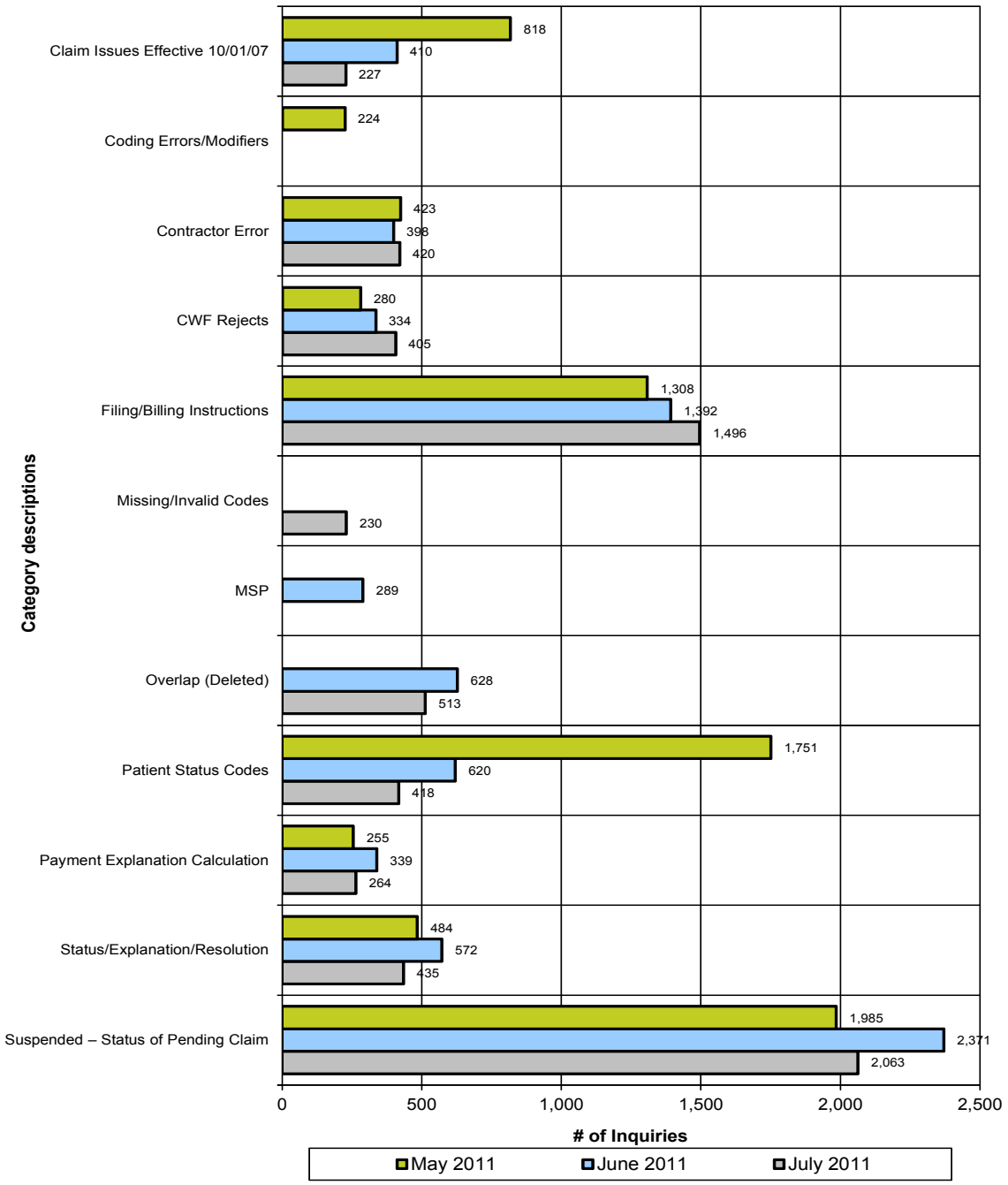
Source: CMS PERL 201108-22

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



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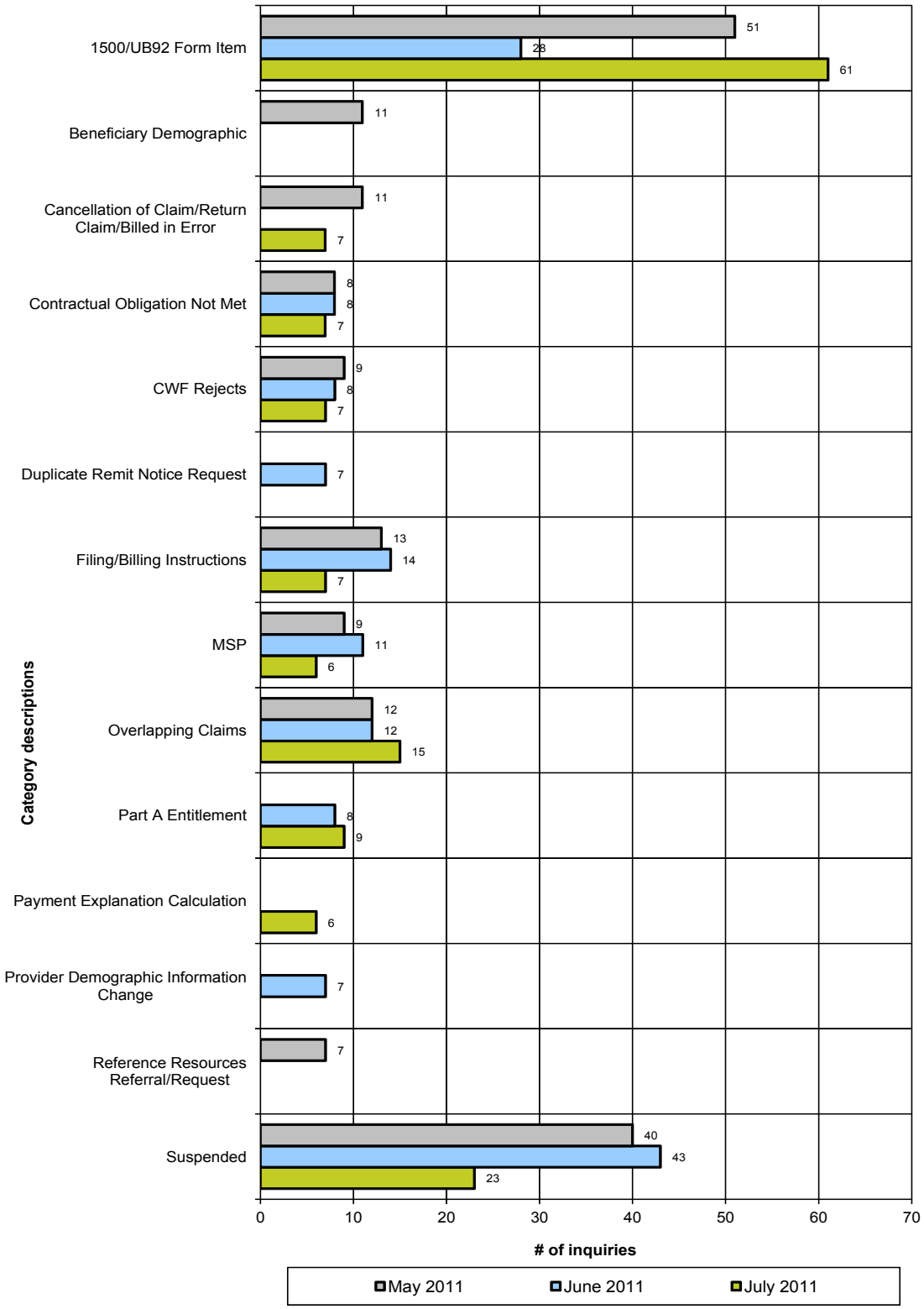
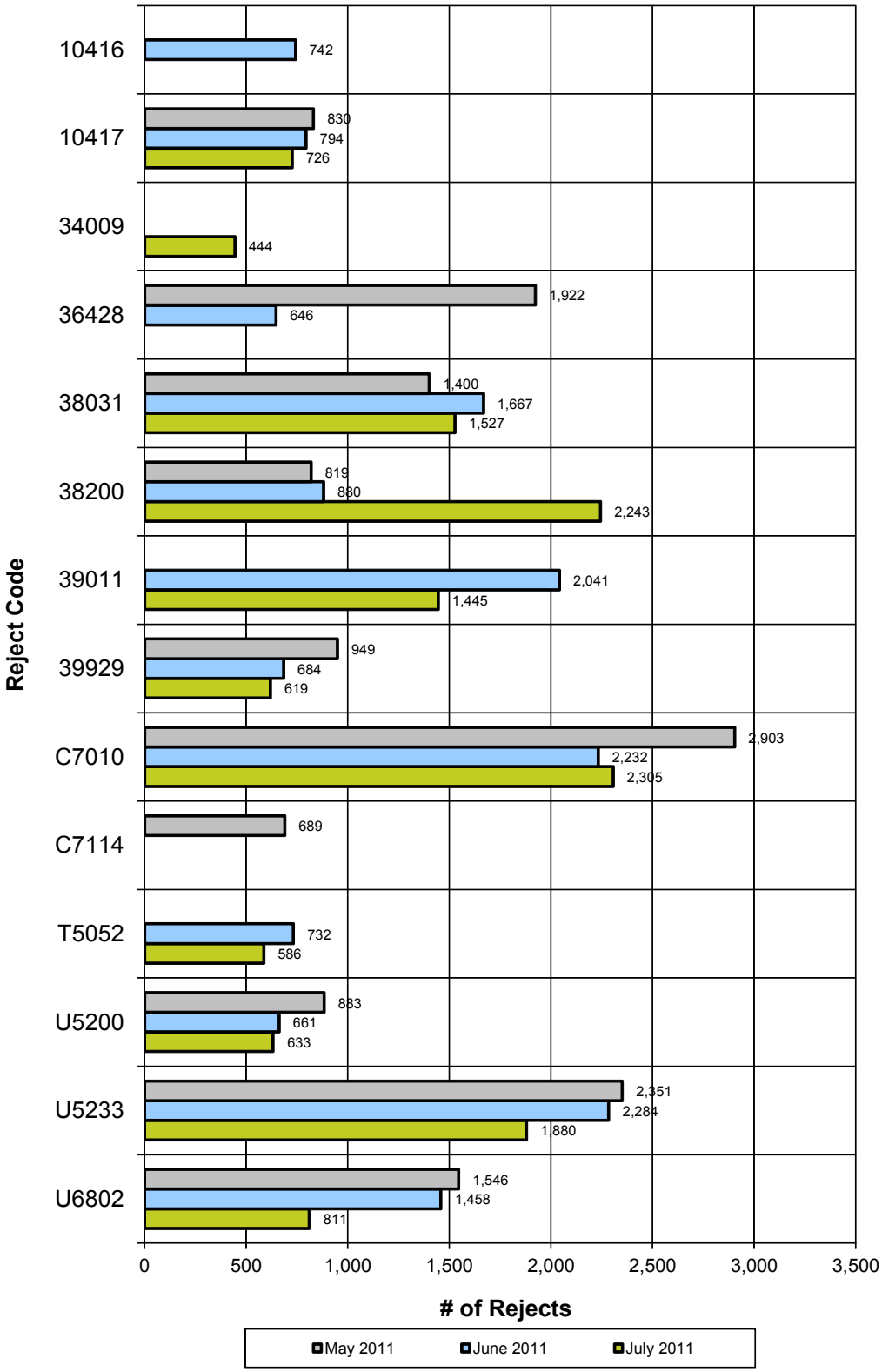
Inquiries...*continued*

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



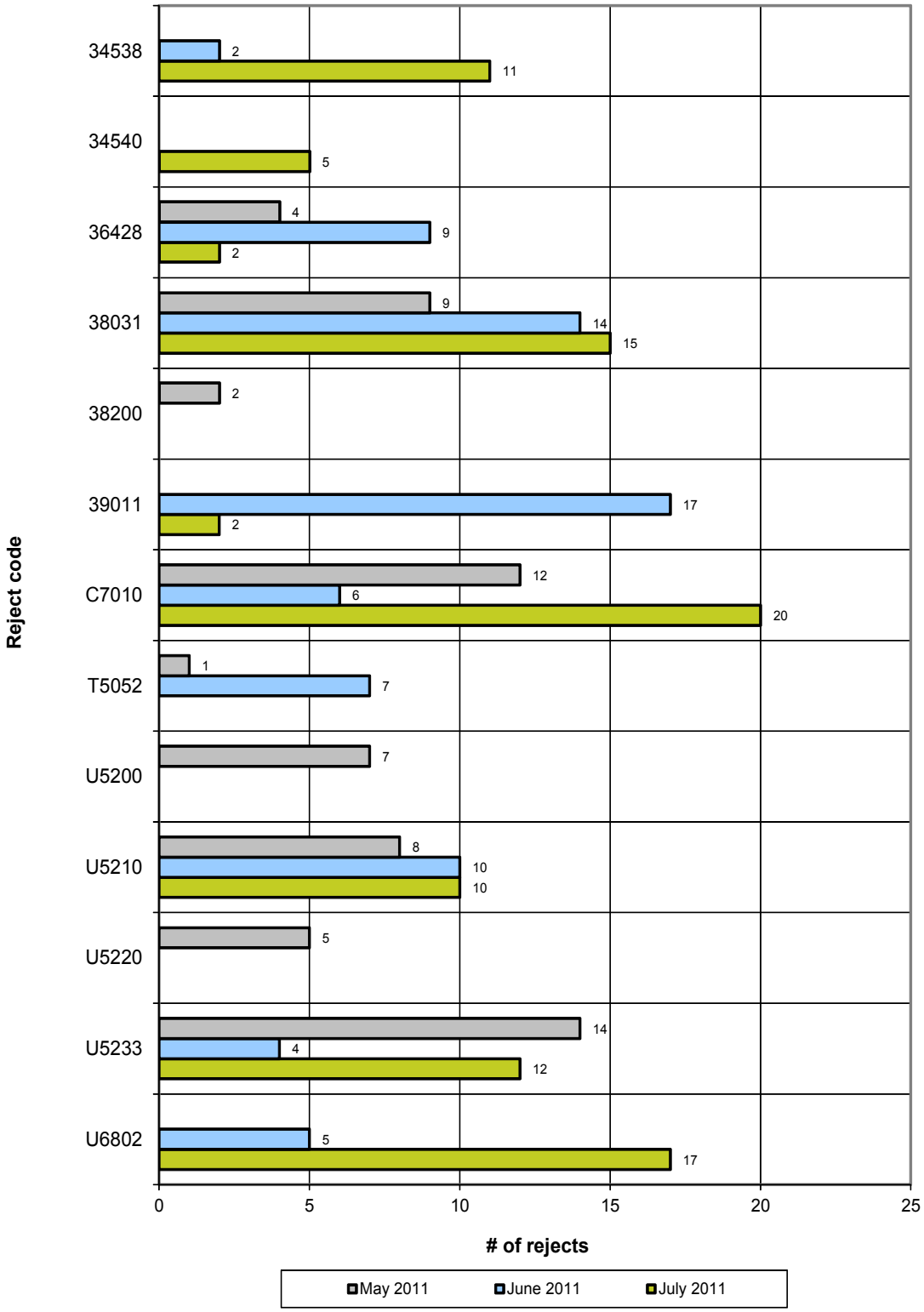
Florida Part A top rejects for May-July 2011



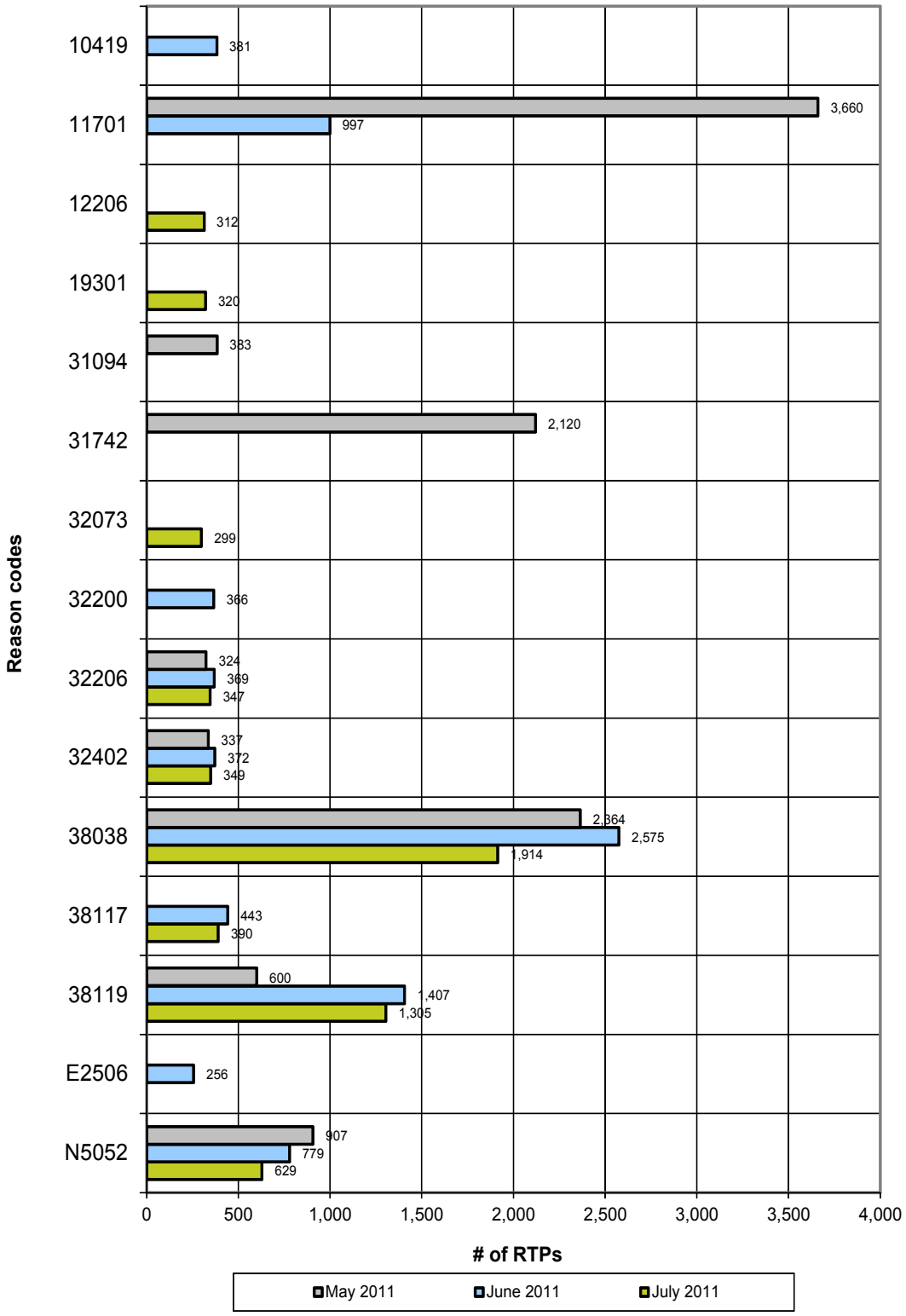
continued on next page

Rejects...*continued*

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



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



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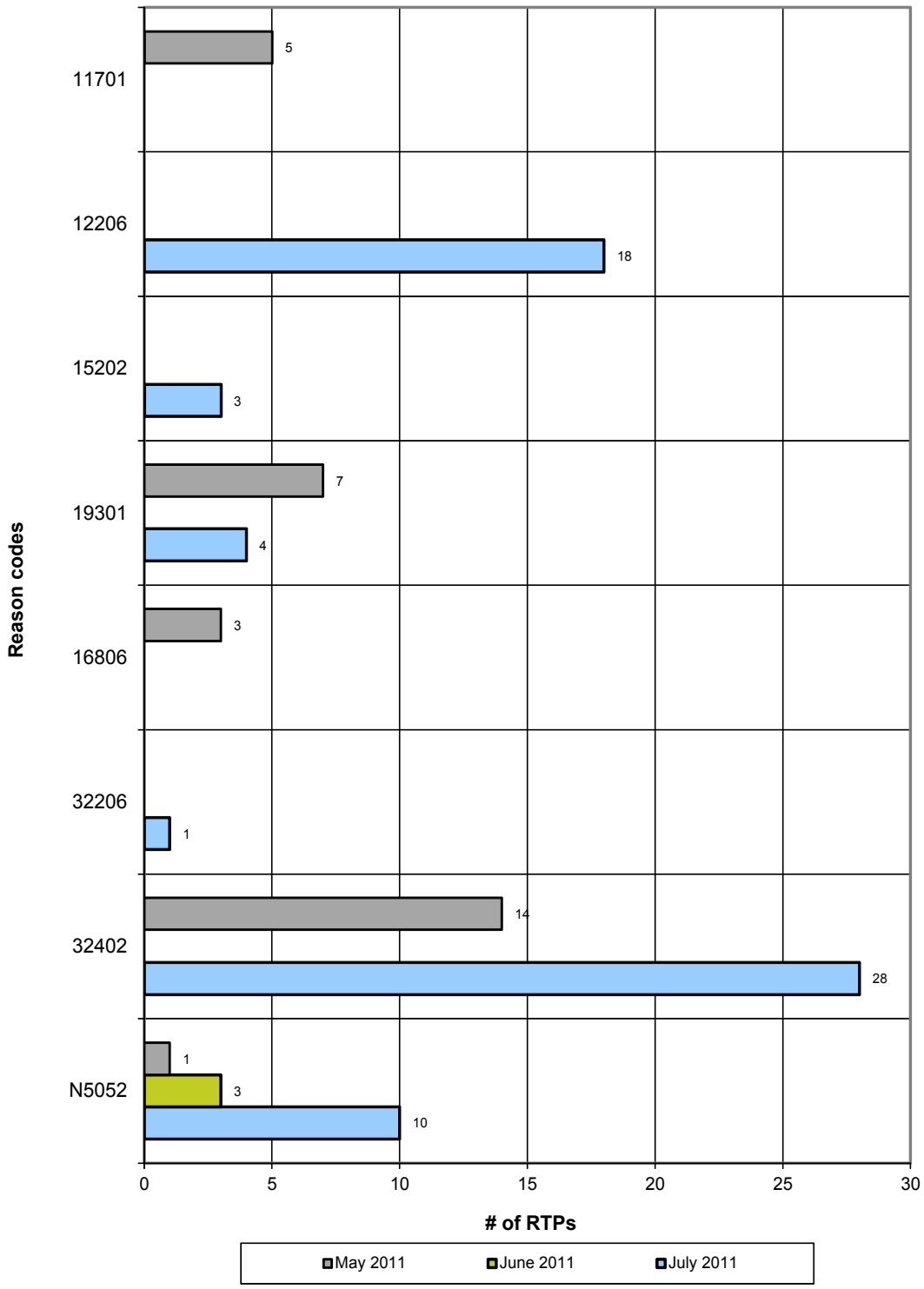
RTPs...*continued*

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



July 2011 quarterly provider specific files corrected

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

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

A new version of the text files has been added with name and address information at the end of the record. If you use the PSF text or SAS file data, please go to the respective page above and download the latest version of the 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 201107-57

Adjustments being made to claims processed for medically-unlikely edit "51MUE"

On June 7, 2010, the Centers for Medicare & Medicaid Services implemented a correction/fix to change request (CR) 6820, "Quarterly Update to Medically Unlikely Edits (MUEs), Version 4.1, Effective April 1, 2010," under recurring CR R21028R1. This correction caused paid claim records to be incorrectly built when a claim has a "51MUE" in the denial reason code field on a claim line. Additionally, remits and provider statistical reimbursement (PS&R) systems had incorrect data in the non-covered fields of these claims.

A correction to this fix has been installed under CR FS6189, effective June 6, 2011; fiscal intermediaries (FIs) and A/B MACs were instructed to create and process mass adjustments after the CR was installed. In order to be submitted for reprocessing, claims should meet the following criteria:

- Receipt date between June 7, 2010, and June 5, 2011
- Type of bill equal to 13x, 14x, or 85x
- Line denial reason code 51MUE

FIs and A/B MACs had until close-of-business Friday, July 29, 2011, to complete the processing of adjustments.

Source: CMS PERL 201108-30

Inpatient Psychiatric Facility Prospective Payment System fact sheet available in hard copy

The *Medicare Learning Network's®* (*MLN's*) *Inpatient Psychiatric Facility Prospective Payment System* fact sheet is now available in print format. This fact sheet is designed to provide education on the inpatient psychiatric facility prospective payment system (IPF PPS) and includes information on background, coverage requirements, how payment rates are set, and the rate year 2012 update to the IPF PPS. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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

Source: CMS PERL 201108-12

July 2011 integrated I/OCE specifications version 12.2

Note: This article was revised on August 8, 2011, to add a reference to MM7443 (*http://www.MLNMattersArticles/downloads/MM7443.pdf*) for the changes to various payment policies and billing instructions implemented in the July 2011 outpatient prospective payment system (OPPS) update. All other information remains the same. This information was previously published in the June issue of the *Medicare A Connection*, page 49.

Provider types affected

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

Provider action needed

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

Background

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

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

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

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

Additional information

The official instruction, CR 7439 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2224CP.pdf*. If you have any questions, please contact your Medicare MAC, RHHI or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7488, which instructs Medicare contractors to download and implement the October 2011 average sales price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

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

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

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

Additional information

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

The official instruction (CR 7488) issued to your Medicare MAC, carrier, and FI may be found at *http://www.cms.gov/Transmittals/downloads/R2264CP.pdf*.

MLN Matters® Number: MM7488
Related Change Request (CR) #: 7488
Related CR Release Date: July 29, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2264CP
Implementation Date: October 3, 2011

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Update to hospice payment rates, cap, wage index and pricer for FY 2012

Provider types affected

Hospice providers submitting claims to Medicare contractors [fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)] for services provided to Medicare beneficiaries need to be aware of this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7518 which provides the annual update to the hospice payment rates for fiscal year (FY) 2012, the hospice aggregate cap amount for the cap period ending October 31, 2011, and the hospice wage index and Pricer for FY 2012. Be sure your billing staffs are aware of these changes, which are described in the *Background* and *Key Points* sections, below.

Background

CMS updates the payment for hospice care, the hospice aggregate cap amount, and the hospice wage index annually. The Social Security Act (the Act) (Section 1814(i)(1)(C)(ii)) stipulates that the payments for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for that FY, and this payment methodology is codified in the Code of Federal Regulations (refer to Title 42, Section 418.306 (a)&(b)).

Key points

FY 2012 hospice payment rates

The FY 2012 payment rates will be the FY 2011 payment rates, increased by 3.0 percentage points, which is the total hospital market basket percentage increase forecasted for FY 2012. The FY 2012 hospice payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2011, through September 30, 2012.

Code	Description	Rate	Wage component subject to index	Non-weighted amount
651	Routine home care	$151.03	$103.77	$47.26
652	Continuous home care full rate = 24 hours of care $36.73= hourly rate	$881.46	$605.65	$275.81
655	Inpatient respite care	$156.22	$84.56	$71.66
656	General inpatient care	$671.84	$430.04	$241.80

Reference to the hospice payment rate is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates); see *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf*.

Hospice cap

The latest hospice cap amount for the cap year ending October 31, 2011, is $24,527.69. In computing the cap, CMS used the medical care expenditure category of the March 2011 Consumer Price Index for all urban consumers, published by the Bureau of Labor Statistics, (see *http://www.bls.gov/cpi/home.htm* on the Internet), which was 397.726. The hospice cap is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 80.2 (Cap on Overall Hospice Reimbursement); see *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf*).

Hospice wage index

The FY 2012 Hospice Wage Index final rule will be effective October 1, 2011, and published in the *Federal*

continued on next page

Hospice...*continued*

Register before that date. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index final rule.

Be aware: Hospice providers should split claims if dates of service span separate fiscal years, e.g., September/October billing as the FY 2011 rates will be used if the hospice chooses not to split the claim and your Medicare contractor will perform no subsequent adjustments to these claims.

Additional information

The official instruction, CR 7518 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2260CP.pdf*.

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

MLN Matters® Number: MM7518
Related Change Request (CR) #: 7518
Related CR Release Date: July 29, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2260CP
Implementation Date: October 3, 2011

Final wage index changes for Medicare hospices increase FY 2012 payments

Final rule aims to improve patient access, quality of care

Hospices serving people with Medicare will see a 2.5 percent increase in their Medicare payments for fiscal year (FY) 2012, according to a final regulation released by the Centers for Medicare & Medicaid Services (CMS). Hospices are also called upon to begin reporting on the quality of care received by Medicare patients, as a result of this final regulation.

The estimated hospice payments are the net result of a 3.0 percent increase in the "hospital market basket," an indicator of industry-related price increases, offset by an estimated 0.5 percent decrease in payments to hospices due to updated wage index data and the third year of CMS' seven-year phase-out of a wage index budget neutrality adjustment factor (BNAF).

In this final rule, CMS will:

- Change the way it counts hospice patients for the 2012 cap accounting year and beyond. The final policy for counting the number of Medicare hospice beneficiaries in care for a given cap year calculates the cap based on the number of days of care the patient received in that cap year for each hospice. This rule also finalized that the new counting method be applied to past cap years in certain instances.
- Allow hospice providers who do not want a change in their patient counting method to elect to continue using the current method.
- Allow any hospice physician to perform the face-to-face encounter regardless of whether that same physician recertifies the patient's terminal illness and composes the recertification narrative.
- Implement a hospice quality reporting program, which includes a timeframe for reporting, as required by section 3004 of the Affordable Care Act. The measures that are being adopted in this final rule for the FY 2014 program are one measure endorsed by the National Quality Forum related to pain management and one structural measure that assesses whether a hospice administers a Quality Assessment and Performance Improvement (QAPI) program that contains at least three indicators related to patient care.

As finalized, hospices will be required to begin collecting quality data in October 2012, and will submit the data in 2013; hospices may also voluntarily begin collecting data on the QAPI measure in October 2011 for submission in 2012. Hospices failing to report quality data in 2013 will have their market basket update reduced by two percentage points in FY 2014.

continued on next page

Wage...*continued*

Information on the final hospice wage index payment and policy changes and other health care news can also be found on a new web portal, *www.healthcare.gov*, made available by the U.S. Department of Health and Human Services.

The full text of the Notice of Proposed Rulemaking can be found under "Special Filings" at: *http://www.ofr.gov/OFRUpload/OFRData/2011-19719_PI.pdf* or *http://www.federalregister.gov/inspection.aspx*.

To read the entire CMS press issued July 29, go to *https://www.cms.gov/apps/media/press/release.asp?Counter=4031*.

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

Source: CMS PERL 201107-53

Reporting of recoupment for overpayment on the remittance advice with patient control number

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the health insurance claim (HIC) number being sent on the ASC X12 Transaction 835) with the patient control number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR 6870 and CR 7068. The *MLN* Matters article corresponding to CR 6870 can be reviewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf* and CR 7068 can be reviewed at *http://www.cms.gov/transmittals/downloads/R812OTN.pdf*.

It has been brought to the attention of CMS that providing the patient control number as received on the original claim rather than the HIC number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR 7499 instructs the shared systems to replace the HIC number being sent on the ERA with the patient control number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the accounts receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR 7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the standard paper remit or the 004010A1 version of ASC X12 Transaction 835.

Additional information

The official instruction, CR 7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R940OTN.pdf*.

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

MLN Matters® Number: MM7499
Related Change Request (CR) #: CR 7499
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R940OTN
Implementation Date: April 2, 2012

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Recovery audit program: MAC-issued demand letters

Provider types affected

This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors [carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Medicare administrative contractors (MACs)].

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7436 which announces that Medicare's recovery auditors will no longer issue demand letters to you as of January 3, 2012.

Caution – what you need to know

Recovery auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the recovery auditor's review, and issue an automated demand letter to you.

Go – what you need to do

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

Background

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its recovery auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a recovery auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any recovery auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating recovery auditor and his/her contact information in the related demand letter. You should contact that recovery auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

Additional information

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

To see the official instruction (CR 7436) issued to your Medicare contractor, see *http://www.cms.gov/Transmittals/downloads/R192FM.pdf*.

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Effective Date: January 1, 2012
Related CR Transmittal #: R192FM
Implementation Date: January 3, 2012

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Medicare payment rule promotes improved inpatient care

Final rule strengthens tie between payment and quality improvement and will lead to lower costs

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare payment policies and rates for hospitals in fiscal year (FY) 2012. The final rule, which will affect Medicare payments to general acute care hospitals and long-term care hospitals for inpatient stays, supports efforts to promote ongoing improvements in hospital care that will lead to better patient outcomes while addressing long-term health care cost growth.

The final rule updates payment policies and rates for acute care hospitals paid under the inpatient prospective payment system (IPPS), as well as hospitals paid under the long-term care hospital prospective payment system (LTCH PPS). The final rule also strengthens the hospital inpatient quality reporting (IQR) program by placing greater emphasis on preventing health care-associated infections in general acute care hospitals, and establishes the framework for a new quality reporting program that will apply to hospitals paid under the LTCH PPS.

CMS projects that total Medicare operating payments to acute care hospitals for inpatient services occurring in FY 2012 will increase by $1.13 billion, or 1.1 percent, in FY 2012 compared with FY 2011, due to a 1.0 percent increase in payment rates together with other policies adopted in the final rule. Medicare payments to LTCHs in FY 2012 are projected to increase by $126 million or 2.5 percent in FY 2012 relative to FY 2011, due to a 1.8 percent increase in payment rates together with other policies adopted in the final rule.

The final rule, which will apply to approximately 3,400 acute care hospitals and 420 LTCHs, will be effective for discharges occurring on or after October 1, 2011, unless otherwise specified in the rule. The final rule will increase payments to general acute care hospitals under the IPPS by 1.1 percent, compared with a 0.55 percent reduction in the proposed rule, and will increase payments to LTCHs by 2.5 percent, compared with 1.9 percent in the proposed rule. Certain hospitals are excluded from IPPS (such as, cancer and children's hospitals and religious nonmedical health care institutions).

> The final rule will increase payments to acute care hospitals by 1.1 percent and to LTCHs by 2.5 percent.

The full text of the final rule can be found at *http://www.ofr.gov/OFRUpload/OFRData/2011-19719_PI.pdf* or *http://www.federalregister.gov/inspection.aspx*.

For supporting files, go to the first Spotlight on the Hospital Center page. To read the entire CMS press and fact sheets issued August 1, refer to the following links:

- CMS press release link: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.
- CMS fact sheet link: *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

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

Source: CMS PERL 201108-01

Fiscal year 2011 INP PPS PC Pricer update

An error was discovered and fixed in the bill discharge date edit 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. The update is for claims dated from October 1, 2010, to September 30, 2011. The update is dated July 26, 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 201107-51

Processing issue with FY 2010 inpatient prospective payment system hospital claims

The Centers for Medicare & Medicaid Services (CMS) has recently become aware of an error in the payments of fiscal year (FY) 2010 inpatient prospective payment system (IPPS) hospital claims received since July 1, 2011. This affects claims with discharges on or after October 1, 2009, through September 30, 2010. Claims received for discharges on or after October 1, 2010, are unaffected.

CMS is working quickly to resolve this issue. Until it is corrected, your fiscal intermediary (FI) or A/B Medicare administrative contractor (MAC) has:

- Discontinued reprocessing Affordable Care Act and recovery audit contractor IPPS claim adjustments for FY 2010 dates of discharge;
- Held all provider-submitted IPPS adjustment claims with FY 2010 dates of discharge; and
- Held any new IPPS claims received with dates of discharge on or after October 1, 2009, through September 30, 2010, that are still within the timely filing requirements.

Please contact your FI or A/B MAC pertaining to accelerated payments and note that they will reprocess any claims affected by this issue. CMS will notify you when the correction has been implemented.

Source: CMS PERL 201108-13

Addition of MS-DRG 265 to the list subject to IPPS replaced devices offered without cost or with a credit policy

Provider types affected

Hospitals submitting claims to fiscal intermediaries (FIs) and Parts A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries relating to replaced medical devices are affected by this article.

Provider action needed

This article, based on change request (CR) 7457, informs you that medical severity diagnosis related group (MS-DRG) 265 is being added to the list of DRGs subject to the final policy for the inpatient prospective payment system (IPPS) reimbursement of replaced devices offered without cost or with a credit. Please be sure to inform your billing staffs of this change. In addition, **to expedite processing in view of timely filing edits, please reference CR 7457 in the remarks section of applicable claims or adjustments**.

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) was made aware that MS-DRG code 265 was omitted from the list of DRGs subject to the final policy for the IPPS reimbursement of replaced devices offered without cost or with a credit. In FY 2008, both the automatic implantable cardiac defibrillator (AICD) generator procedures and the lead procedures were combined in MS-DRG 245. When the MS-DRGs for FY 2009 were created, the AICD lead procedures were separated from the generators and grouped to MS-DRG 265.

CR 5860 instructed providers to bill the amount of the credit for a replaced device if the hospital receives a credit that is 50 percent or greater than the cost of the device effective for discharges on or after October 1, 2008. Medicare will reduce the hospital reimbursement for one of the applicable MS-DRGs listed in that CR by the full or partial credit a provider received for a replaced device as associated with value code “FD.” CR 5860 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM5860.pdf*.

MS-DRG 265, AICD lead procedures, is being added to the list in the table below of MS-DRGs subject to the policy for adjusting IPPS reimbursement for replaced devices offered without cost or with a credit.

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DRG...*continued*

DRGs subject to final policy

MDC	MS-DRG	Narrative description of DRG
PRE	1 & 2	Heart transplant or implant of heart assist system with and without MCC, respectively (former MS-DRG 103, heart transplant or implant of heart assist system)
1	25 & 26	Craniotomy and endovascular intracranial procedure with MCC or with CC, respectively (former CMS-DRG 1, craniotomy age > 17 with CC)
1	26 & 27	Craniotomy and endovascular intracranial procedure with CC or without CC/MCC, respectively (former CMS-DRGs 2, craniotomy age > 17 without CC)
1	40 & 41	Peripheral & cranial nerve & other nervous system procedure with MCC; or with CC or peripheral neurostimulator, respectively (former CMS-DRG, 7 peripheral & cranial nerve & other nervous system procedures with CC)
1	42	Peripheral & cranial nerve & other nervous system procedure without CC/MCC (former CMS-DRG 8, peripheral & cranial nerve & other nervous system procedures without CC)
1	23 & 24	Craniotomy with major device implant or acute complex central nervous system principal diagnosis with MCC or chemotherapy implant; and without MCC [or chemotherapy implant], respectively (former CMS-DRG 543, craniotomy with major device implant or acute complex central nervous system principal diagnosis)
3	129 & 130	Major head & neck procedures with CC/MCC or major device; or without CC/MCC, respectively (former CMS-DRG 49, major head & neck procedures)
5	216, 217, & 218	Cardiac valve & other major cardiothoracic procedure with cardiac catheterization with MCC; or with CC; or without CC/MCC, respectively (former CMS-DRG 104, cardiac valve & other major cardiothoracic procedures with cardiac catheterization)
5	219, 220, & 221	Cardiac valve & other major cardiothoracic procedure without cardiac catheterization with MCC; or with CC, or without CC/MCC, respectively (former CMS-DRG 105, cardiac valve & other major cardiothoracic procedures without cardiac catheterization)
5	237	Major cardiovascular procedures with MCC or thoracic aortic aneurysm repair (former CMS-DRG 110, major cardiovascular procedures with CC)
5	238	Major cardiovascular procedures without MCC (former CMS-DRG 111, major cardiovascular procedures without CC)
5	260, 261, & 262	Cardiac pacemaker revision except device replacement with MCC, or with CC, or without CC/MCC, respectively (former CMS-DRGs117, cardiac pacemaker revision except device replacement)
5	258 & 259	Cardiac pacemaker device replacement with MCC, and without MCC, respectively (former CMS-DRG 118, cardiac pacemaker device replacement)
5	226 & 227	Cardiac defibrillator implant without cardiac catheterization with MCC and without MCC, respectively (former CMS-DRG 515, cardiac defibrillator implant without cardiac catheterization)
5	215	Other heart assist system implant (former CMS-DRG 525, other heart assist system implant)

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DRG...*continued*

MDC	MS-DRG	Narrative description of DRG
5	222 & 223	Cardiac defibrillator implant with cardiac catheterization with acute myocardial infarction/heart Failure/shock with MCC and without MCC, respectively (former CMS-DRGs 535, cardiac defibrillator implant with cardiac catheterization with acute myocardial infarction/heart failure/shock)
5	224 & 225	Cardiac defibrillator implant with cardiac catheterization without acute myocardial infarction/heart failure/shock with MCC and without MCC, respectively (former CMS-DRG 536, cardiac defibrillator implant with cardiac catheterization without acute myocardial infarction/heart failure/shock)
5	242, 243, & 244	Permanent cardiac pacemaker implant with MCC, with CC, and without CC/MCC, respectively (MS-DRG 551, permanent cardiac pacemaker implant with major cardiovascular diagnosis or AICD lead or generator)
5	242, 243, & 244	Permanent cardiac pacemaker implant with MCC, with CC, and without CC/MCC, respectively (former CMS-DRG 552, other permanent cardiac pacemaker implant without major cardiovascular diagnosis)
5	245	AICD generator procedures (this is a new MS-DRG, created from AICD and generator codes moved out of CMS DRG 551)
5	265	AICD lead procedures
8	461 & 462	Bilateral or multiple major joint procedures of lower extremity with MCC, or without MCC, respectively (former CMS-DRG 471, bilateral or multiple major joint procedures of lower extremity)
8	469 & 470	Major joint replacement or reattachment of lower extremity with MCC or without MCC, respectively (former CMS-DRG 544, major joint replacement or reattachment of lower extremity)
8	466, 467, & 468	Revision of hip or knee replacement with MCC, with CC, or without CC/MCC, respectively (former CMS-DRG 545, revision of hip or knee replacement)

Additional information

The official instruction, CR 7457, issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R922OTN.pdf*.

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

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Method of cost settlement for inpatient services for rural hospitals participating under demonstration

Provider types affected

This article is for specific rural inpatient acute care hospitals (see following list of provider numbers) that bill Medicare contractors (fiscal intermediaries (FIs) or Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

Provider action needed

If you are an affected hospital, make sure your billing and reimbursement staffs are aware of these changes.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated a demonstration that establishes rural community hospitals. An eligible hospital is located in a rural area, has fewer than 51 acute care beds, makes available 24-hour emergency services, and is not eligible for critical access hospital designation. As of November 2010, out of 18 hospitals chosen between 2004 and 2008, eight hospitals were still participating in the demonstration. Holy Cross Hospital in Taos, NM is withdrawing, effective with its cost report ending on May 31, 2011. Its participation in the continuation period will be effective for the cost report year June 1, 2010 – May 31, 2011.

Sections 3123 and 10313 of the Affordable Care Act both expanded and extended the demonstration. Hospitals continuing participation from the initial period are grandfathered into the project – with a 5-year continuation period for each hospital.

In addition, 18 new hospitals will begin the demonstration. Each will participate for a period of 5 years, beginning on its first cost report start date on or after April 1, 2011. The period of performance will conclude December 31, 2016.

Key points

For each participating hospital:

1. In the first cost reporting period (the first cost reporting period starting in calendar year (CY) 2010 for continuing hospitals, the first cost reporting period on or after April 1, 2011, for newly participating hospitals), the hospital's payment for covered inpatient services, excluding services in a psychiatric or rehabilitation unit that is a distinct part of the hospital, will be the reasonable cost of providing such services. Swing bed services are included among the covered services for which the hospital receives payment on the basis of reasonable costs.
2. Reimbursement for the reasonable cost of services to beneficiaries is made according to the principles stated in 42 CFR 413 and Chapter 21 of Part I of the *Provider Reimbursement Manual*. As stated in these documents, only costs that can be directly attributed to patient care will be reimbursed.
3. One hundred percent of bad debt will be included in the determination of reasonable cost.
4. Capital costs will be included in the determination of reasonable cost.
5. Costs of outpatient services performed within 72 hours prior to inpatient admission will be bundled, as appropriate, as part of the cost of the inpatient service.
6. The reasonable cost payment for the first cost reporting period applies to the first cost reporting period starting in CY 2010 for the eight hospitals continuing from the initial demonstration period. It applies to the first cost reporting period on or after April 1, 2011, for the 18 newly participating hospitals.
7. In subsequent cost reporting periods of the demonstration program, payment for covered inpatient services is the lesser of reasonable costs of providing such services or the target amount. This methodology applies to all 26 participating hospitals.
8. The payment methodology for covered inpatient services during subsequent cost reporting periods, i.e., years two through five, is described in Attachment A of CR7505, which is viewable at *http://www.cms.gov/Transmittals/downloads/R77DEMO.pdf* on the Centers for Medicare & Medicaid services (CMS) website.
9. If a hospital offers swing bed services, the Medicare FI/MAC will calculate two separate target amounts for the purpose of calculating reimbursement:
   - for acute care services; and
   - for swing-bed services.
10. If a hospital provides only acute care services, then there will be only one target amount for acute care services.
11. Hospitals participating in the demonstration will be able to participate in other CMS demonstrations.

continued on next page

Rural...*continued*

12. Hospitals participating in the demonstration will not be able to receive the low volume payment adjustment in addition.
13. The MAC or FI will not make any Medicare disproportionate share payment in addition to the cost-based payment for inpatient services. For each cost reporting period, the MAC or FI will collect necessary data from each hospital for the provider specific file in order to calculate disproportionate share percentages. The purpose of this data collection is that hospitals will use these percentages to potentially be eligible for non-Medicare benefit programs tied to the disproportionate share percentage or status.
14. Under the demonstration, a hospital will also not receive add-on payments as a sole community hospital or Medicare dependent hospital.
15. If in either fiscal year (FY) 2011 or FY 2012 a participating hospital receives an additional payment for qualifying hospitals with lowest enrollee Medicare spending under section 1109 of the Affordable Care Act, the MAC or FI will subtract the amount paid under this provision from the cost-based payment for Medicare inpatient services calculated under this demonstration methodology. This deduction will be made only if the additional payment being made to the hospital under Section 1109 occurs at a point in time concurrent with the hospital's period of performance in the demonstration. For example: if payment under Section 1109 occurs in September 2011, and:
    - A hospital is one of the originally participating hospitals, beginning the extension period with cost report period starting January 1, 2010, then the amount received under Section 1109 will be subtracted from the demonstration payment for the cost report year January 1, 2011 –December 31, 2011.
    - A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year July 1, 2011 – June 30, 2012, then the amount received under Section 1109 will be subtracted from the demonstration payment for that cost report year.
    - A hospital is one of the newly selected hospitals and it begins the demonstration with cost report year January 1, 2012 – December 31, 2012, then the amount of the payment for FY 2011 will not be subtracted for the hospital.
16. Since hospitals participating in the demonstration are considered to be subsection (d) hospitals, they will be able to participate in the Medicare Health Information Technology (HIT) incentive payment program. They will be required to follow the regulations as subsection (d) hospitals.

The following hospitals are participating in the demonstration and they will also be receiving additional payments under Section 1109:

Originally participating hospitals

- Columbus Community Hospital, Columbus, NE;
- Holy Cross Hospital, Taos, NM;
- Brookings Hospital, Brookings, SD; and
- Garfield Memorial Hospital, Panguitch, UT.

Newly selected hospitals

- Yampa Valley Medical Center, Steamboat Springs, CO;
- St Anthony Regional Hospital, Carroll, IA;
- Skiff Medical Center , Newton, IA;
- Lakes Regional Healthcare, Spirit Lake, IA;
- Grinnell Regional Medical Center, Grinnell, IA;
- Geary Community Hospital, Junction City, KS;
- Miles Memorial Hospital, Damariscotta, ME;
- Inland Hospital, Waterville, ME;
- San Miguel Hospital Corporation, Las Vegas, NM; and
- Cibola General Hospital, Grants, NM.

Additional information

The official instruction, CR 7505 issued to your FI or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R77DEMO.pdf*.

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

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Section 5503: Distribution of additional residency positions

On August 15, 2011, the Centers for Medicare & Medicaid Services (CMS) released the results of its decisions regarding which teaching hospitals are receiving reductions and/or increases to their direct graduate medical education (GME) and indirect medical education (IME) full-time equivalent (FTE) resident caps. Section 5503 of the Affordable Care Act provides for reductions in the direct GME and IME FTE resident caps for certain hospitals, and authorizes a "redistribution" to certain hospitals of the estimated number of FTE resident slots resulting from the reductions.

Effective for portions of cost reporting periods occurring on or after July 1, 2011, for direct GME and IME, a hospital's FTE resident caps will be reduced by 65 percent of the "excess" resident slots. The Secretary of the Health and Human Services Department is also authorized to increase the otherwise applicable FTE resident caps for each qualifying hospital that submits a timely application by a number that the Secretary may approve, effective for portions of cost reporting periods occurring on or after July 1, 2011.

Hospitals' requests for FTE resident cap increases were limited to no more than 75 FTE positions for direct GME and IME, respectively. Section 5503 specifies that the slots are to be distributed in the following manner: 70 percent of the resident slots are to be distributed to hospitals located in states with resident-to-population ratios in the lowest quartile, and 30 percent of the resident slots are to be distributed to hospitals located in a state, a territory of the United States, or the District of Columbia that are among the top 10 states, territories, or districts in terms of the ratio of Health Professional Shortage Area (HPSA) population to the total population, and/or to hospitals located in rural areas of any state. Hospitals not located in these states or in a rural area do not qualify for redistributed slots.

To see the list of hospitals receiving FTE resident cap decreases or increases or both, click on the link below and scroll down until you find the file called "Section 5503 Cap Decreases and Increases."

http://www.cms.gov/AcuteInpatientPPS/06_dgme.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 201108-31

Critical Access Hospitals

Anesthesiologist services in a method II critical access hospital

Provider types affected

Method II critical access hospitals (CAHs) billing Medicare administrative contractors (A/B MACs) and/or fiscal intermediaries (FIs) for anesthesiologists that have reassigned their billing rights to the CAH on type of bill 85x with revenue code 0963, modifier AA [professional fees for anesthesiologist (MD)] for payment of the anesthesia services rendered to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7465 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 7465 to highlight the revision to the *Medicare Claims Processing Manual*, Chapter 4, Section 250.3.2: "Physician Rendering Anesthesia in a Hospital Outpatient Setting." This revision eliminates the 20 percent reduction applied to anesthesia services rendered by anesthesiologists in a method II CAH, effective for such services on or after January 1, 2008.

Background

Physicians billing on type of bill 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. Currently payment is calculated for anesthesia services performed by an anesthesiologist with a modifier of AA in a method II CAH on a 20 percent reduction of the fee schedule amount before deductible and coinsurance are calculated. CR 7465 removes the 20 percent reduction that should not be applied in the payment calculation for these services.

Key points

- For dates of services on or after January 1, 2008, contractors will pay for anesthesia services (*CPT codes 00100 through 01999*) submitted by a method II CAH on an 85x bill type with revenue code of 963 and modifier AA based on the lesser of the actual charges or the fee schedule amount as follows: [(Sum of base units plus time (anesthesia time divided by 15)] times conversion factor minus deductible times 0.80 times 1.15.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 7465 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2268CP.pdf*.

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

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Implementation Date: January 3, 2012

FY 2012 payments for Medicare SNF case-mix indexes recalibrated to better align payments with costs

Also requires a new assessment to capture changes in therapy services, and allocation of group therapy time to ensure payment accuracy

The Centers for Medicare & Medicaid Services (CMS) announced a final rule reducing Medicare skilled nursing facility (SNF) prospective payment system (PPS) payments in fiscal year (FY) 2012 by $3.87 billion, or 11.1 percent lower than payments for FY 2011. The FY 2012 rates correct for an unintended spike in payment levels and better align Medicare payments with costs.

"CMS is committed to providing high quality care to those in skilled nursing facilities and to pay those facilities properly for that care," said CMS Administrator Donald M. Berwick, M.D. "The adjustments to the payment rates for next year reflect that policy."

CMS is now recalibrating the case-mix indexes (CMIs) for FY 2012 to restore overall payments to their intended levels on a prospective basis. The SNF PPS uses a resource classification system known as Resource Utilization Groups Version 4 (RUG-IV), which assigns a patient to a RUG group to determine a daily payment rate. Each RUG group consists of CMIs that reflects a patient's severity of illness and the services that a patient requires in the SNF. In transitioning from the previous classification system to the new RUG-IV, CMS adjusted the CMIs for FY 2011 based on forecasted utilization under this new classification system to establish parity in overall payments. SNFs have been paid under RUG-IV since October 1, 2010.

CMS found that the parity adjustment made in FY 2011, which was intended to ensure that the new RUG-IV system would not change overall spending levels from the prior year, instead resulted in a significant increase in Medicare expenditures during FY 2011. This increase in spending was primarily due to shifts in the utilization of therapy modes under the new classification system differing significantly from the projections on which the original parity adjustment was based.

"Additional data analyzed by CMS since publication of the proposed rule confirmed the extent of the overpayments that have occurred since implementation of the RUG-IV system," said Jonathan Blum, Deputy Administrator and Director of the Center for Medicare. "We are also making several improvements to our payment system to strengthen its integrity."

The FY 2012 recalibration of the CMIs will result in a reduction to SNF payments of $4.47 billion or 12.6 percent. However, this reduction would be partially offset by the FY 2012 update to Medicare payments to SNFs. The update – an increase of 1.7 percent or $600 million for FY 2012 – reflects a 2.7 percent increase in the prices of a "market basket" of goods and services reduced by a 1.0 percent multi-factor productivity (MFP) adjustment mandated by the Affordable Care Act. The combined MFP-adjusted market basket increase and the FY 2012 recalibration will yield a net reduction of $3.87 billion, or 11.1 percent.

For FY 2012, the recalibration will reflect the intent of the new RUG-IV system to pay SNF providers more accurately based on the service needs of Medicare beneficiaries in their care. The adjustment was determined using claims and assessment data from the first eight months of FY 2011. It will ensure that payments more accurately reflect the resources required to provide care for the range of SNF patients, including those requiring more medically complex care.

The recalibration will reflect the intent of the new RUG-IV system to pay SNFs more accurately based on the needs of Medicare beneficiaries in their care.

It is important to note that this recalibration removes an unintended spike in payments that occurred in FY 2011 rather than decreasing an otherwise appropriate payment amount. Even with the recalibration, the FY 2012 payment rates will be 3.4 percent higher than the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels.

Along with recalibrating and updating the SNF PPS payment rates for FY 2012, this final rule makes a number of additional revisions aimed at enhancing SNF PPS accuracy and integrity. The rule modifies the patient assessment windows and grace days to minimize duplication and overlap in observation periods between assessments. The final rule also:

- Clarifies circumstances when SNFs must report breaks of three or more days of therapy.
- Eliminates the distinction between facilities regularly furnishing therapy services on a 5- or 7-day basis for purposes of setting the date for the

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Indexes...*continued*

End of Therapy (EOT) Other Medicare Required Assessment (OMRA).

- Streamlines procedures for documenting situations involving a brief interruption in therapy, where therapy resumes without any change in the patient's RUG-IV classification level.
- Introduces a new Change of Therapy (COT) OMRA to capture those changes in a patient's therapy status that would be sufficient to affect the patient's RUG-IV classification and payment, even though they may not increase to the level of a significant change in clinical status.
- Provides for the allocation of a therapist's time for group therapy (defined in the rule as a single therapist leading four patients in a common activity) to ensure that Medicare payments better reflect resource utilization and cost for these services, and specifically that the therapist's time is being appropriately counted and reimbursed.
- Discusses the impact of certain provisions of the Affordable Care Act, and announces that proposed provisions regarding ownership disclosure requirements set forth in the Affordable Care Act will be finalized at a later date.

More information on this SNF PPS final rule and other health care related news can be found at *www.healthcare.gov*, a new Web portal made available by the U.S. Department of Health and Human Services.

For further information, see *http://www.cms.gov/center/snf.asp*. A copy of the final rule is available on the *Federal Register* website at *http://www.ofr.gov/OFRUpload/OFRData/2011-19544_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 201107-54

Payment policy changes for inpatient rehabilitation facilities

Final rule adopts measures for new IRF quality reporting program

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare payment policies and rates for more than 1,200 freestanding and hospital-based inpatient rehabilitation facilities (IRFs) in fiscal year (FY) 2012. The final rule increases IRF payment rates under the IRF prospective payment system (PPS) by 2.2 percent and establishes a new quality reporting system authorized by the Affordable Care Act. CMS projects that total payments under the IRF PPS will increase by $150 million in FY 2012.

Initially, IRFs will submit data on two quality measures, a urinary catheter-associated urinary tract infection measure and a measure for new or worsening pressure ulcers, with a third measure – "30-day comprehensive all cause risk standardized readmission" – under development. IRFs that do not submit performance data will see their payments reduced by two percentage points beginning in FY 2014. CMS anticipates adding measures for reporting in the future through rulemaking and establishing a process for making the data available to the public. As with other data on the CMS website, the IRFs would have an opportunity to review the data for accuracy before it becomes public.

The final rule will affect payments to more than 200 freestanding rehabilitation hospitals and more than 1,000 IRF units in acute care hospitals and critical access hospitals, beginning with discharges on or after October 1, 2011. Under the IRF PPS, the Medicare payment to an IRF increases after the IRF's costs for treating a beneficiary exceed an outlier threshold amount. The threshold is set for FY 2012 at an amount that is projected to maintain outlier payments at three percent of total payments under the IRF PPS.

The final rule also:

- Updates the case-mix group (CMG) relative weights using FY 2010 IRF claims and FY 2009 IRF cost report data;
- Uses the final FY 2011 pre-reclassified and pre-floor hospital wage data to determine the FY 2012 rates;
- Freezes the facility-level adjustment factors for FY 2012 at FY 2011 levels for one additional year while the agency explores ways to improve upon the accuracy and consistency of the current methodology used to calculate the facility-level adjustment factors;
- Allows IRFs to receive temporary adjustments to their FTE intern and resident caps if they take on interns and residents who are unable to complete their training because the IRF that had originally been their assigned training site either closed or ended its resident training program; and
- Allows IRF and inpatient psychiatric facility units to expand in the middle of a cost reporting period, rather than restricting such expansions to the start of a cost reporting period.

The final rule went on display on July 29, 2011, at the Office of the Federal Register's Public Inspection Desk and is available under "Special Filings" at *http://www.ofr.gov/OFRUpload/OFRData/2011-19516_PI.pdf* and *http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1*.

It appeared in the August 5, 2011 *Federal Register*.

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

To read the entire CMS press release issued July 29, go to *https://www.cms.gov/apps/media/press/release.asp?Counter=4032*.

The CMS fact sheet is available at *https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4033*.

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

Source: CMS PERL 201107-55

How can the PDS help my practice?

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

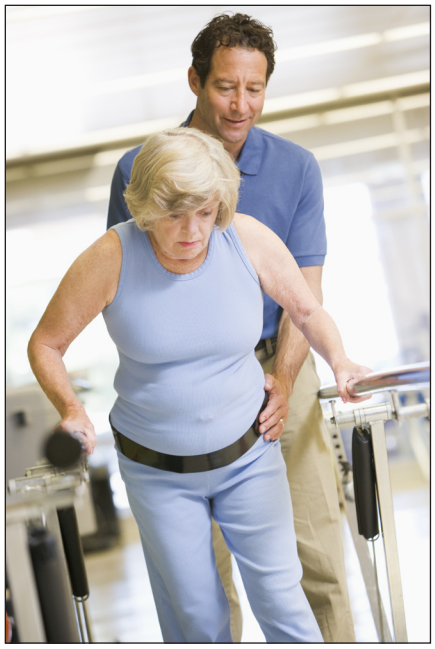
Inpatient rehabilitation facility annual update: PPS Pricer changes for fiscal year 2012

Provider types affected

This article is for inpatient rehabilitation facilities (IRFs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7510 which provides updated rates used to correctly pay inpatient rehabilitation facility prospective payment system (IRF PPS) claims for fiscal year (FY) 2012. Be sure your billing staff is aware of these changes.



Key points of CR 7510

The FY 2012 IRF PPS update notice published on July 29, 2011, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF PRICER software package will be released prior to October 1, 2011, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2011, through September 30, 2012.

Pricer updates: for IRF PPS FY 2011 (October 1, 2011 – September 30, 2012)

- The standard federal rate is $14,076;
- The fixed loss amount is $10,660;
- The labor-related share is 0.70199;
- The non-labor related share is 0.29801;
- Urban national average cost-to-charge ratio (CCR) is 0.520;
- Rural national average CCR is 0.669;
- The low income patient (LIP) adjustment is 0.4613;
- The teaching adjustment is 0.6876; and
- The rural adjustment is 1.184.

Additional information

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

The official instruction (CR 7510) issued to your Medicare MAC and/or FI is available at *http://www.cms.gov/Transmittals/downloads/R2275CP.pdf*.

MLN Matters® Number: MM7510
Related Change Request (CR) #: 7510
Related CR Release Date: August 12, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2275CP
Implementation Date: October 3, 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.

Inpatient rehabilitation facilities to receive PEPPER report – register now for training

Beginning in September 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for inpatient rehabilitation facilities (IRFs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges that may be at risk for improper Medicare payments. Facilities can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing an IRF's Medicare billing practices with other IRFs in the state, among Medicare administrative contractor (MAC) or fiscal intermediary (FI) jurisdictions and in the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to IRF distinct part units of short-term acute care hospitals through a MyQualityNet secure file exchange to hospital QualityNet administrators and user accounts with the PEPPER recipient role. Free-standing IRFs will receive their PEPPER in hardcopy format via FedEx addressed to the CEO/ Administrator, with delivery around Thursday, September 22, 2011.

Register for PEPPER training for IRF staff

TMF Health Quality Institute will conduct a Web-based training session for IRF staff providing information on PEPPER and how to use it on Friday, September 23, 2011, from 11 a.m. – 12:30 p.m. CT. To register for the training, IRF staff should visit *http://TMFevents.webex.com*. Because registration is limited, IRFs are encouraged to coordinate internally to prevent duplicate registrations per facility. The training session will be recorded and posted on *http://www.PEPPERresources.org*.

For more information, visit the *PEPPER website*. IRF staff is encouraged to join the email list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

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

Source: CMS PERL 201108-23

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.

Quarterly update to the ESRD prospective payment system

Provider types affected

Physicians, providers, and suppliers, including end-stage renal disease (ESRD) facilities and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, submitting claims to fiscal intermediaries (FIs), DME Medicare administrative contractors (DME MACs), or A/B MACs for ESRD supplies and services provided to Medicare beneficiaries are affected by this article.

Provider action needed

This article, based on change request (CR) 7476, advises you about the following corrections to Attachment 4 and Attachment 5 provided in CR 7064:

- Removes equipment and supply codes from Attachment 4 that are not separately payable to DMEPOS suppliers, and
- Adds these removed codes to Attachment 5.

You are also advised of the update to Attachment 8 provided with CR 7064, which is the list of ICD-9-CM codes eligible for the ESRD prospective payment system (PPS) co-morbidity payment adjustment. The list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective January 1, 2011, and the list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011, is available at *http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage* on the Centers for Medicare & Medicaid Services (CMS) website.

The revised attachments 4 and 5 are attached to CR 7476 at *http://www.cms.gov/Transmittals/downloads/R2255CP.pdf*. Items and services that are subject to the ESRD PPS consolidated billing requirements can be found at *http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage*.

Please be sure to inform your staffs of these changes.

Background

MM7064, entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," advised you about the implementation of a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. You may review this article by going to *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*.

The ESRD PPS provides payment adjustments for six categories (three acute and three chronic) of co-morbid conditions. When applicable, ESRD facilities can report specific ICD-9-CM diagnosis codes on ESRD facility claims to be eligible for a co-morbidity payment adjustment. The ICD-9-CM codes are updated annually and are published in the *Federal Register* in April/May of each year as part of the proposed changes to the hospital inpatient prospective payment systems and are effective each October 1. CR 7476 provides updates to attachment 8 of CR 7064, which includes the ICD-9-CM codes eligible for the ESRD PPS co-morbidity payment adjustment in accordance with the annual ICD-9-CM update, which is effective October 1, 2011.

Changes to the ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 include:

1. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.41 – Sickle-cell thalassemia without crisis has been revised to include microdrepanocytosis.
2. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, the 5 new ICD-9 codes added are as follows:
   - **282.43 Alpha thalassemia**
     - Alpha thalassemia major
     - Hemoglobin H Constant Spring
     - Hemoglobin H disease
     - Hydrops fetalis due to alpha thalassemia
     - Severe alpha thalassemia
     - Triple gene defect alpha thalassemia

     Excludes: alpha thalassemia trait or minor (282.46); hydrops fetalis due o isoimmunization (773.3); hydrops fetalis not due to immune hemolysis (778.0)
   - **282.44 Beta thalassemia**
     - Beta thalassemia major
     - Cooley's anemia
     - Homozygous beta thalassemia
     - Severe beta thalassemia
     - Thalassemia intermedia
     - Thalassemia major

     Excludes: beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); hemoglobin E beta thalassemia (282.47); sickle-cell beta thalassemia (282.41, 282.42)

conttinued on next page

Update...*continued*

- **282.45 Delta-beta thalassemia**
  - Homozygous delta-beta thalassemia

  Excludes: delta-beta thalassemia trait (282.46)

- **282.46 Thalasesmia minor**
  - Alpha thalassemia minor
  - Alpha thalassemia trait
  - Alpha thalassemia silent carrier
  - Beta thalassemia minor
  - Beta thalassemia trait
  - Delta-beta thalassemia trait
  - Thalassemia trait NOS

  Excludes: alpha thalassemia (282.43); beta thalassemia (282.44); delta beta thalassemia (282.45); hemoglobin E-beta thalassemia (282.47); sickle-cell trait (282.5)

- **282.47 Hemoglobin E-beta thalassemia**

  Excludes: beta thalassemia (282.44); beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); delta-beta thalassemia trait (282.46); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle-cell beta thalassemia (282.41, 282.42)

3. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to no longer include Cooley's anemia, Hb-Bart's disease, Microdrepanocytosis, Thalassemia (alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait), and Thalassemia NOS.
4. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to include dominant thalassemia, Hemoglobin C thalassemia, mixed thalassemia, and continues to include thalassemia with other hemoglobinopathy.
5. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to exclude hemoglobin C disease (282.7); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle cell anemias (282.60-282.69); and sickle-cell beta thalassemia (282.41-282.42)

Attachment 4 of CR 7064, *DME ESRD Supply Healthcare Common Procedure Coding System (HCPCS) for ESRD PPS Consolidated Billing Edits*, included the list of equipment and supplies that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Attachment 5 of CR 7064, *DME ESRD Supply HCPCS Not Payable to DME Suppliers*, included the list of the DME ESRD supply codes that are no longer separately payable to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers. To allow DMEPOS suppliers to get paid for furnishing these services under other circumstances covered by Medicare, CR 7064 provided instructions stating that DMEPOS suppliers may bill the items listed on Attachment 4 with the AY modifier to indicate that the item is used for reasons other than for the treatment of ESRD. Currently, there are equipment and supplies listed on Attachment 4 that are not used in other provider settings and would therefore never be used for reasons other than for the treatment of ESRD. Therefore, these items would not be covered by Medicare because there is no other benefit category that can provide coverage. CR 7476 rescinds and replaces Attachments 4 and 5 of CR 7064 as follows: Removes equipment and supply codes from Attachment 4 that are either not separately payable or not payable by Medicare and add these codes to Attachment 5. Surgical dressing code A6204 will also be included in Attachment 5.

Additional information

The official instruction, CR 7476, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2255CP.pdf*.

If you have any questions, please contact your FI, 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: MM7476
Related Change Request (CR) #: 7476
Related CR Release Date: July 15, 2011
Effective date s: 10/1/2011-ICD-9 Updates; 1/1/2011-DME Updates
Related CR Transmittal #: R2255CP
Implementation Date: October 3, 2011

Implementation of the ESRD quality incentive program

Provider types affected

Providers submitting claims to Medicare contractors (fiscal Intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7460 which announces the implementation of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153c) ESRD quality incentive program (QIP) and other requirements for ESRD claims.

Caution – what you need to know

MIPPA (Section 153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD QIP effective January 1, 2012, that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures.

Go – what you need to do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Section 153c) requires the CMS to implement a quality based payment program for dialysis services with payment consequences effective January 1, 2012. This QIP will result in payment reductions to providers of ESRD services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. The ESRD QIP is the first Medicare program which will link payments to performance based on outcomes as assessed through specific quality measures.

These measures are defined in the annual dialysis facility report (DFR) that each provider receives in addition to the final rule. The payment reductions will:

- Apply to payment for renal dialysis services furnished on or after January 1, 2012;
- Be up to 2.0 percent of payments otherwise made to ESRD facilities;
- Apply only to the year involved for an ESRD facility; and
- Not be taken into account when computing future payment rates for the impacted facility.

In addition to implementing the QIP, CMS will require ESRD facilities to provide the following on ALL ESRD claims with dates of service on or after January 1, 2012:

- The hemoglobin and/or hematocrit value(s);
- The route of administration of erythropoiesis stimulating agents (ESAs) using the JA or JB modifier code for any claim indicating the administration of ESAs;
- The Kt/V (calculated using a specified formula) indicating the measurement of dialysis adequacy.

Note: Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081 or J0882 on a 72x type of bill will result in that bill being returned to the provider.

CMS is making these changes to assess:

- The management of anemia for ESRD patients;
- The safety of the administration of ESAs; and
- The adequacy of the dialysis provided to ESRD patients using a standardized methodology for the calculation of Kt/V.

These changes will enable CMS to meet the intent of the MIPPA (Section 153c) legislation to monitor safety and outcomes delivered by ESRD providers for the entire ESRD population as part of the QIP. QIP reductions, where appropriate, will be applied to ESRD PPS payments (and composite rate portion of the payment for transitioning providers). In addition, any QIP reduction will also apply to ESRD related separately billable services for ESRD facilities under the ESRD PPS transitional payment through December 31, 2013.

continued on next page

Quality...*continued*

Reporting hemoglobin and/or hematocrit:

CMS will require the submission of the most recent hemoglobin or hematocrit lab value taken prior to the start of the billing period on all ESRD claims irrespective of ESA administration. Failure to submit a hemoglobin and/or hematocrit value on all ESRD claims will adversely impact a facility's QIP score and public reporting on dialysis facility compare (DFC).

Required reporting for ESA route of administration:

When reporting the administration of ESAs, CMS will require the reporting of modifiers JA (intravenous administration) or JB (subcutaneous administration) indicating the route of administration on all ESRD claims with dates of service on or after January 1, 2012.

ESRD claims that do not contain modifier JA or JB (when ESA administration is indicated) will be returned to the provider for correction. Patients with ESRD receiving administrations of ESAs [such as epoetin alfa (EPO) and Darbepoetin alfa (Aranesp)] for the treatment of anemia may receive intravenous administration or subcutaneous administrations of the ESA. Existing instructions require that ESRD facilities submit each administration on a separate line item. Renal dialysis facility claims including administrations of the ESAs by both methods must report the appropriate route of administration for each line item.

Calculation of the Kt/V value:

CMS will require the use of the following Kt/V calculations based on the dialytic modality when entering value code D5 on ESRD claims:

- **Hemodialysis:** For in-center and home-hemodialysis patients prescribed for three or fewer treatments per week, the Kt/V must be reported for the last dialysis session covered by the claim, each month. Facilities must report single pool Kt/V using the following preferred National Quality Forum (NQF) endorsed methods for deriving the single pool Kt/V value:
  - Daugirdas 2, or
  - Urea Kinetic Modeling (UKM)

  For patients routinely prescribed four or more hemodialysis treatments per week, a value of 8.88 should be entered on the claim; however, the 8.88 value should not be used for patients who are receiving "extra" treatments for temporary clinical need.
- **Peritoneal dialysis:** When measured, the delivered weekly total Kt/V (dialytic and residual) should be reported.

Note: All other requirements associated with ESRD claims will remain unchanged.

Additional information

The official instruction, CR 7460, issued to your FI or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2262CP.pdf*.

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

MLN Matters® Number: MM7460
Related Change Request (CR) #: CR 7460
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2262CP
Implementation Date: January 3, 2012

Correction to the date of first dialysis on claims for renal disease facilities

The Center for Medicare & Medicaid Services would like to inform renal dialysis facilities about an issue that may have impacted some of their claims for beneficiaries with a recent onset of dialysis. The first date of dialysis stored in the common working file (CWF) is used to determine if dialysis sessions billed on an end-stage renal disease (ESRD) claim should receive a new patient onset of dialysis adjustment. The issue was impacting beneficiaries that had a Medicare entitlement date prior to September 1, 2010. In those cases where a beneficiary was entitled to Medicare prior to September 1, 2010, and had a new onset of dialysis starting on or after September 1, 2010, the onset of dialysis date was defaulting to the first of the month. For example, if a beneficiary was entitled to Medicare on July 1, 2010, and had an onset of dialysis beginning November 7, 2010, the date of first dialysis appearing in the CWF would be November 1, 2010.

This issue resulted in some providers not receiving the full 120 days of the onset of dialysis adjustment for the patients meeting this criterion. This problem has been corrected as of July 11, 2011. Providers may adjust their claims within the timely filing period in order to receive the full 120 days of the onset of dialysis adjustment.

Source: CMS PERL 201108-14

Educational Events

Upcoming provider outreach and educational events – September 2011

5010 testing support

When: September 8-9
Time: 10:00 – 11:30 a.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Transition to HIPAA version 5010 technical seminar

When: Monday, September 12
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 Jacksonville 2011

When: September 13-15
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

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 the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you 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 *medicare.fcso.com*, 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

Introduction to the Medicare Program booklet available in hard copy

The *Medicare Learning Network's* (*MLN's*) *Introduction to the Medicare Program* booklet is now available in print format. This booklet is designed to provide education on the Medicare program and includes information about the four parts of the Medicare program, other health insurance plans, and organizations of interest to providers and beneficiaries. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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

Source: CMS PERL 201108-12

Medicare Quarterly Provider Compliance Newsletter now available

The July 2011 issue of the *Medicare Quarterly Provider Compliance Newsletter* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903687.pdf*. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. In this issue, several recovery audit findings that affect inpatient hospitals and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers are presented. Please visit *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf* to download, print, and search newsletters from previous quarters.

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

Source: CMS PERL 201108-12

New "Fast Fact" posted on MLN® provider compliance Web page

The Centers for Medicare & Medicaid Services (CMS) has posted a new "Fast Fact" to the *Medicare Learning Network*® (*MLN*) *provider compliance Web page*. This page features educational fee-for-service (FFS) provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions. Bookmark the page and check back often as a new "Fast Fact" is added each month.

Source: CMS PERL 201108-12

New preventive services FAQs available

The Centers for Medicare & Medicaid Services (CMS) has posted 27 frequently asked questions (FAQs) regarding preventive services for Medicare fee-for-service providers/suppliers to the "*Medicare Learning Network*® Products Preventive Services" Web page. To access the entire list of 27 FAQs, scroll to the "Related Links Inside CMS" section at *http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp* and select "Preventive Services FAQs." You may also find the answer to each individual FAQ below.

Annual wellness visit

- Who can perform the annual wellness visit (AWV)? *Read the answer*.
- Is the AWV the same as a beneficiary's yearly physical? *Read the answer*.
- Are clinical laboratory tests part of the AWV? *Read the answer*.
- Is there a deductible or coinsurance/copayment for the AWV? *Read the answer*.
- Can a separate evaluation and management (E/M) service be billed at the same visit as the AWV? *Read the answer*.
- Are the "new" preventive services codes for the annual Medicare wellness visit included in applicable 2011 Physician Quality Reporting System measures? *Read the answer*.

Initial preventive physical examination

- Is the initial preventive physical examination (IPPE) the same as a beneficiary's yearly physical? *Read the answer*.
- Who can perform the IPPE? *Read the answer*.
- Are clinical laboratory tests part of the IPPE? *Read the answer*.
- Is there a deductible or coinsurance/copayment for the IPPE? *Read the answer*.
- If a beneficiary enrolled in Medicare in 2010, can he or she have the IPPE in 2011 if it was not performed in 2010? *Read the answer*.
- Can a separate evaluation and management (E/M) service be billed at the same visit as the IPPE? *Read the answer*.

Medicare immunization billing (seasonal influenza virus, pneumococcal, and hepatitis B)

- Does a Part B deductible or coinsurance apply to adult immunizations covered by Medicare? *Read the answer*.
- If a beneficiary receives a seasonal influenza virus vaccination more than once in a 12-month period, will Medicare still pay for it? *Read the answer*.
- Are HCPCS codes Q2035 and Q2039 payable by Medicare? *Read the answer*.
- Will Medicare pay for the pneumococcal vaccination if a beneficiary is uncertain of his or her vaccination history? *Read the answer*.
- Does Medicare cover the hepatitis B vaccine for all Medicare beneficiaries? *Read the answer*.
- When a beneficiary receives both the seasonal influenza virus and pneumococcal vaccines on the same visit, would a provider continue to report separate administration codes for each type of vaccine? *Read the answer*.
- Can the seasonal influenza virus, pneumococcal, and hepatitis B vaccines all be roster billed? *Read the answer*.
- What is a mass immunizer? *Read the answer*.
- Do providers that only provide immunizations need to enroll in the Medicare program? *Read the answer.*

continued on next page

FAQs...*continued*

- May a single roster claim be submitted containing information for both the pneumococcal and seasonal influenza virus vaccines when the vaccines are administered on the same visit? *Read the answer*.
- End-stage renal disease (ESRD) dialysis facilities currently bill for the flu, pneumonia, and hepatitis B vaccines. Will the administration of these vaccines also remain separately payable after January 1, 2011? *Read the answer*.
- How should a provider that is not enrolled in Medicare bill for the flu vaccine? *Read the answer.*
- How should the Physician Quality Reporting Initiative influenza immunization measure #110 (Preventive care and screening: influenza immunization for patients ≥ 50 years old) be reported for patients seen outside of the flu season (September through February)? What if the flu immunization was administered by another provider? *Read the answer*.

Colorectal cancer screening

- Do the Medicare deductible and standard coinsurance apply for colorectal cancer screening services under the revised ambulatory surgical center payment system? *Read the answer*.

Smoking cessation counseling

- What are the two *Current Procedural Terminology* (*CPT*) codes for smoking and tobacco use cessation counseling services that replace the temporary Healthcare Common Procedure Coding System (HCPCS) G codes (G0375 and G0376) previously used for billing these services? *Read the answer*.

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

Source: CMS PERL 201108-25

Updates from the *Medicare Learning Network®*

Medicare Learning Network Catalog of products updated

The *Medicare Learning Network® Catalog of Products* has been updated and is available as a free interactive downloadable document at *http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf*. The catalog lists all *MLN* products available to the Medicare fee-for-service provider community. In the catalog, click on the title of a product to go directly to a downloadable copy or, if the product is available in hard copy, click on "Hard Copy" next to "Formats Available," to link to the MLN Product Ordering Page.

MLN Provider Exhibit Program schedule

The *Medicare Learning Network® (MLN) Provider Exhibit Program* is an educational and marketing resource within the Centers for Medicare & Medicaid Services (CMS). The mission of the *MLN* Provider Exhibit Program is to reach the Medicare fee-for-service (FFS) provider community by providing a formal and consistent CMS presence at national and regional provider association meetings and conferences to promote awareness and use of the MLN products.

The MLN will be exhibiting at the following health care provider conferences in the coming weeks:

Healthcare Billing & Management Association – 2011 Annual Fall Conference
Wednesday, September 14 through Friday, September 16
Bellagio Hotel – Las Vegas, NV
Booth #217

American Academy of Family Physicians Scientific Assembly
Wednesday, September 14 through Saturday, September 17
Orange County Convention Center – Orlando, FL
Booth #249

Please make a note of these dates and locations and add them to your calendar. If you are interested in having a MLN exhibit at your event, please contact CMS at *MLNexhibits@cms.hhs.gov*.

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Source: CMS PERL 201108-26

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

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

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

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

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

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

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

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

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

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

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

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

Other Medicare carriers and intermediaries

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

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

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

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

Phone numbers

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

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

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

Electronic data interchange
888-670-0940

Provider audit and reimbursement
904-791-8430

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

Provider enrollment
877-602-8816

Websites

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

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

Beneficiaries:
www.medicare.gov

Medicare Part A Connection subscription form

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

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

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