Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

November 2011

In this issue

Reduced Medicare regulatory burdens for health care providers would save nearly $1.1 billion

On October 18, the Centers for Medicare & Medicaid Services (CMS) took steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps would help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and would save nearly $1.1 billion across the health care system in the first year for a total of over $5 billion over five years.

CMS proposed two sets of regulatory reforms and finalized a third. All are designed to improve transparency and help providers operate more efficiently by reducing their regulatory burden. One set proposes updates to the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). The second set addresses regulatory requirements for a broader range of health care providers and suppliers who are regulated under Medicare and Medicaid. CMS also finalized a third rule reducing regulatory burden for ambulatory surgical centers (ASCs).

CMS estimates that annual savings to hospitals from the proposed revisions to the CoP could exceed $900 million in its first year as hospitals increasingly use this new flexibility. The Medicare Regulatory Reform rule could save up to $200 million in the first year. The final rule for ASCs could generate an extra $50 million in savings per year.

Together these three rules would reduce hospital and other health care provider costs by nearly $1.1 billion the first year. These cost savings would come directly from reduced regulatory burdens, and are not accompanied by reimbursement reductions. As such, all of these savings would be available to help providers improve the quality of care they provide to Medicare beneficiaries and all Americans.

Background

The proposed rules were developed through a retrospective review of existing regulations called for by President Obama's January 18, 2011, executive order 13563, to "modify, streamline, or repeal" regulations which impose unnecessary burdens, including on hospitals and other providers that must comply with requirements under Medicare.

The rules take into consideration numerous burden reduction recommendations from hospitals, critical access hospitals, and patient advocates, among others.

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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.

Burdens...*continued*

Medicare Conditions of Participation

The Conditions of Participation (CoP) are federal health and safety requirements ensuring high quality care for all patients. Hospitals and critical access hospitals must meet these conditions to participate in the Medicare and Medicaid programs. The proposed rule is designed to reduce the regulatory burden on hospitals by the following:

- Eliminating burdensome requirements that do not permit hospital patients or their caregivers/support persons to administer certain medications.
- Allowing hospitals to determine the best ways to oversee and manage outpatients by removing the unnecessary requirement for a single director of outpatient services.
- Increasing flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system.
- Enabling hospitals to have a single, interdisciplinary care plan that supports coordination of care instead of requiring a separate stand-alone nursing care plan.
- Allowing CAHs to provide certain services, including laboratory and radiology services, under arrangement.

Medicare regulatory reform

The Medicare Regulatory Reform rule would identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for health care providers and suppliers, including hospitals, ambulatory surgical centers (ASCs), end-stage renal disease (ESRD) facilities, durable medical equipment (DME) suppliers, and a host of other health care providers and suppliers regulated under Medicare and Medicaid. The goal of this proposed rule is to both reduce regulatory burdens and help providers improve care for patients.

This rule would help reduce unnecessary burdens on health care providers, allowing them to dedicate more resources to improving patient care. Some of the more than two dozen proposed regulatory changes include:

- Eliminating obsolete regulations, including expired Office of Management and Budget paperwork control numbers, outmoded infection control instructions for ambulatory surgical centers (ASCs), outdated Medicaid qualification standards for physical and occupational therapists, and duplicative requirements for governing bodies of organ procurement organizations.
- Clarifying which higher risk ESRD facilities are required to comply with the full federal Life Safety Code requirements. CMS estimates that this burden reduction could save an estimated $108.7 million for the ESRD program.
- Eliminating the current Medicare requirement that automatically deactivates a provider or supplier who has not submitted a claim for 12 consecutive months, keeping providers from inadvertently being barred from re-enrolling in Medicare for a certain period. Savings from this regulatory reform are projected to be $26.7 million annually.
- Eliminating the specific list of emergency equipment ASCs must have on hand, and allowing facilities, in conjunction with medical staff and their governing bodies, to develop policies and procedures that specify emergency equipment appropriate to the services they provide.
- Replacing inflexible time-limited agreements which govern intermediate care facilities for the mentally retarded participation in Medicaid, with open-ended agreements and reducing states' paperwork burden by requiring inspection of these facilities once a year. The regulation also takes up a recommendation from stakeholders to replace the term "mental retardation" with the term "intellectual disability," which has gained wide public acceptance in recent years.
- Updating e-prescribing technical requirements so Medicare prescription drug plans meet current standards.

Regulatory reform for ambulatory surgical centers

This announcement also includes a final rule from CMS that would update the conditions for coverage regulations for ASCs, based on a proposed rule CMS issued in April 2010.

This new final rule simplifies requirements that ASCs must follow in notifying patients about their rights. Specifically, the final rule will allow ASCs to provide the patient, the patient's representative, or the patient's surrogate with patient rights information prior to the start of the surgical procedure. Before this final rule (*CMS-3217-F*), ASCs were required to notify patients in advance of the date of the procedure. This caused particular logistical problems and inconveniences for patients who needed ASC services on the same day they received a physician referral.

For more information

To view the proposed rules, please visit *CMS-9070-P* or *CMS-324-P*. To submit a comment, visit *www.regulations.gov*, enter the ID number CMS-9070-P or CMS-3244-P, and click on "Submit a Comment."

For additional information on hospital and critical access hospital Conditions of Participation, visit *http://www.cms.gov/CFCsAndCoPs/06_Hospitals.asp*.

The proposed rule also invites public comment on a broad range of recommendations to improve patient

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Burdens...*continued*

safety and hospital quality of care beyond those specified in the Conditions of Participation.

CMS' final rule on ASCs was effective on Tuesday, October 18. More information about ASCs is online at *http://www.cms.gov/CFCsAndCoPs/16_ASC.asp*.

The Department of Health and Human Services also has launched the Partnership for Patients initiative, a national collaboration with hospitals, employers, physicians, nurses, patient advocates, and state governments to protect patient safety, provide better care, and reduce costs. For more about the Partnership for Patients, go to: *http://www.healthcare.gov/center/programs/partnership/index.html*.

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

Source: CMS PERL 201110-38

Health care innovation challenge will improve care, save money, focus on health care jobs

New funding available for next generation of health care innovations

Up to $1 billion dollars will be awarded to innovative projects across the country that test creative ways to deliver high quality medical care and save money. Launched by the Department of Health and Human Services, the health care innovation challenge will also give preference to projects that rapidly hire, train and deploy health care workers.

"We've taken incredible steps to reduce health care costs and improve care, but we can't wait to do more," said HHS Secretary Kathleen Sebelius. "Both public and private community organizations around the country are finding innovative solutions to improve our health care system and the health care innovation challenge will help jump start these efforts."

Funded by the Affordable Care Act, the health care innovation challenge will award grants in March to applicants who will implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program, particularly those with the highest health care needs. The challenge will support projects that can begin within six months. Additionally, projects that focus on rapid workforce development will be given priority when grants are awarded.

"When I visit communities across the country, I continually see innovative solutions at the very ground level – a large health system working with community partners to decrease the risk of diabetes with nutrition programs or a church group that sends volunteers to help home-bound seniors so they can live at home," said Donald M. Berwick, M.D., administrator of the Centers for Medicare & Medicaid Services. "By putting more programs like this in place and more "boots on the ground," these types of programs can truly transform our health care system."

Awards will be expected to range from approximately $1 million to $30 million over three years. Applications are open to providers, payers, local government, community-based organizations, and particularly to public-private partnerships and multi-payer approaches. Each grantee project will be evaluated and monitored for measurable improvements in quality of care and savings generated.

For more information, including a fact sheet and the funding opportunity announcement, please see the health care innovation challenge initiative website at *www.innovation.cms.gov*.

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

Source: CMS PERL 201111-30

HHS announces new incentives for providers to work together through accountable care organizations when caring for people with Medicare

New tools help doctors and other health care providers improve quality of care

People with Medicare will be able to benefit from a new program designed to encourage primary care doctors, specialists, hospitals, and other health care providers to coordinate their care under a final regulation issued on Thursday, October 20, 2011, by the Department of Health and Human Services (HHS). Created by the Affordable Care Act, these final rules on accountable care organizations add to the menu of options for providers looking to better coordinate care for patients and will make it easier for providers to deliver high quality care and use health care dollars more wisely.

The initiatives are just two of *several efforts* made possible by the Affordable Care Act to help bring better health, better care and lower costs not just to Medicare beneficiaries, but to all Americans. For example, the Bundled Payments for Care Improvement Initiative and Comprehensive Primary Care Initiative offer alternatives to coordinate and improve health care.

The two initiatives launched on October 20 – the Medicare Shared Savings Program and the advance payment model – will help providers form accountable care organizations and reflect the significant input provided by stakeholders as well as lessons learned by innovators in care coordination in the private sector.

- The **Medicare Shared Savings Program** will provide incentives for participating health care providers who agree to work together and become accountable for coordinating care for patients. Providers who band together through this model and who meet certain quality standards based upon, among other measures, patient outcomes and care coordination among the provider team, may share in savings they achieve for the Medicare program. The higher the quality of care providers deliver, the more shared savings the providers may keep.
- The **advance payment model** will provide additional support to physician-owned and rural providers participating in the Medicare Shared Savings Program who also would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems. The advanced payments would be recovered from any future shared savings achieved by the accountable care organization.

The Shared Savings Program final rule is posted at: *http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf*.

The Centers for Medicare & Medicaid Services (CMS) press release is available at: *http://www.cms.gov/apps/media/press/release.asp?Counter=4132*.

The advanced payment solicitation is posted at: *http://innovations.CMS.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/*.

For more information, fact sheets are posted at: *http://www.HealthCare.gov/news/factsheets/2011/10/accountable-care10202011a.html* and *http://www.CMS.gov/ACO/*.

The joint CMS and HHS Office of Inspector General (OIG) interim final rule with comment period addressing waivers of certain fraud and abuse laws in connection with the Shared Savings Program is posted at: *www.OFR.gov/inspection.aspx*.

The Antitrust Policy Statement is posted at: *www.FTC.gov/opp/aco/* and *http://www.justice.gov/atr/public/health_care/aco.html*.

The Internal Revenue Service (IRS) fact sheet, *Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care* (FS-2001-11), will be posted at: *http://www.IRS.gov*.

For additional information you may view the CMS fact sheets (10/20) posted at: *https://www.CMS.gov/apps/media/fact_sheets.asp*.

Federal Register links:

- Accountable care organizations: *http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf*.
- Stark waivers: *http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27460.pdf*.
- Advanced payment: *http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27458.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 201110-35

500 federally qualified health centers to receive funding, participate in a program to improve care

Affordable Care Act to help improve care for Medicare beneficiaries

Thanks to the Affordable Care Act, 500 community health centers in 44 states across the country will receive approximately $42 million over three years to improve the coordination and quality of care they deliver to people with Medicare and other patients, the Department of Health and Human Services announced.

"Health centers are integral parts of our communities," said Centers for Medicare & Medicaid Services (CMS) Administrator Donald M. Berwick, M.D. "This initiative will give participating health centers the help they need to improve care for many people with Medicare who rely on them as their main source of care."

Under this advanced primary care practice demonstration, created by the Affordable Care Act, Medicare will pay community health centers based on the quality of care they deliver. This improved payment system will reward clinics for such things as helping patients manage chronic conditions like diabetes or high blood pressure.

In addition, health centers will use this funding to expand their hours, make same day appointments and accommodate patients with urgent care needs.

"The goal of this demonstration is to help patients get the care they need in a primary care setting rather than in an emergency department," said Dr. Berwick "When patients are able to use a health center as their primary source of care, it helps primary care doctors, nurses and specialists coordinate their care. Health centers will also use health care dollars more wisely as patients receive the right tests, right medications and right treatments in the right setting."

The demonstration will be conducted from November 1, 2011, through October 31, 2014. Participating health centers will be paid a monthly fee for each eligible person with Medicare that receives primary care services. The CMS Center for Medicare and Medicaid Innovation (Innovation Center) and the Health Resources Services Administration (HRSA) will provide technical assistance to help participating community health centers throughout the demonstration.

"The lessons learned from this demonstration project will help all community health centers improve on their long–standing commitment to providing high quality, patient-centered primary care," said Health Resources and Services Administration (HRSA) Administrator Mary K. Wakefield, PhD., R.N. "This program will help strengthen the relationship between the more than 8,100 health center sites HRSA helps fund and the communities they serve."

To study the process and challenges involved in transforming community health centers into advanced primary care practices, the Innovation Center will conduct an independent evaluation of the demonstration. The evaluation will assess the project's impact on hospital admission rates, emergency department visits rates, access, quality and cost of care provided to Medicare beneficiaries. The evaluation will also assess whether the demonstration was cost effective.

This advanced primary care practice demonstration is operated by the Innovation Center in partnership with HRSA. It is one of a number of initiatives made possible by the Affordable Care Act to help bring better health and better health care not just to Medicare beneficiaries, but to all Americans, while helping use healthcare dollars more wisely.

For example, the HRSA Health Center Quality Improvement and Patient Centered Medical Home Supplemental Funding initiative is providing 904 community health centers nationwide new support to provide care coordination services to patients including care planning and efforts to help doctors work together to deliver better care for patients.

Health centers improve the health of the nation and assure access to quality primary health care services at more than 8,100 service delivery sites around the country. They are also an integral source of local employment and economic growth in many underserved and low-income communities. Since the beginning of 2009, health centers across the country have added more than 18,600 new full-time positions in many of the nation's most economically distressed communities. In 2010, they employed more than 131,000 staff and new funds, made available by the Affordable Care Act in September, will help create thousands more jobs nationwide.

For more information on how the Affordable Care Act is finding better ways to improve health care, visit *www.HealthCare.gov*.

More information on the advanced primary care practice demonstration project, including a fact sheet, and a list of participating health centers can be found at: *http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/fqhc/*.

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

Source: CMS PERL 201110-37

Update for providers on completing the Medicare enrollment application (CMS-855A)

The July 2011 version of the CMS-855A application contains various new data elements in sections 5 and 6. This message notifies providers that they need not complete the following data elements on either the paper or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) versions of the CMS-855A application:

Section 5 Ownership Interest and/or Managing Control Information (Organizatons)

- "Exact percentage of operational/managerial control this organization has in the provider"

Section 6 Ownership Interest and/or Managing Control Information (Individuals)

- "Exact percentage of control as an officer this individual has in the provider"
- "Exact percentage of control as a director this individual has in the provider"
- "Exact percentage of management control this individual has in the provider" (under the "W-2 Managing Employee" heading)
- "Exact percentage of this contracted managing employee's control in the provider"
- "Exact percentage of operational/managerial control this individual has in the provider"

In addition, under the "Other ownership or control/interest" headings in sections 5 and 6, the "Exact percentage of ownership or control/interest…" data element need not be completed if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider.

The Medicare contractors have already received guidance to this effect.

If you have any questions regarding this message, please contact your local Medicare contractor. Contact information can be found at *http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.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 201110-48

Payment of the Medicare enrollment application fee for institutional providers

Institutional providers (i.e., all providers **except** physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) must submit the application fee with their revalidation or other enrollment actions. Institutional providers which submit enrollment actions using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) pay the application fee during the online submission process.

Providers that submit the paper 855 will now pay the fee at *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*.

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

Source: CMS PERL 201110-36

Implementation of provider enrollment provisions in CMS-6028-FC

Note: MM7350 was revised on October 31, 2011, to provide a new Web address for making payment of the application fees. All other information remains the same. This information was previously published in the March 2011, *Medicare A Update*, pages 10-12.

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "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*.

Caution – what you need to know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

Go – what you need to do

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Screening processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR7350.

> Beginning on March 25, 2011, providers will be placed in one of three risk levels of screening: limited, moderate, or high.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. **Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee**.

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The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, email, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request

As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a) Considerable bad debt expenses,

b) Significant amount of charity care/financial assistance furnished to patients,

c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. **Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.**

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's

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Enrollment...*continued*

decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual* (PIM), which is attached to CR7350.

Temporary Moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional information

The official instruction, CR7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/transmittals/downloads/R371PI.pdf*. Complete details regarding this issue, as defined in the PIM revisions, are attached to CR 7350.

MLN Matters® article SE1126, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf*, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to *MLN* Matters® article SE1130, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf*. A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf*.

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

MLN Matters® Number: MM7350 Revised
Related Change Request (CR) #: 7350
Related CR Release Date: March 23, 2011
Effective Date: March 25, 2011
Related CR Transmittal #: R371PI
Implementation Date: March 25, 2011

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Further details on the revalidation of provider enrollment information

Note: This article was revised on November 1, 2011, to provide a new web address for payment of the Medicare enrollment application fees. Clarification language was also added regarding the revalidation process. All other information remains the same. This information was previously published in the August 2011 *Medicare A Connection*, pages 3-4.

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.

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc. – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*; 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 generally not impacted.

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. **Important:** This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through Internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application 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.

The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

- For providers **not** in PECOS – the revalidation letter will be sent to the special payments or

continued on next page

Revalidation...*continued*

primary practice address because CMS does not have a correspondence address.

- For providers in PECOS – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at *http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

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*. 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.

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 (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* 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

For more information about the application fee payment process, refer to *MLN* Matters® Article SE1130, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1130.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*.

A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf*.

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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Implementation Date: N/A

Improvements to Internet-based PECOS facilitate Medicare's revalidation process for providers

Over the coming months and years, the Centers for Medicare & Medicaid Services (CMS) Medicare administrative contractors will ask providers to submit a complete and up-to-date enrollment application. You will be able to submit your application via paper (CMS-855 form) or electronically through the Internet-based PECOS (Provider Enrollment, Chain, and Ownership System). CMS urges you to use Internet-based PECOS for responding to the request for revalidation – and for most other updates that may need to be made to your provider enrollment records.

Between now and April 2012, CMS will continue to improve Internet-based PECOS to make it easier for you to update your information and submit your revalidation application. CMS has already streamlined the application process with fewer screens and new helpful prompts to let you know if information is incomplete. Once enrolled in PECOS, you can review your existing information online, make changes, and submit the revalidated application without having to complete the entire application. You are also able to pay the application fee (if applicable) during the online submission process.

Internet-based PECOS will be improved to:

- Allow you to view all application data on a single screen, reducing data entry and duplication of data
- Allow you to easily manage and search your enrollment applications, as well as upload multiple applications at one time
- Simplify the registration process for authorized representatives
- Eliminate separate mailing of most documents through digital document upload for support documents

Use Internet-based PECOS – it's faster, safe, and secure. To log on, visit *https://PECOS.CMS.hhs.gov*.

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

Source: CMS PERL 201110-17

Now available online: List of providers sent a revalidation request

In response to provider requests, the Centers for Medicare & Medicaid Services (CMS) has posted a listing of providers who have been sent a request to revalidate their Medicare enrollment information. The listing contains the name and national provider identifier (NPI) of each provider sent a letter, as well as the date the letter was sent. To see the listing, click on "Revalidation Phase 1 Listing" in the Downloads section of the *Medicare provider supplier enrollment revalidation page*. **Note:** You must widen each column in the spreadsheet to view the contents. CMS will be updating this list monthly.

If you are listed, and have not received the request, please contact your Medicare contractor. Their toll-free number may be found at *Medicare Fee-For-Service Contact Information*.

For more information on revalidation of Medicare provider enrollment, see MLN article SE1126 *Further Details on the Revalidation of Provider Enrollment Information*.

Source: CMS PERL 201111-23

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*.

Information on the revalidation of Medicare provider enrollment

The Centers for Medicare & Medicaid Services (CMS) has reevaluated the revalidation requirement in the Affordable Care Act. CMS now believes that it affords the flexibility of extending the revalidation period for another two years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March 2015. **Important:** This does not affect those providers, which have already received a revalidation notice. If you have received a revalidation notice from your contractor, respond to the request by completing the application either through internet-based PECOS or completing the appropriate 855 application form.

The first set of revalidation notices went to providers who are billing but are not currently in the Provider Enrollment, Chain and Ownership System (PECOS). To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

For providers **not** in PECOS – the revalidation letter will be sent to the special payments or primary practice address because CMS doesn't have a correspondence address. For providers in PECOS – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously; if these are the same it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at *http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

Institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices, and non-physician practitioner group practices) must submit the application fee with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee.

CMS has posted a listing of providers who have been sent a request to revalidate their Medicare enrollment information. To see the listing, click on "Revalidation Phase 1 Listing" in the Downloads section of the *Medicare provider supplier enrollment revalidation 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 201111-12

All Medicare provider and supplier payments to be made by EFT

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act of 2010 (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of the revalidation efforts, all suppliers and providers that do not currently receive EFT payments will be identified and required to submit the CMS-588 EFT form with their provider enrollment revalidation applications.

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

Source: CMS PERL 201111-19

2011 version of ABN must be used beginning January 1, 2012

In May 2011, the Centers for Medicare & Medicaid Services (CMS) released an updated version of the advance beneficiary notice of noncoverage (ABN) (form CMS-R-131), which will replace the 2008 version of this form. The 2011 version contains no substantive changes from the 2008 version of the notice and was approved by the Office of Management and Budget. The 2008 and 2011 ABN notices are identical except that the release date of "3/11" is printed in the lower left hand corner of the new version. The ABN is used by all providers, practitioners, and suppliers paid under Medicare Part B, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under Part A.

When the 2011 ABN was posted to the CMS website on Monday, May 16, CMS announced a mandatory use date of Thursday, September 1 and permitted providers and suppliers to begin using the new form immediately. Subsequently, we received requests from the industry to extend this deadline in order to permit providers and suppliers with pre-printed stockpiles of ABNs, time to exhaust their supplies.

Providers and suppliers are allowed to use either the 2008 or 2011 version of the ABN through the end of this year; beginning Sunday, January 1, 2012, they must begin using the 2011 version. ABNs issued after Sunday, January 1 that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors. 2008 versions of the ABN that were issued prior to Sunday, January 1 as long-term notification for repetitive services delivered for up to one year will remain effective for the length of time specified on the notice.

Information and a copy of the 2011 version of the ABN (form CMS-R-131) can be found online at *http://www.CMS.gov/BNI*, under the "FFS Revised ABN" link.

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

Source: CMS PERL 201110-31

Predictive modeling analysis of Medicare claims

Provider types affected

This *MLN* Matters® special edition article is intended for all physicians, providers, and suppliers who submit fee-for-service (FFS) claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), durable medical equipment (DME) MACs, and home health and hospice MACs (HH+H MACs)).

What providers need to know

Stop – impact to you

As of June 30, 2011, the Centers for Medicare & Medicaid Services (CMS), has implemented a predictive analytics system that will analyze all Medicare FFS claims to detect potentially fraudulent activity.

Caution – what you need to know

The predictive analytics system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. This article briefly explains the predictive modeling system, its purpose, and how CMS is incorporating the system into its claims payment process.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for more information about this change.

Background

Section 4241 of the Small Business Jobs Act of 2010 (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. Signed by the President in fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. This new process is similar to the pre-payment analysis already done by the financial and credit card industries. The entire text of the SBJA is available at *http://www.gpo.gov/fdsys/pkg/BILLS-111hr5297enr/pdf/BILLS-111hr5297enr.pdf*.

Real time claims streaming to build profiles and create risk scores

As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

Risk scores enable CMS to quickly identify unusual billing activity and flag claims for more thorough review prior to releasing payment. The system automatically

continued on next page

Modeling...*continued*

prioritizes claims, providers, beneficiaries, and networks that are generating the most alerts and highest risk scores. CMS is leveraging the benefits of its new high-tech system to complement, not replace, the expertise of its experienced analysts:

- Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.
- If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.
- Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and zone program integrity contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.

Risk scores enable CMS to identify unusual billing activity and flag claims for more thorough review prior to releasing payment.

Effect of risk scores on claims payment

Risk scores alone do not initiate administrative action and serve only to alert CMS to the necessity of more careful review of claims activity. While providers will be unable to appeal risk scores, CMS's new technology will in no way alter a provider or supplier's existing rights to appeal administrative actions or overpayment recovery efforts.

Currently, CMS is not denying claims solely based on the alerts generated by predictive models. CMS is focused on developing and refining models that identify unusual behavior without disrupting its claims processing for Medicare providers.

Working closely with clinical experts across the country and of every provider specialty, CMS is developing and refining algorithms that reflect the complexities of medical treatment and billing. The new technology will ultimately benefit the program's many honest providers and suppliers by enabling the agency to prioritize the highest-risk cases for investigation and review. Prioritizing the alerts will minimize the disruption to providers who may occasionally exhibit unusual but honest billing.

CMS's predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases. Automating checks that were previously performed manually will help CMS to more quickly identify and resolve any issues that may delay payment to providers and suppliers. Even as CMS implements a more thorough claims screening process, the Agency remains dedicated to ensuring prompt payment for the providers. Prompt payment of claims is a statutory requirement; only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.

Additional information

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

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Get ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 2 and the national mail-order competitions are coming soon.

Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

- **Update your contact information:** The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:
  - The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
  - The correspondence address.

  DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011, version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website (*www.cms.gov/MEDICAREPROVIDERSUPENROLL/*) or reviewing the PECOS fact sheet at *www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website (*www.palmettogba.com/nsc*) and by following this path: Supplier Enrollment/Change of Information/ Change of Information Guide.
- **Get licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a competitive bidding area (CBA), you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is **very important** that you make sure that current versions of all required licenses are in your enrollment file with the NSC **before** you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.
- **Get accredited:** Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS website: *www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed -- visit the CBIC website at *www.dmecompetitivebid.com* to subscribe to email updates and for the latest information on the DMEPOS competitive bidding program.

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

Source: CMS PERL 201111-01

Medicare pilot project for electronic submission of medical documentation (esMD)

Note: This article was revised on October 14, 2011, to correct the contractor for durable medical equipment Medicare administrative contractor (DME MAC) C on page 5. It had incorrectly listed Palmetto GBA. The correct contractor is CGS Administrators, LLC. All other information remains the same. This information was previously published in the September 2011 *Medicare A Connection*, pages 7-9.

Provider types affected

This special edition (SE) affects all Medicare fee-for-service (FFS) providers who submit medical documentation to Medicare review contractors.

Provider action needed

Stop – impact to you

Each year, the Medicare FFS program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers' compliance with Medicare's rules. Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

Caution – what you need to know

Medicare's electronic submission of medical documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions can be found at *http://go.usa.gov/kr4*. The esMD pilot will begin in September of 2011. The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors. In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.

- Certain larger providers, such as hospital chains, may choose to build their own gateway.
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a Health Information Handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 can be found in the "Key Points" section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services can also be found at *http://go.usa.gov/krg*. CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

Go – what you need to do

You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts portable document format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

Key points

The following are tentative schedules of when HIHs will be ready to offer esMD services and when review contractors will be ready to accept esMD:

continued on next page

esMD...*continued*

HIH/Web address	Scheduled readiness*
HealthPort (*http://www.healthport.com*)	September 2011
IVANS (*http://www.ivans.com*)	September 2011
MRO (*http://www.mrocorp.com*)	September 2011
NaviNet (*http://www.navinet.net*)	September 2011
RISARC (*http://www.risarc.com*)	September 2011
eSolutions (*http://www.ecorpnet.com*)	November 2011
Cobius (*http://www.cobius.com*)	November 2011
IOD, Inc. (*http://www.iodincorporated.com*)	November 2011
Proficient Health (*http://www.proficienthealth.com*)	November 2011
Craneware (*http://www.craneware.com*)	November 2011
MDClick (*http://www.mdclick.com*)	November 2011
Medical Electronic Attachment (*http://www.mea-fast.com*)	November 2011
EHR Doctors (*http://www.ehrdoctors.com*)	November 2011
ApeniMED (*http://www.Apenimed.com*)	November 2011
HealthIT+ (*http://www.healthitplus.com*)	November 2011
ECC Technologies (*http://www.ecctec.com*)	January 2012
Stratice Healthcare (*http://straticehealthcare.com/*)	January 2012
AT&T (*http://www.att.com/healthcare*)	January 2012
CureMD (*http://www.curemd.com*)	January 2012
MediConnect (*http://www.mediconnect.net*)	January 2012
MediCopy (*http://www.medicopy.net*)	January 2012
Cal eConnect (*http://www.caleconnect.org*)	January 2012
LMRP Manager (*http://www.racmanager.com*)	January 2012
SSI (*http://www.thessigroup.com/*)	January 2012
Verisma Systems (*http://www.verismasystems.com*)	January 2012
Zydoc (*http://www.zydoc.com*)	January 2012
Ivertex (*http://www.ivertex.com*)	April 2012

Medicare review contractors include the recovery auditors (RACs), Medicare administrative contractors (MACs), the Comprehensive Error Rate Testing (CERT) contractor, the program error rate measurement (PERM) contractor, and zone program integrity (ZPIC) contractors. The following shows when some of these contractors will be accepting esMD transactions:

Review contractors	Scheduled readiness*
RAC A – Diversified Collection Services (DCS)	September 2011
RAC B – CGI Technologies and Solutions	September 2011
MAC J1 and J11 – Palmetto GBA	September 2011
MAC J3 – Noridian Administrative Services	September 2011
MAC J4 – Trailblazer Health Enterprises	September 2011
MAC J5 – Wisconsin Physicians Services Health Insurance Corporation	September 2011
MAC J9 – First Coast Service Options	September 2011
MAC J12 – Highmark Medicare Services	September 2011
MAC J14 – NHIC	September 2011
DME MAC A – NHIC	September 2011
DME MAC D – Noridian Administrative Services, LLC	September 2011
CERT – Livanta	September 2011
PERM – A+ Government Solution	November 2011
MAC J10 – Cahaba Government Benefit Administrators	November 2011

continued on next page

esMD...*continued*

Review contractors	Scheduled readiness*
MAC J13 – National Government Services	November 2011
DME MAC B – NGS	November 2011
ZPIC 1 – Safeguard Services LLC	November 2011
ZPIC 7 – Safeguard Services LLC	November 2011
RAC D – HealthDataInsights	November 2011
MAC J15 – CIGNA Government Services, LLC	January 2012
DME MAC C – CGS Administrators, LLC	January 2012

*These are anticipated dates and subject to change. Please check the esMD website (*http://www.cms.gov/ESMD*) for more information.

Note: CMS expects that the Region C and D recovery auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.

Additional information

If you have any questions, please contact the review contractor to which you wish to send esMD transactions. MAC toll-free numbers can be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

For more information, visit the esMD Web page at *http://www.cms.gov/esmd*. You might also try the Twitter Link, which is *@CMSGov* (Look for #CMS_esMD).

For more information on the Medicare recovery audit program, see the MLN Matters® article SE1024 at *http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf*. You may contact your recovery auditor for questions you have of them. Their contact information is at *http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf*.

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Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both *English* and *Spanish.* Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2011 through September 2012.

To order an annual subscription, complete the *Medicare A Connection Subscription Form.*

Incentive Programs

Medicare eRx payment adjustments begin January 1, 2012

Beginning Sunday, January 1, 2012, eligible professionals who have not successfully met the requirements of the eRx incentive program (or, alternately, qualify for a significant hardship exemption) will be subject to the 2012 eRx payment adjustment. The adjustment will reduce Medicare payment rates by 1 percent of the provider's allowable Medicare Part B charges.

The Centers for Medicare & Medicaid Services (CMS) would like to remind eligible professionals and group practices participating in the Medicare electronic prescribing (eRx) incentive program that the deadline to request a hardship exemption for the 2012 eRx payment adjustment is November 1, 2011.

Eligible professionals and group practices should determine if they are subject to the 2012 eRx payment adjustment by reviewing the *MLN Article SE1107*, "2011 Electronic Prescribing Incentive Program Update – Future Payment Adjustments." If you believe that you may be subject to the 2012 eRx payment adjustment, you should determine if you meet any of the hardship exemption categories specified by CMS in the 2011 Medicare electronic prescribing (eRx) incentive program final rule.

In addition, a *Quick Reference Guide* is available to help you understand the changes that the eRx final rule made to the 2011 Medicare eRx incentive program. As a result of changes to the program, eligible professionals and group practices have until November 1, 2011, to submit a significant hardship exemption request and rationale.

Please note, to be considered for an exemption under the significant hardship exemption category "Eligible professionals who register to participate in the Medicare or Medicaid electronic health record (EHR) incentive programs and adopt certified EHR technology," an eligible professional:

- Must have registered for either the Medicare or Medicaid EHR incentive program (for instructions on how to register for one of the EHR incentive programs, we refer readers to the registration and attestation page of the EHR incentive programs section of the CMS website at *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp*) and
- Show that they adopted certified EHR technology no later than October 1, 2011, and provide identifying information about the certified EHR technology. Please note that, in order to qualify for an exemption to the 2012 eRx payment adjustment under this significant hardship exemption category, it is not necessary that an eligible professional receive an incentive payment under the Medicare or Medicaid EHR incentive program.

Eligible professionals wishing to register for the Medicaid EHR incentive program in states that have not yet launched their respective programs may initiate the registration process at the CMS registration and attestation system, and obtain a registration number but will not be able to successfully complete registration. If a state has not launched its Medicaid EHR incentive program, the state name will not appear in the drop-down menu for eligible professionals to choose from. However, a registration number is assigned even if registration is not successfully completed.

In order to initiate registration for the Medicaid EHR incentive program, please visit *https://ehrincentives.cms.gov/hitech/login.action* and follow the instructions to begin the registration process. Obtaining a CMS EHR incentive programs registration number, even if the registration is not successfully completed, suffices for the purposes of applying for a significant hardship exemption for the 2012 Medicare eRx payment adjustment.

To request an exemption, individual eligible professionals must submit their hardship exemption requests through the *Quality Communications Support Page* and group practices participating under the group practice reporting option (GPRO) must submit hardship exemption requests via a letter to CMS.

Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

For additional information and resources, please visit *www.cms.gov/erxincentive* and review the new *frequently asked question (FAQ)* on the topic.

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

Source: CMS PERL 201110-33

Updates on registration for the EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) wants to remind eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) of the key registration dates for the electronic health record (EHR) incentive programs, and provide information to help them successfully register and start their path to payment for 2011.

Important registration details for Medicare and Medicaid

- **Medicare – Wednesday, November 30, 2011** – last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for fiscal year (FY) 2011.
- **Medicare – Wednesday, February 29, 2012** – last day for EPs to register and attest to receive an incentive payment for calendar year (CY) 2011
- **Medicaid –** each state may have different attestation deadlines. Please check with your *state Medicaid agency* to find out the last day you can attest.

When should providers register?

CMS encourages providers to register for the Medicare and/or Medicaid EHR incentive program(s) as soon as possible to avoid payment delays. Note that not all states have launched a Medicaid EHR incentive program yet; providers will not be able to complete their registration for the Medicaid EHR incentive program until their state's program has launched and that state's site has opened. Providers should check their state's *status*.

Note: Providers can register before they have a certified EHR and can also register if they do not have an enrollment record in Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

Registration resources

CMS has several resources to help providers successfully register for the EHR incentive programs:

- Step-by-step registration guides, available on the CMS EHR *Registration page*
- Several FAQs about registration on the EHR incentive programs website
- Webinars on YouTube to help guide providers through the registration process – one for *EPs* and one for *hospitals*

Want more information about the EHR incentive programs? Make sure to visit CMS' *EHR incentive programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201110-52

New Medicare and Medicaid EHR incentive programs FAQs

The Centers for Medicare & Medicaid Services wants to keep you updated with the latest information about the Medicare and Medicaid Electronic Health Record (EHR) incentive programs. These new frequently asked questions (FAQs) include information about clinical quality measures (CQMs), meaningful use, attestation, and other Medicare and Medicaid EHR incentive programs topics.

1. Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete CQM data for the Medicare and Medicaid EHR incentive programs? *Read the answer*.
2. Do providers have to contribute a minimum dollar amount toward their certified EHR technology for the Medicare and Medicaid EHR incentive programs? *Read the answer*.
3. Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives for the EHR incentive programs? *Read the answer*.
4. Can two separate practices with two different tax identification numbers (TINs) purchase a single certified EHR system and share it in order to participate in the Medicare and Medicaid EHR incentive programs? *Read the answer*.
5. For the Medicare and Medicaid EHR incentive programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with

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EHR...*continued*

certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures? *Read the answer*.

6. For the EHR incentive programs, how should an eligible hospital or CAH with multiple certified EHR systems report their CQMs? *Read the answer*.
7. Does the person who completes the registration for the EHR incentive programs need to be the same person who completes the attestation? *Read the answer*.
8. For the meaningful use objective "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"? *Read the answer*.

Want more information about the EHR incentive programs?

Make sure to visit the *CMS EHR incentive programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201111-11

What does attestation for the EHR incentive programs entail?

Over 114,000 eligible professionals and hospitals have registered for the Medicare and Medicaid electronic health record (EHR) incentive programs. As more hospitals move towards meeting meaningful use and attesting, the Centers for Medicare & Medicaid Services (CMS) wants to make sure everyone understands what attestation entails.

In order to attest, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR incentive program, eligible hospitals must indicate that they agree with several attestation statements.

Eligible hospitals must agree that the information submitted:

- Is accurate to the knowledge and belief of the hospital or the person submitting on behalf of the hospital
- Is accurate and complete for numerators, denominators, exclusions, and measures applicable to the hospital
- Includes information on all patients to whom the measure applies.
- For clinical quality measures (CQMs), was generated as output from an identified certified EHR technology

By agreeing to the above statements, the hospital is attesting to providing all of the information necessary from certified EHR technology, uncertified EHR technology, and/or paper-based records in order to render complete and accurate information for all meaningful use core and menu set measures except CQMs.

Attesting to CQM data's validity

CMS considers information to be accurate and complete for CQMs to the extent that it is identical to the output that was generated from certified EHR technology. In other words, the hospital is only attesting that what was put in the attestation module is identical to the output generated by its certified EHR technology. Therefore, the numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology.

CMS, through meaningful use, does not require any data validation. Eligible hospitals are not required to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information, even if the reported values include zeros. If a hospital has concerns about the accuracy of its output, the hospital can still attest but should work with its vendor and/or the *Office of the National Coordinator for Health Information Technology* to improve the accuracy of the individual product and/or the level of accuracy guaranteed by certification.

CMS recommends that hospitals print out or save an electronic copy of the CQM report used at attestation from their certified EHR. The eligible hospital should retain this copy for its records so that the hospital can show its numbers in the event of an audit. Upon audit, this documentation will be used to validate that the hospital accurately attested and submitted CQMs.

For more information about the Medicare and Medicaid EHR incentive programs, please visit the *CMS EHR website*. Also, see the *frequently asked questions page* for answers on various topic areas of the programs.

Source: CMS PERL 201110-51

Reminder – beneficiary cost-sharing for Medicare-covered preventive services under the Affordable Care Act

Provider types affected

This article is informational in nature and of interest to all providers who provide Medicare-covered preventive services to Medicare beneficiaries.

What you need to know

Effective for dates of service (DOS) on or after January 1, 2011, Medicare provides 100 percent payment (in other words, waives any deductible, coinsurance or copayment) for many Medicare-covered preventive services. This article serves as a reminder and quick reference for the changes to deductibles, copayments, or coinsurances for these services.

Background

Section 4104 of the Affordable Care Act waived deductibles, copayments, or coinsurance effective for DOS on or after January 1, 2011, for the following Medicare-covered preventive services:

- The initial preventive physical examination (IPPE or "Welcome to Medicare Visit");
- The annual wellness visit (AWV); and
- Those preventive services that:
  - Are identified with a grade of A or B by the United States Preventive Services Task Force (UPSTF) for any indication or population; and
  - Are appropriate for the beneficiary.

Note: To get more information about Medicare coverage, coding, and payment policies for these services, please consult the resources in the *Additional information* section below.

Copayment/coinsurance and deductibles

The table below provides information for the copayment/coinsurance and deductibles for Medicare-covered preventive services.

Note: In some cases, the copayment, coinsurance and deductibles have not changed and will be the same for DOS prior to January 1, 2011, as they are for DOS on or after January 1, 2011.

Preventive benefit	Copayment/coinsurance/ deductible for DOS prior to January 1, 2011	Copayment/coinsurance/ deductible for DOS on or after January 1, 2011
IPPE/"Welcome to Medicare Visit"	For dates of service between January 1, 2009, and January 1, 2011, the deductible for the IPPE only is waived (not the screening electrocardiogram [EKG]). For DOS prior to January 1, 2009, the deductible is not waived. Coinsurance or copayment still applies to both the IPPE and the screening EKG.	The beneficiary will pay nothing for the IPPE (there is no coinsurance or copayment and no Medicare Part B deductible). Coinsurance or copayment and the Medicare Part B deductible still apply to the screening electrocardiogram (EKG).

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Cost-sharing...*continued*

Preventive benefit	Copayment/coinsurance/ deductible for DOS prior to January 1, 2011	Copayment/coinsurance/ deductible for DOS on or after January 1, 2011
AWV	Medicare did not cover this service prior to January 1, 2011	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). However, if a medically necessary Evaluation and Management service is also furnished with an AWV visit, coinsurance and deductible will apply for the additional services.
Colorectal cancer screening	For the fecal occult blood test (FOBT), the beneficiary will pay the coinsurance or copayment, but Medicare Part B deductible is waived. For the flexible sigmoidoscopy, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the procedure in a hospital outpatient department or ambulatory surgical center, the beneficiary pays 25 percent of the Medicare-approved amount. For the colonoscopy, coinsurance or copayment and the Medicare Part B deductible are waived. The Medicare law requires that a beneficiary must pay coinsurance, but not the Part B deductible, when a screening colonoscopy results in a biopsy or removal of a lesion or growth. For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the screening in a CAH, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	For the FOBT, flexible sigmoidoscopy, and colonoscopy, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the screening in a critical access hospital (CAH), the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Bone mass measurements	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).

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Cost-sharing...*continued*

Preventive benefit	Copayment/coinsurance/ deductible for DOS prior to January 1, 2011	Copayment/coinsurance/ deductible for DOS on or after January 1, 2011
Cardiovascular screening blood tests	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes self-management training (DSMT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Diabetes supplies	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Glaucoma screening	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Hepatitis B virus (HBV) vaccination	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Human immunodeficiency virus (HIV) screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Medical nutrition therapy (MNT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Pneumococcal vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Prostate cancer screening	For the screening prostate specific antigen (PSA) blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the digital rectal examination (DRE), both the coinsurance or copayment and the Medicare Part B deductible apply.	For the screening PSA blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the DRE, both the coinsurance or copayment and the Medicare Part B deductible apply.
Screening mammography	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).

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Cost-sharing...*continued*

Preventive benefit	Copayment/coinsurance/ deductible for DOS prior to January 1, 2011	Copayment/coinsurance/ deductible for DOS on or after January 1, 2011
Screening pap test	For screening Pap test services paid under the Medicare physician fee schedule (MPFS), the coinsurance or copayment applies and the Medicare Part B deductible is waived. For screening Pap test services paid under the clinical laboratory fee schedule, both the coinsurance or copayment and the Medicare Part B deductible are waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Screening pelvic examination (includes a clinical breast examination)	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Seasonal influenza virus vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Smoking and tobacco-use cessation counseling services and counseling to prevent tobacco use	Both the coinsurance or copayment and the Medicare Part B deductible apply	Asymptomatic beneficiaries will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Ultrasound screening for abdominal aortic aneurysm	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. Must be referred for this service as a result from an IPPE.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible) if the referral for this service resulted from the IPPE.

Additional information

For more information about Medicare-covered preventive services, including coverage and payment policies, refer to the following:

- Change request 7012, "Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the Patient Protection and Affordable Health Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare" is available at *http://www.cms.gov/Transmittals/downloads/R864OTN.pdf*.
- *The Guide to Medicare Preventive Services*, which contains coverage, coding, and payment information for all the services referenced above, is available at *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- A complete listing of *MLN*® products related to Medicare-covered preventive services is available at *http://www.cms.gov/MLNProducts/downloads/education_products_prevserv.pdf*.

MLN Matters® Number: SE1129
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

Changes to the laboratory NCD edit software for January 2012

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) 7621, which announces the changes that will be included in the January 2012 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 October 2011. Please ensure that your billing staffs are aware of 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. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 7621 changes to the NCD code lists

CR 7621 announces changes to the laboratory edit module for changes in laboratory NCD code lists for January 2012. The changes to the NCD code lists are described below and are effective for dates of service on and after January 1, 2012.

Deleted ICD-9-CM codes

- Delete ICD-9-CM codes 425.11 and 425.18 from the list of ICD-9- CM codes that are covered by Medicare for the Alpha-fetoprotein (190.25) NCD.

Added ICD-9-CM codes (effective October 1, 2011)

- Add ICD-9-CM codes 786.50 and 786.51 to the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT)(190.17) NCD.

ICD-10-CM codes

- CR 7621 also contains two ICD-10 codes that contractors will track to ensure that the edits are properly updated during the ICD-10 implementation (see table below).

ICD-9-CM code	ICD-10-CM code
786.50	R07.9
786.51	R07.2

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

Additional information

The official instruction, CR 7621 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2344CP.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: MM7621
Related Change Request (CR) #: 7621
Related CR Release Date: November 4, 2011
Effective Date: January 1, 2012, except one item (note below, which has an effective date of October 1, 2011)
Related CR Transmittal #: R2344CP
Implementation Date: January 3, 2012

Autologous cellular immunotherapy treatment of metastatic prostate cancer

Note: This article was revised on November 7, 2011, to reflect a revised CR 7431 issued on November 2, 2011. The article has been revised to show that a separate payment for the cost of administration is allowed. In addition, the transmittal numbers, release date, and the Web address for accessing CR 7431 have been revised. All other information is the same. This information was previously published in the July 2011, *Medicare A Connection*, pages 12-15.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval. The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

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

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

The new HCPCS code Q2043 will:

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

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Immunotherapy...*continued*

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

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

The language given in the long descriptor of PROVENGE® that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs, except for the cost of administration. Please note that the cost of administration can now be billed separately. .

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

Coding and billing information

ICD-9 diagnosis coding

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

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

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Immunotherapy...*continued*

Coding for off-label PROVENGE® services

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

ICD-10 diagnosis coding

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

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

Types of bill (TOB) and revenue codes

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

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

Payment methods

Payment for PROVENGE® is as follows:

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

continued on next page

Immunotherapy...*continued*

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

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

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

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

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

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

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

- RARC N362 – the number of days or units of service exceeds our acceptable maximum.
- CARC 149 – Lifetime benefit maximum has been reached for this service/benefit category.
- Group code – CO.

When denying claims for PROVENGE®, HCPCS Q2043® that are provided more than 30 weeks from the date of the 1st PROVENGE® administration, contractors shall use the following messages:

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

Additional information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the *National Coverage Determinations Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R136NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2339CP.pdf*.

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

MLN Matters® Number: MM7431 Revised
Related Change Request (CR) #: CR 7431
Related CR Release Date: November 2, 2011
Effective Date: June 30, 2011
Related CR Transmittal #: R2339CP and R136NCD
Implementation Date: August 8, 2011

Important reminders about advanced diagnostic imaging accreditation requirements

Note: This article was revised on November 7, 2011, to clarify that providers need not submit their ADI data on their 855 enrollment forms or via the PECOS enrollment system. CMS receives that data from the accrediting organizations. This information was previously published in the June 2011 *Medicare A Connection*, pages 9-11.

Provider types affected

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

What you need to know

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

What are the requirements for ADI accreditation?

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

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

Who do the requirements affect?

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

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

When are the requirements mandatory?

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

How do I comply with the requirements?

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

- Call or email each of the accreditation organizations to determine the one that best fits your business needs. The accreditation organizations each have their own published standards.
- Follow all of the application requirements so that your application is not delayed. It may take up to 5 months to be accredited.

Who are the three national accreditation organizations approved by CMS?

The approved accreditation organizations are:

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

What are the quality standards that I must meet?

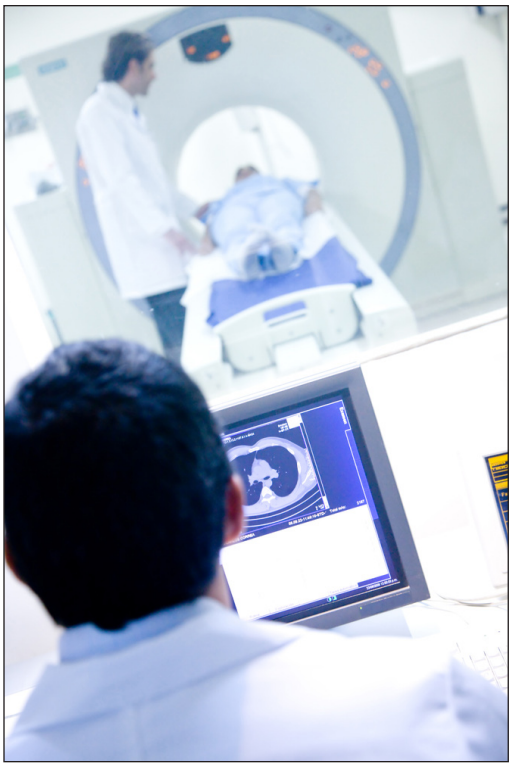
There are many quality standards, for which you must be in compliance, and you will need to show

continued on next page

Imaging...*continued*

that compliance to the accreditation organization. The quality standards at a minimum address:

- Qualifications of medical personnel who are not physicians;
- Qualifications and responsibilities of medical directors and supervising physicians;
- Procedures to ensure that equipment used meets performance specifications;
- Procedures to ensure the safety of personnel who furnish the imaging;
- Procedures to ensure the safety of beneficiaries; and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity, and accuracy of the technical quality of the image.



What does the accreditation process consist of?

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

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

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

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

The accreditation process may include:

- An un-announced site visit;
- Random site visits;
- Review of phantom images;
- Review of staff credentialing records;
- Review of maintenance records;
- Review of beneficiary complaints;
- Review of patient records;
- Review of quality data;
- Ongoing data monitoring; and
- Triennial surveys.

What else do I need to know?

Here are some helpful facts about the ADI Accreditation:

- Hospitals are exempt from this requirement, since hospitals generally are not paid under the MPFS.
- The accreditation requirement does not apply to the radiologists, per se. However, the interpreting physicians must meet the accreditation organization's published standards for training and residency.
- If you are accredited before January 1, 2012, by one of the designated accreditation organizations, you are considered to have met the accreditation requirement. However,
  - You must apply for reaccreditation if your accreditation is due to expire before this date, and
  - You must remain in good standing.
- The accreditation organization will transmit all necessary data to CMS on an ongoing basis. Your Medicare billing contractor will receive these

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Imaging...*continued*

data from CMS. Due to this file being received at CMS from the accrediting organizations, it is not necessary for the providers to supply the ADI information on their respective 855 form(s) or in the PECOS enrollment system.

- The *Current Procedural Terminology (CPT)* codes that are affected by this requirement are published on the CMS website.
- No suppliers are exempt.
  - Oral surgeons and dentists must be accredited if they perform the TC of MRI, CT, or nuclear medicine for the TC of the codes that require ADI accreditation.
  - If your facility uses an accredited mobile facility, you, as a Medicare supplier billing for the TC of ADI, must also be accredited. The accreditation requirement is attached to the biller of the services.

What does it cost to be accredited?

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

When will claims for Medicare services be affected?

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

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

Additional information

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

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

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

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

MLN Matters® Number: SE1122 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: Accreditation Date, January 1, 2012
Related CR Transmittal #: N/A
Implementation Date: N/A

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Hospice claims processing procedures when required face-to-face encounters do not occur timely

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.

What you need to know

When a required face-to-face encounter occurs prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and prior to, but no more than 30 calendar days prior to every recertification thereafter, it is considered timely. A timely face-to-face encounter would be evident when examining the face-to-face attestation, which is part of the recertification, as that attestation includes the date of the encounter. **If the required face-to-face encounter does not occur on time, the beneficiary is no longer certified as terminally ill, and consequently is not eligible for the Medicare hospice benefit.** When this occurs, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes.

When a discharge from the Medicare hospice benefit occurs due to failure to perform a required face-to-face encounter timely, the claim should include the most appropriate patient discharge status code and occurrence code 42, as described in Chapter 11, Section 30.3 of the *Medicare Claims Processing Manual,* which is attached in its revised form to CR 7478. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements, and the patient (or representative) signs a new election statement. Requirements for eligibility and election are found in the *Medicare Benefit Policy Manual*, Chapter 9, Section 10 and Section 20.2. You will find this manual on the Centers for Medicare & Medicaid Services (CMS) Hospice Center website.

Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, we would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

Occurrence span code 77 does not apply to the above described situations when the face-to-face encounter has not occurred timely.

While the face-to-face encounter itself must occur prior to, but no more than 30 calendar days prior to, the start of the third benefit period recertification and each subsequent recertification, its accompanying attestation must be completed before the claim is submitted.

Background

To be eligible for the Medicare hospice benefit, a beneficiary must have Medicare Part A, and must be certified as terminally ill by a physician (42 CFR 418.20). The Medicare hospice benefit requires that a written certification or recertification be on file prior to the submission of a claim, in order to cover and pay for hospice services. A number of elements comprise a complete certification or recertification, including the physician's prognosis of the patient's life expectancy, a physician narrative, and clinical information or other documentation supporting the diagnosis. Section 3132(b) of the Affordable Care Act added a new element. Effective January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each patient prior to the start of the 180th-day recertification, and each subsequent recertification, in order to determine continued eligibility for the hospice benefit.

This Affordable Care Act requirement was based on a recommendation by the Medicare Payment Advisory Commission (MedPAC). In its March 2009 Report to Congress, MedPAC wrote that additional controls are needed to ensure adequate accountability for the hospice benefit. MedPAC reported that greater physician engagement is needed in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. The Commission reported that measures to ensure accountability would also help ensure that hospice is used to provide the most appropriate care for eligible patients.

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Hospice...*continued*

In the November 17, 2010, home health prospective payment system final rule, CMS interpreted the 180th-day recertification mentioned in Section 3132(b) of the Affordable Care Act to occur at the third benefit period (see 75 FR 70436-70437). In that same Final Rule, CMS required that as of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the third benefit period, no more than 30 calendar days prior to the third benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care (75 FR 70438). When a required face-to-face encounter does not occur within these timeframes, it is not timely, and the beneficiary is not certified as terminally ill. Therefore, when a required face-to-face encounter does not occur timely, the beneficiary is not eligible for the Medicare hospice benefit.

Finally, the physician or nurse practitioner who performs the face-to-face encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification, and must be clearly titled.

Additional information

The official instruction, CR 7478, issued to your RHHI, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2316CP.pdf*. If you have any questions, please contact your RHHI, 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: MM7478
Related Change Request (CR) #: 7478
Related CR Release Date: October 7, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2316CP
Implementation Date: January 9, 2012

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Additional provider and supplier enrollment requirements for fixed wing and helicopter air ambulance operators

Provider types affected

Ambulance suppliers submitting claims for air ambulance services to Medicare carriers and A/B Medicare administrative contractors (A/B MACs) are affected by this article.

Provider action needed

This article, based on change request (CR) 7363, informs you that, on November 29, 2010, the Centers for Medicare & Medicaid Services (CMS) published a final rule that clarified the reporting requirements for air ambulance suppliers. The rule states that within 30 days of any revocation or suspension of a federal or state license or certification including Federal Aviation Administration (FAA) certification, an air ambulance supplier must report the revocation or suspension of its license or certification to the applicable Medicare contractor.

You must maintain all applicable federal and state licenses and certifications and report the following FAA certifications: Specific pilot certification, instrument and medical certifications, and air worthiness certification.

Background

Medicare contractors will ensure that the air ambulance suppliers are consistently meeting all federal and state requirements for Medicare enrollment. That process will include accessing the FAA website available at *http://www.faa.gov/about/office_org/headquarters_offices/agc/operations/agc300/reports/* at least quarterly in order to validate the air ambulance supplier's licenses and certifications. In addition,

- Medicare contractors will deny enrollment to an air ambulance supplier if you do not maintain your FAA certification; and
- Medicare contractors will revoke enrollment to an air ambulance supplier if you do not maintain your FAA certification.

Additional information

The official instruction, CR 7363 issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R400PI.pdf*.

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

MLN Matters® Number: MM7363 Revised
Related Change Request (CR) #: 7363
Related CR Release Date: November 21, 2011
Effective Date: February 3, 2012
Related CR Transmittal #: R400PI
Implementation Date: February 3, 2012

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

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

Effective and notice dates

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

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

AJ9041: Bortezomib (Velcade®) – revision to the LCD

LCD ID number: L28787 (Florida)
LCD ID number: L28789 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bortezomib (Velcade®) was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made under the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD to add the off label subcutaneous route of administration and the indication for multiple myeloma and patients with mantle cell lymphoma who have received at least one prior therapy. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated to add the additional compendia and an article reference considered for this revision.

Effective date

This LCD revision is effective for claims provided **on or after November 1, 2011** for services provided **on or after September 6, 2011.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

AJ9201: Gemcitabine (Gemzar®) – revision to the LCD

LCD ID number: L28847 (Florida)
LCD ID number: L28880 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for gemcitabine (Gemzar®) was most recently revised on December 15, 2010. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add the following off-labeled indication: Relapsed or refractory non-Hodgkin's lymphoma (diffuse large B-cell lymphoma) in combination with oxaliplatin (Eloxatin®) as second-line therapy. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

This LCD revision is effective for services provided **on or after November 15, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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.

AJ9206: Irinotecan (Camptosar®) – revision to the LCD

LCD ID number: L28897 (Florida)
LCD ID number: L28919 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for irinotecan (Camptosar®) was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, the off-label indication of "metastatic breast cancer, refractory" was added under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. Also, ICD-9-CM diagnosis codes 174.0-174.9 (Malignant neoplasm of female breast) were added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services provided **on or after November 16, 2011**. First Coast Service Options Inc. LCDs are available through the "CMS Medicare Coverage Database" at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

AJ9305: Pemetrexed – revision to the LCD

LCD ID number: L28947 (Florida)
LCD ID number: L28968 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pemetrexed was most recently revised on February 18, 2010. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add the following off-label indications:

- Second-line therapy as a single agent for local/regional recurrent or distant metastatic cervical cancer.
- Single-agent recurrence therapy, if platinum resistant, for ovarian cancer that is recurrent after prior chemotherapy; progressive, stable, or persistent on primary chemotherapy; relapse has occurred after complete remission following primary chemotherapy; or stage II-IV disease has shown partial response to primary treatment.
- Second-line therapy as a single agent for metastatic bladder cancer.

The "ICD-9 Codes that Support Medical Necessity" section of the LCD has also been revised to add the following ICD-9-CM codes: 180.0-180.9, 183.0-183.9, 188.0-188.9, 189.1, 189.2, and 233.7.

Effective date

This LCD revision is effective for services provided **on or after November 30, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

ASKINSUB: Skin substitutes -- revision to the LCD

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

The local coverage determination (LCD) for skin substitutes was most recently revised on July 1, 2011. Since that time, a revision was made to the LCD based on a reconsideration request to allow OASIS® ultra tri-layer matrix, per square centimeter (HCPCS code C9365) as a covered product.

After review of the submitted information, it was determined that HCPCS code C9365 would be included for coverage. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for

continued on next page

ASKINSUB...*continued*

"OASIS® wound matrix", language was revised to address coverage for HCPCS code C9365 for OASIS® ultra tri-layer matrix. The contraindications were updated and other specified indications for OASIS® ultra tri-layer matrix were added. Under the "*CPT*/HCPCS Codes" section of the LCD, and sub-section "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products:" HCPCS code C9365 was deleted. Under the "*CPT*/HCPCS Codes" section, HCPCS code C9365 was added. In addition, the "Sources of Information and Basis for Decision" section of the LCD and the "Coding Guidelines" attachment were updated.

Additional information: HCPCS code C9365 is being deleted effective January 1, 2012, and is being replaced with HCPCS code Q4124 (Oasis ultra tri-layer wound matrix, per square centimeter).

Effective date

This LCD revision is effective for services provided **on or after November 30, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

A93965: Non-invasive evaluation of extremity veins – revision to the LCD

LCD ID number: L28936 (Florida)
LCD ID number: L28957 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was most recently revised on October 1, 2011. Since that time, the "Training Requirements" section of the LCD has been revised to add "Registered technologist in vascular sonography (R.T. [VS])" as an additional example of certification in vascular technology for non-physician personnel performing the services addressed in this LCD and to add language to indicate that this credential is provided by the American Registry of Radiologic Technologists (ARRT).

Effective date

This LCD revision is effective for services provided **on or after November 15, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Retired LCDs

A93451: Cardiac catheterization – retired LCD

LCD ID number: L28792 (Florida)
LCD ID number: L28797 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiac catheterization was most recently revised on January 1, 2011. Since that time, a decision was made to retire the LCD based on data analysis and standards of local practice.

Effective date

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

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Additional Information

Self-administered drug (SAD) list – Part A: J0630

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

Effective for services provided **on or after December 26, 2011,** the following drug has been added to the MAC J-9 Part A SAD list.

- J0630-Injection, calcitonin (salmon), up to 400 units (Fortical, Miacalcin)

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

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

Inpatient prepayment review notification for MS-DRG 641 and MS-DRG 392

As the Medicare administrative contractor jurisdiction 9 (MAC J9), First Coast Service Options Inc. (FCSO) is committed to assisting the Centers for Medicare & Medicaid Services (CMS) in reaching the goal of reducing the national Medicare fee-for-service (FFS) paid claims error rate. Short stay diagnosis related groups (DRGs), in particular, demonstrate a high potential for payment error at the national and MAC J9 level. Therefore, FCSO focused previous MAC J9 (excluding Puerto Rico) post payment medical review activities on several short stay DRGs deemed to be at high risk for claims payment error, including MS-DRG 392 (esophagitis, gastroenteritis, and miscellaneous digestive w/o MCC) and MS-DRG 641 (nutritional miscellaneous metabolic disorder w/o MCC). Widespread probe reviews for MS-DRG 392 resulted in a 49 percent error rate in 2009 and 41 percent in 2010. Widespread probe reviews for MS-DRG 641 resulted in an error rate of 49 percent in 2009 and 36 percent in 2010. Therefore, effective November 1, 2011, FCSO will perform 10 percent prepayment medical review on MS-DRG 392 and MS-DRG 641 in MAC J9 (excluding Puerto Rico and U.S. Virgin Islands).

CMS' Office of E-Health Standards and Services announces a discretionary enforcement period for 5010 compliance

On November 17, 2011, the CMS Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement action until Saturday, March 31, 2012, with respect to any HIPAA-covered entity that is not in compliance with the ASC X12 version 5010 (version 5010), NCPDP Telecom D.0 (NCPDP D.0), and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. **Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains Sunday, January 1, 2012** (small health plans have until Tuesday, January 1, 2013, to comply with NCPDP 3.0).

CMS' Office of E-Health Standards and Services is the U.S. Department of Health and Human Services' component that enforces compliance with HIPAA transaction and code set standards.

OESS encourages all covered entities to continue working with their trading partners to become compliant with the new HIPAA standards, and to determine their readiness to accept the new standards as of Sunday, January 1, 2012. While enforcement action will not be taken, OESS will continue to accept complaints associated with compliance with version 5010, NCPDP D.0, and NCPDP 3.0 transaction standards during the 90-day period beginning Sunday, January 1, 2012. If requested by OESS, covered entities that are the subject of complaints (known as "filed-against entities") must produce evidence of either compliance or a good faith effort to become compliant with the new HIPAA standards during the 90-day period.

OESS made the decision to create a discretionary enforcement period based upon industry feedback. Although approximately 45 days remain before the January 1, 2012, compliance date, feedback revealed that testing among some covered entities and their trading partners has not yet reached a threshold that would indicate that the majority of covered entities would be able to be in compliance by Sunday, January 1, 2012. In addition, feedback indicated that the number of submitters, the volume of transactions, and other testing data used as indicators of the industry's readiness to comply with the new standards have been low across some industry sectors. OESS has also received reports that many covered entities are still awaiting software upgrades.

Version 5010, NCPDP D.0, and NCPDP 3.0 standards represent significant improvement over the current standard versions. NCPDP D.0 addresses certain pharmacy industry needs. NCPDP 3.0 allows state Medicaid programs to recoup payments for pharmacy services in cases where a third party payer has primary financial responsibility. Version 5010 in particular provides more functionality for transactions such as eligibility requests and healthcare claims status. Implementation of version 5010 also is a prerequisite for using the updated ICD-10 CM diagnosis and ICD-10-PCS inpatient procedure code set in electronic healthcare transactions effective Tuesday, October 1, 2013.

Links to information on version 5010, NCPDP D.0, and NCPDP 3.0 are available at *www.CMS.gov/ICD10.*

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

Source: CMS PERL 201111-37

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.

Make sure you are prepared for version 5010 – risk mitigation strategies

All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) that submit transactions electronically are required to upgrade from version 4010/4010A to version 5010 transaction standards by Sunday, January 1, 2012. It is important to remember that the upcoming version 5010 transition is not only mandatory, but is also an integral step toward a successful ICD-10 transition.

It is essential to test both internally and externally with business partners prior to the version 5010 deadline in order to assure that all trading partners are able to send and receive compliant transactions effectively, and in advance of the transition deadline. Take action now to ensure compliance and avoid problems with submitting claims for reimbursement after Sunday, January 1, 2012.

If you have not yet begun external testing, you should make use of the following risk mitigation strategies:

- **Communicate with vendors and trading partners regularly**. Encourage them to take action now and establish a communication plan.
- **Reach out to a clearinghouse for assistance**. A clearinghouse ensures that claims smoothly transition between practices and payers and can serve as a translator for non-compliant transactions from the version 4010/4010A to the version 5010 system. If you are concerned that your internal systems may not be ready by Sunday, January 1, using a clearinghouse that is already ready to process version 5010 claims can help ensure your reimbursements are not interrupted while you bring your own systems into compliance.
- **Establish a line of credit**. Establishing or increasing a line of credit will help cover potential cash flow disruptions from delayed reimbursement claims.
- **Take advantage of available resources**. There are many different resources offering valuable information to organizations looking to streamline their version 5010 transition. The Centers for Medicare & Medicaid Services (CMS) offers *several tools* to help you plan and execute your transitions to version 5010 and ICD-10. Beyond CMS, many professional societies and organizations offer guidance and resources to help you transition.

Keep up to date on version 5010 and ICD-10

Please visit the *ICD-10 website* for the latest news and resources to help you prepare, and to download and share the implementation *widget* today.

Source: CMS PERL 201111-10

Hurry, time is running out – HIPAA version 5010 and D.0 will be required to submit claims beginning January 1, 2012

As of Sunday, January 1, 2012, version 5010 and NCPDP D.0 will be required for all HIPAA standard transactions. This means:

- Beginning Sunday, January 1, 2012, HIPAA version 4010A1 will no longer be accepted by Medicare
- All trading partners must operate in HIPAA version 5010 and D.0.

The Centers for Medicare & Medicaid Services (CMS) strongly encourages providers to take advantage of the many resources provided on:

- *www.CMS.gov/ICD10*
- *www.CMS.gov/Versions5010andD0/01_overview.asp*
- *www.CMS.gov/MFFS5010D0/*

It is essential to begin the transition now to prevent a disruption to your claims processing and cash flow.

5010/D.0 implementation calendar

Upcoming events

- Wednesday, December 7 – CMS-hosted 5010 national provider call – question and answer session
- Saturday, December 31 – end of the transition year; beginning of 5010 production environment

Past events

For a complete list of past 5010 national provider calls, please visit the *5010 National Provider Calls section of the versions 5010 & D.0 website.*

Source: CMS PERL 201111-31

Correct provider billing of admission date and statement covers period

Note: This article was revised on November 7, 2011, to clarify that the issue applies to claims submitted on or after October 1, 2011, that contain a discharge date on or after July 1, 2011. The revised edit logic does not apply to claims with discharge dates prior to July 1, 2011. This article was previously published in the June 2011 *Medicare A Connection*, page 11.

Provider types affected

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

What you need to know

In collaboration with the National Uniform Billing Committee's (NUBC) definition for reporting of the admission date and statement covers period elements on claims, the Centers for Medicare & Medicaid Services (CMS) would like to remind you to review the NUBC definitions for claims submitted **on or after October 1, 2011, with a discharge date of July 1, 2011 forward.** This edit logic change does not apply for claims with a discharge date prior to July 1, 2011.

This special article reminds you of the definitions for reporting the admission date and statement covers period on claims.

- The admission date (form locator 12) is the date the patient was admitted as an inpatient to the facility (or indicates the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.
- The statement covers period ("from" and "through" dates in form locator 6) identifies the span of service dates included in a particular bill. The "from" date is the earliest date of service on the bill.

Previously, Medicare's fiscal intermediary shared system (FISS) edits required that the admission date not be later than the "from" date on initial provider claims as required to match NUBC UB-92 definitions. In order to pass FISS edits and avoid getting a claim rejected, providers may have engineered workarounds that force the two dates to match.

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

- Based on UB-04 definitions of these two data elements, CMS has modified FISS edits so admission date and "from" dates are not required to match.
- Based on UB-04 definitions of these two data elements, CMS has modified FISS edits so as not to compare the number of days in the statement covers period to any other data element (e.g., total accommodation days reported in the revenue code section).

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

Additional information

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

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

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

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FISS claims processing updates for ambulance services

Provider types affected

Providers and suppliers submitting claims to Centers for Medicare & Medicaid Services (CMS) contractors (fiscal intermediaries (FIs) and/or Part A/Part B Medicare administrative contractors (A/B MACs) for ambulance services provided to Medicare beneficiaries.

Provider action needed

This article identifies two changes in ambulance claims submissions. The first applies to UB-04 hard copy claims beginning with dates of service on or after January 1, 2011, submitted August 1, 2011, and after. Mileage must be reported as fractional units. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9). For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9). This applies on trips of up to 100 miles.

The second change applies to claims with dates of service on or after April 1, 2012. Only non-emergency trips (i.e., Healthcare Common Procedure Coding System (HCPCS) codes A0426, A0428) require a National Provider Identifier (NPI) in the attending physician field. Entry of a NPI in the attending physician field is not required for emergency trips (i.e., HCPCS codes A0427, A0429, A0430, A0431, A0432, A0433, and A0434).

Background

The *Medicare Claims Processing Manual*, Chapter 15, 30.2.1, requires that ambulance providers submitting claims to Medicare contractors use the appropriate HCPCS code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. On January 1, 2011, fractional mileage billing was implemented for electronic claims. However, the hardcopy UB-04 form could not accommodate fractional billing. Effective July 1, 2011, the National Uniform Billing Committee (NUBC) has updated instructions for reporting units that now allows for fractional unit billing, therefore, CMS is now providing notice that the exception to bill whole units on paper ambulance claims is now rescinded as of August 1, 2011.

The following guidelines now apply to paper billing.

- Medicare will accept and process paper claims with ambulance services, identified by revenue code 0540, with fractional mileage units rounded reported in Form Locator (FL) 46.
- Medicare will accept and process claims with fractional mileage units up to one decimal place (i.e., the tenths place) on ambulance claims submitted on paper.
- Medicare will truncate fractional mileage units rounded to greater than one decimal place on ambulance revenue code 0540 lines on paper claims. For example, if 1.23 miles are submitted, contractors shall automatically convert the units to 1.2 and process the paper claim accordingly.
- Medicare will accept and process paper claims with ambulance services, identified by revenue code 0540, submitted with less than 1 whole mileage unit reported in FL 46.
- Medicare will continue to accept and process paper claims with ambulance services, identified by revenue code 0540, submitted with whole number miles for trips totaling 100 covered miles and greater as reported in FL 46.
- Medicare will truncate fractional mileage totaling 100 miles or greater submitted on ambulance revenue code 0540 lines. For example, if 100.5 mileage units are submitted, Medicare will automatically convert the units to 100 and process the paper claim accordingly.

For claims with dates of service on or after April 1, 2012, Medicare will assure that only non-emergency trips (i.e., HCPCS A0426, A0428) require an NPI in the attending physician field. Emergency trips do not require an NPI in the attending physician field (i.e., A0427, A0429, A0430, A0431, A0432, A0433, A0434).

Additional information

The official instruction, CR 7557 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2336CP.pdf*.

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

MLN Matters® Number: MM7557
Related Change Request (CR) #: 7557
Related CR Release Date: October 28, 2011
Effective Date: For UB-04 Hardcopy Claims, August 1, 2011. For NPI requirement changes, April 1, 2012
Related CR Transmittal #: R2336CP
Implementation Date: April 2, 2012

Instructions to accept and process all ambulance transportation HCPCS codes

Note: This article was revised on October 13, 2011, to add a sentence to the "Go – what you need to do" section. All other information remains the same. This information was previously published in the August 2011 *Medicare A Connection*, pages 20-21.

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. In addition, if you are a facility-based ambulance provider billing a CMS-1450 claim form or the electronic equivalent (837I), you should be aware that you need to bill using the following non-covered revenue codes: 541, 542, 544, 547, 549, as applicable to the excluded ambulance transportation and transportation related-services that you are billing.

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 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.

continued on next page

Ambulance...*continued*

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/R1003OTN.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: November 25, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R1003OTN
Implementation Date: January 3, 2012

Medicare Billing Information for Rural Providers and Suppliers now available in hardcopy

The revised publication *Medicare Billing Information for Rural Providers and Suppliers* is now available in hardcopy. This booklet is designed to provide education on Medicare rural billing, and includes rural billing information about rural health clinics, Federally-qualified health centers, skilled nursing facilities, home health agencies, critical access hospitals, and swing beds. To place your order, visit *http://www.CMS.gov/MLNProducts/01_Overview.asp*, 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 201110-22

New podcast released on avoiding Medicare billing errors

The *MLN* has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and other improper activities when dealing with the Medicare Program. *"Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements"* discusses the documentation and coverage requirements needed to submit Medicare claims for PAP devices.

Please visit the *MLN Multimedia Web page* to download this and other podcasts from the *MLN*. The Centers for Medicare & Medicaid Services (CMS) also encourages you to visit the *MLN Provider Compliance Web page* for the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the *MLN*.

Source: CMS PERL 201110-22

New influenza virus vaccine code

Provider types affected

Providers and physicians 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 influenza vaccines provided to Medicare beneficiaries are affected by this article.

What you need to know

Effective May 9, 2011, claims with influenza virus vaccine code *90654* (*influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64*) will be payable by Medicare for claims with dates of service on or after May 9, 2011, if submitted on or after April 2, 2012. HCPCS code *90654* was added to the 2011 HCPCS file effective January 1, 2011. However, *90654* didn't become payable by Medicare until May 9, 2011. Please make sure your billing staff is aware of these changes. Medicare contractors will not adjust claims submitted prior to May 9, unless you bring such claims to their attention.

Background

Change request (CR) 7580 advises that payment for this code to institutional providers is as follows:

- Hospitals (types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) (TOBs 22x and 23x), home health agencies (HHAs) (TOB 34x), hospital-based renal dialysis facilities (RDFs) (TOB 72x) and critical access hospitals (CAHs) (TOB 85x) are paid on reasonable cost;
- Indian health service (IHS) hospitals (TOB12x and 13x) and IHS CAHs (TOB 85x) are paid based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and
- Comprehensive outpatient rehabilitation facilities and independent RDFs (TOB 72x) are paid based on the lower of the actual charge or 95 percent of the AWP.

Additional information

The official instruction, CR 7580, issued to your carrier, RHHI, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2337CP.pdf*.

If you have any questions, please contact your carrier, RHHI, 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: MM7580 Revised
Related Change Request (CR) #: 7580
Related CR Release Date: October 28, 2011
Effective Date: May 9, 2011
Related CR Transmittal #: R2337CP
Implementation Date: April 2, 2012

Medicare Claim Submission Guidelines fact sheet now available

The new *Medicare Claim Submission Guidelines* fact sheet is now available in downloadable format. It includes information about applying for a National Provider Identifier and enrolling in the Medicare program, filing Medicare claims, and private contracts with Medicare beneficiaries.

Source: CMS PERL 201110-22

Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), 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 during an episode of home health care are affected.

Provider action needed

This article announces that change request (CR) 7599 is a recurring update notification that provides the annual home health (HH) consolidated billing update, effective January 1, 2012. Make sure your billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the HH prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a HH episode (i.e., under a HH plan of care administered by a home health agency). Medicare will only directly reimburse the primary HH agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., "K" codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. New updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key points

The HCPCS codes in the table below are being added to the HH consolidated billing supply code list.

Added HCPCS code	Descriptor
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each.
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each.

Additional information

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

The official instruction (CR7599) issued to your Medicare Carrier/FI/RHHI/MAC is available at *http://www.cms.gov/Transmittals/downloads/R2317CP.pdf*.

MLN Matters® Number: MM7599
Related Change Request (CR) #: 7599
Related CR Release Date: October 7, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2317CP
Implementation Date: January 3, 2012

Billing for donor post-kidney transplant complication services

Provider types affected

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.

What you need to know

Change request (CR) 7523 does not convey any new or changed policy, but does convey clarification language for two Medicare manuals. This clarification is being provided to ensure consistency among all Medicare contractors in processing claims for donor post-kidney transplant complications services. Be sure your staff is aware of the clarifications.

Key points of CR 7523

Section 140.9 of Chapter 11 of the *Medicare Benefit Policy Manual* is being updated to show the following:

The donor of an organ for a Medicare transplant is covered for an unlimited number of days of care in connection with the organ removal operation. Days of inpatient hospital care used by the donor in connection with the organ removal operation shall not be charged against either party's utilization record.

Regarding donor follow-up:

- Expenses incurred by the transplant center for routine donor follow-up care are included in the transplant center's organ acquisition cost center.
- Follow-up services performed by the operating physician are included in the 90-day global payment for the surgery. Beyond the 90-day global payment period, follow-up services are billed using the recipient's health insurance claim number.
- Follow-up services billed by a physician other than the operating physician for up to 3 months should be billed under the recipient's health insurance claim number.

Regarding donor complications:

- Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the donation surgery. Complications that arise after the date of the donor's discharge will be billed under the recipient's health insurance claim number. This is true of both facility cost and physician services. Billings for donor complications will be reviewed.
- In all of these situations, the donor is not responsible for coinsurance or deductible.

In addition, CR 7523 is adding language to Section 90.1.3 of Chapter 3 of the *Medicare Claims Processing Manual* to provide clarifications as follows:

- Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.
- All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor's transplant discharge will be billed under the recipient's health insurance claim number and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's Medicare number).
- Modifier Q3 (Live kidney donor and related services) appears on each covered line of the claim.
- Institutional claims will be required to also include:
  - Occurrence code 36 (Date of inpatient hospital discharge for covered transplant patients); and
  - Patient relationship code 39 (Organ Donor).

Sample claims appear at the end of this article to provide examples of the above coding instructions.

Additional information

The official instruction, CR 7523, was issued to your RHHI, FI or A/B MAC via two transmittals. The first modifies the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R148BP.pdf* and the second at *http://www.cms.gov/Transmittals/downloads/R2334CP.pdf* modifies the *Medicare Claims Processing Manual*.

If you have any questions, please contact your RHHI, 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: MM7523 Revised
Related Change Request (CR) #: 7523
Related CR Release Date: October 28, 2011
Effective Date: April 1, 2012 for claims processing, but policy effective November 28, 2011
Related CR Transmittal #: R148BP and R2334CP
Implementation Date: April 2, 2012

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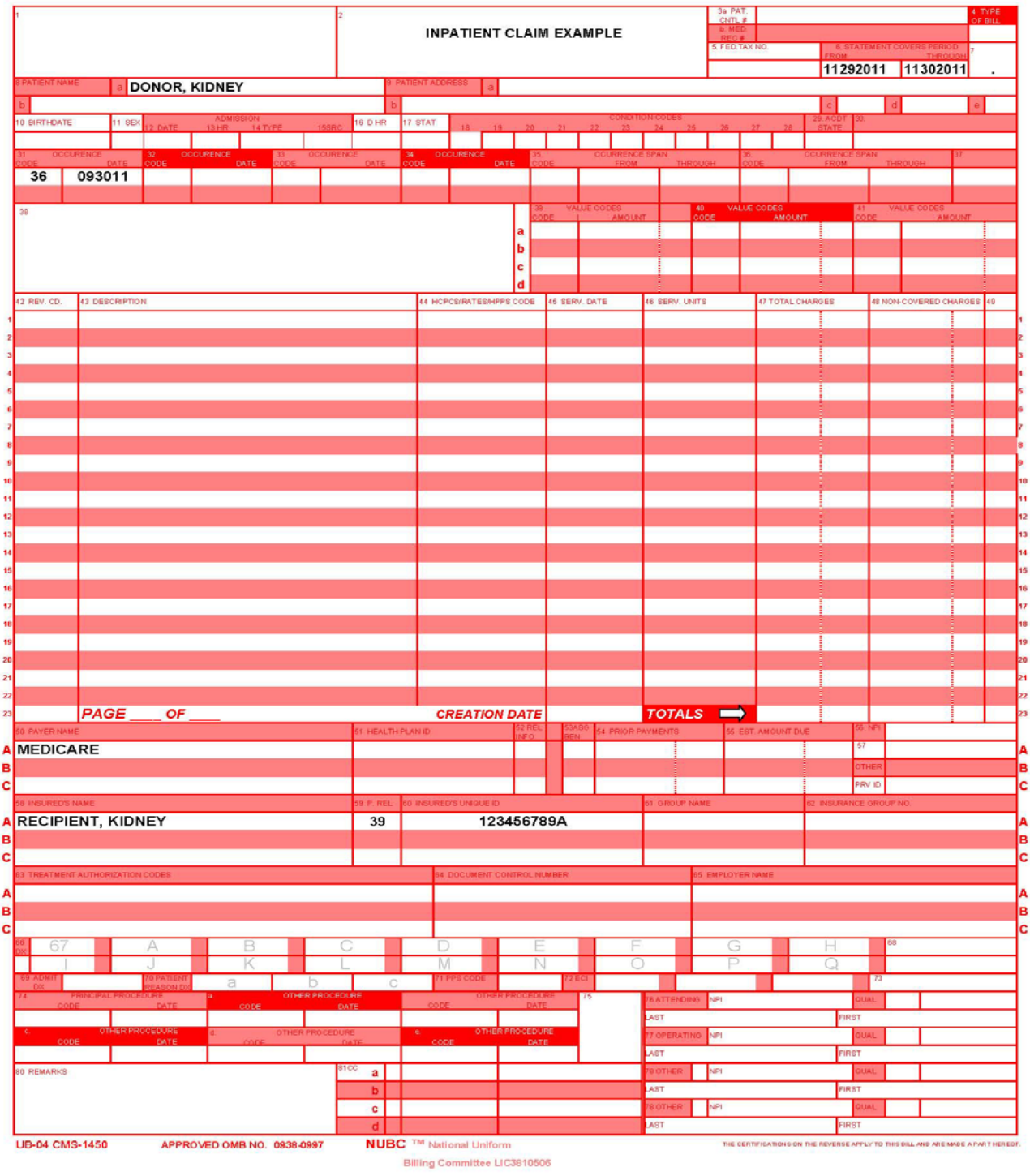
Transplant...*continued*



INPATIENT CLAIM EXAMPLE

6 STATEMENT COVERS PERIOD FROM	11292011
6 STATEMENT COVERS PERIOD THROUGH	11302011
8 PATIENT NAME a	DONOR, KIDNEY
31 OCCURRENCE CODE	36
31 OCCURRENCE DATE	093011
50 PAYER NAME A	MEDICARE
58 INSURED'S NAME A	RECIPIENT, KIDNEY
59 P. REL A	39
60 INSURED'S UNIQUE ID A	123456789A

PAGE ____ OF ____ CREATION DATE TOTALS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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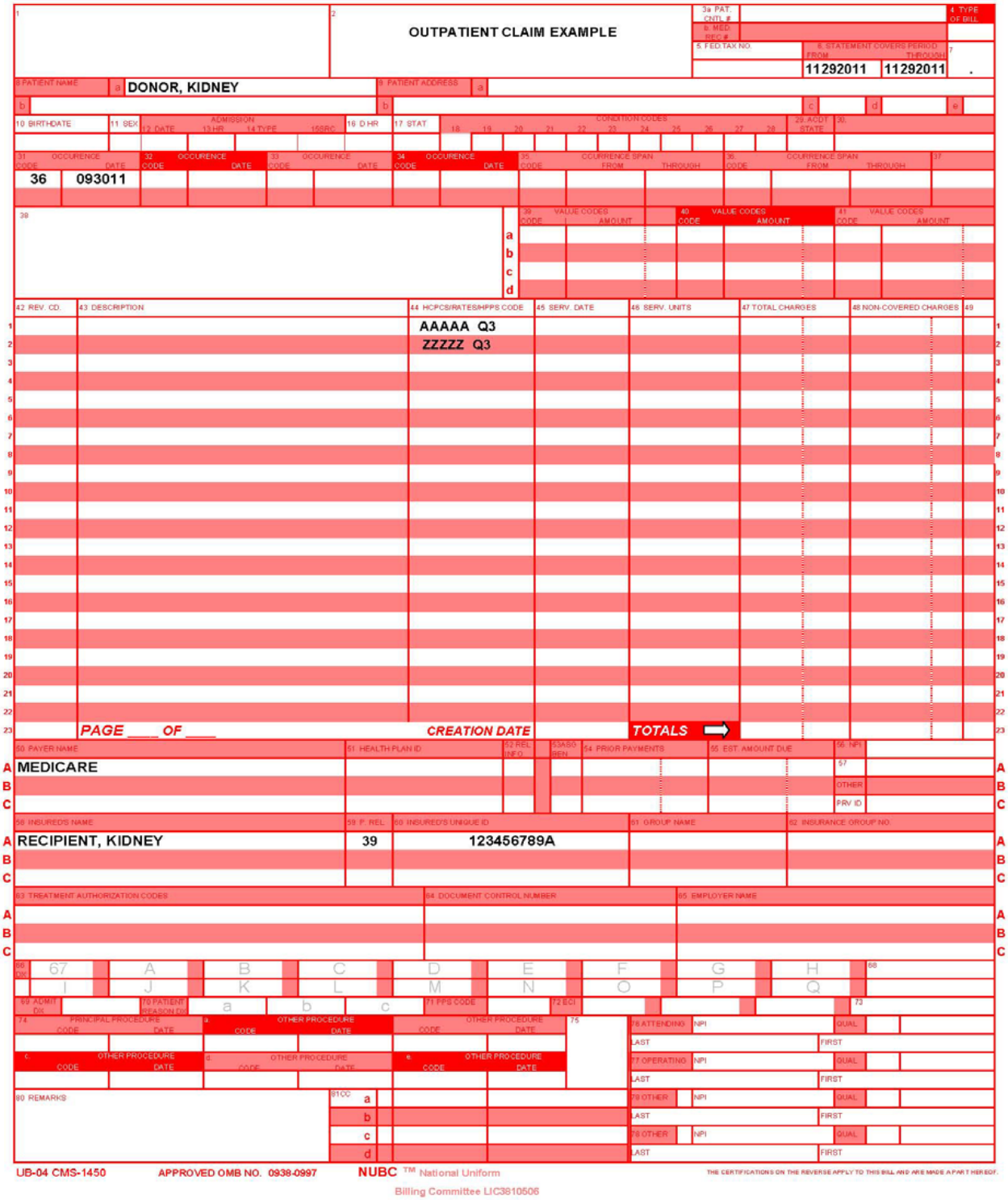
Transplant...*continued*



OUTPATIENT CLAIM EXAMPLE

11292011 11292011

8 PATIENT NAME: DONOR, KIDNEY

31 OCCURRENCE CODE/DATE: 36 093011

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS/RATES/HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES

1 AAAAA Q3

2 ZZZZZ Q3

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME: A MEDICARE

58 INSURED'S NAME: A RECIPIENT, KIDNEY | 59 P REL: 39 | 60 INSURED'S UNIQUE ID: 123456789A

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

CMS has created implementation handbooks to help transition to ICD-10

All entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must transition to the ICD-10 code sets by October 1, 2013. The Centers for Medicare & Medicaid Services (CMS) has developed four implementation handbooks to assist you with your transition to ICD-10. These handbooks are step-by-step guides that have been created specifically for small and medium provider practices, large provider practices, small hospitals, and payers.

The appendix of each handbook references relevant templates, which are available for download in both Excel and PDF formats. The templates are customizable and have been created to help entities clarify staff roles, set internal deadlines/responsibilities, and assess vendor readiness.

View the step-by-step plans and relevant templates for each of the following audiences:

- *Small/medium provider practices*
  - *Relevant templates*
- *Large provider practices*
  - *Relevant templates*
- *Small hospitals*
  - *Relevant templates*
- *Payers*
  - *Relevant templates*

The ICD-10 implementation handbooks outline suggested steps and processes to take for a smooth transition to ICD-10. Providers, hospitals, and payers may use the guides to:

- Ensure the appropriate steps and actions are taken throughout the ICD-10 implementation process
- Stay on top of deadlines by viewing the timelines within the handbooks
- Customize your transition plan by filling out the Excel templates listed in the appendices; the templates will assist you with clarifying staff roles, setting internal deadlines and responsibilities, and assessing vendor readiness

Reminder – the version 5010 compliance deadline is less than 60 days away

All affected entities must first convert to version 5010 by Sunday, January, 1, 2012, in order for the ICD-10 medical code sets to work. In order to meet this compliance deadline, you need to conduct both level I internal testing, and level II external testing of transactions. Once your practice is fully transitioned to version 5010, take the necessary steps listed in the ICD-10 implementation handbooks to help you prepare for ICD-10.

Keep up to date on version 5010 and ICD-10

Please visit the *ICD-10-website* for the latest news and resources to help you prepare and to download and share the implementation *widget* today.

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

Source: CMS PERL 201111-20

Now available – video, podcasts, and written transcript of the August 3 ICD-10 national provider call

The Centers for Medicare & Medicaid Services (CMS) has released four podcasts and two video slideshow presentations from the August 3 national provider call on "ICD-10 Implementation Strategies for Physicians."

Did you miss the August 3 ICD-10 national provider call?

The entire narrated presentation is now available on the CMS YouTube channel as a video slideshow that includes the call audio and captioning. A second video slideshow from this national provider call is also available of Dr. Daniel Duvall's presentation on "Implementation Strategies for Physicians and Non-Physician Practitioners."

Limited on time?

Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available from the August 3 ICD-10 call:

- Podcast 1 of 4: Welcome and Implementation Strategies for Physicians
- Podcast 2 of 4: Overview and Presentations by CMS Subject Matter Experts
- Podcast 3 of 4: Question and Answer Session
- Podcast 4 of 4: Question and Answer Session Continued

The podcasts, video slideshows, and written transcript are now available on the CMS website at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1249632*.

The four audio podcasts with corresponding written transcripts, as well as the full written transcript of the call may be accessed by scrolling to the "Downloads" section at the bottom of the page. To access the video slideshows, select the links in the "Related Links Outside CMS" section of the Web page.

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

Source: CMS PERL 201110-28

Updated ICD-10 MS-DRG software and definitions manual

Based on public comments, the Centers for Medicare & Medicaid Services (CMS) decided to provide the public with an updated version of the ICD-10 Medicare severity (MS)-DRGs v28.0 (fiscal year 2011) software and definitions manual. CMS believes this software will allow the public to more easily review and provide feedback on updates to the ICD-10 MS-DRGs.

Further information is available on the CMS website at *http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp*.

To access the definitions manual, please select the link in the "Related Links Inside CMS" section of the Web page.

To access the software, please select the link in the "Related Links Outside CMS" section of the Web page.

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

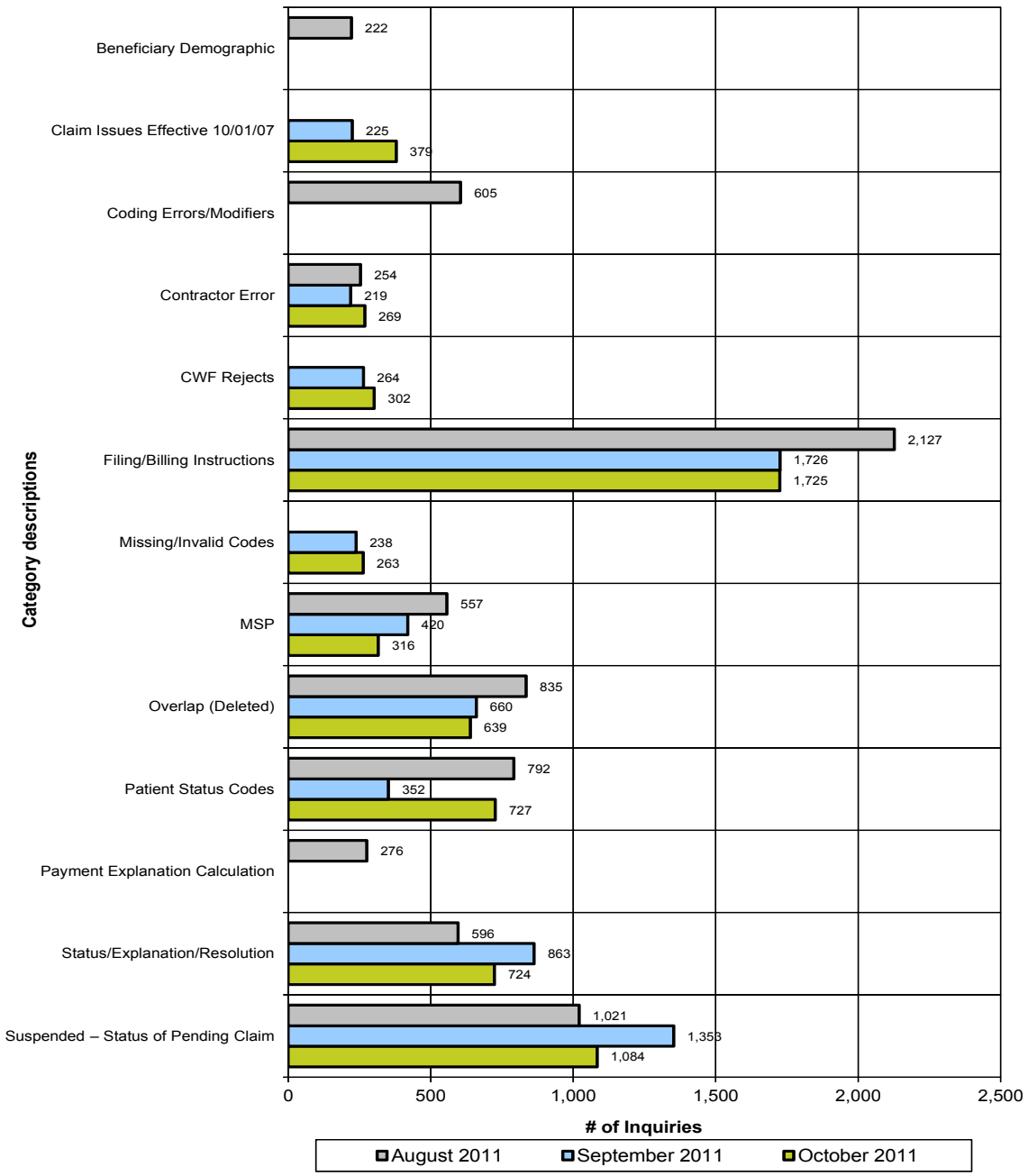
Source: CMS PERL 201110-34

Top inquiries, rejects, and return to provider claims – August-October 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 August-October 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 August-October 2011



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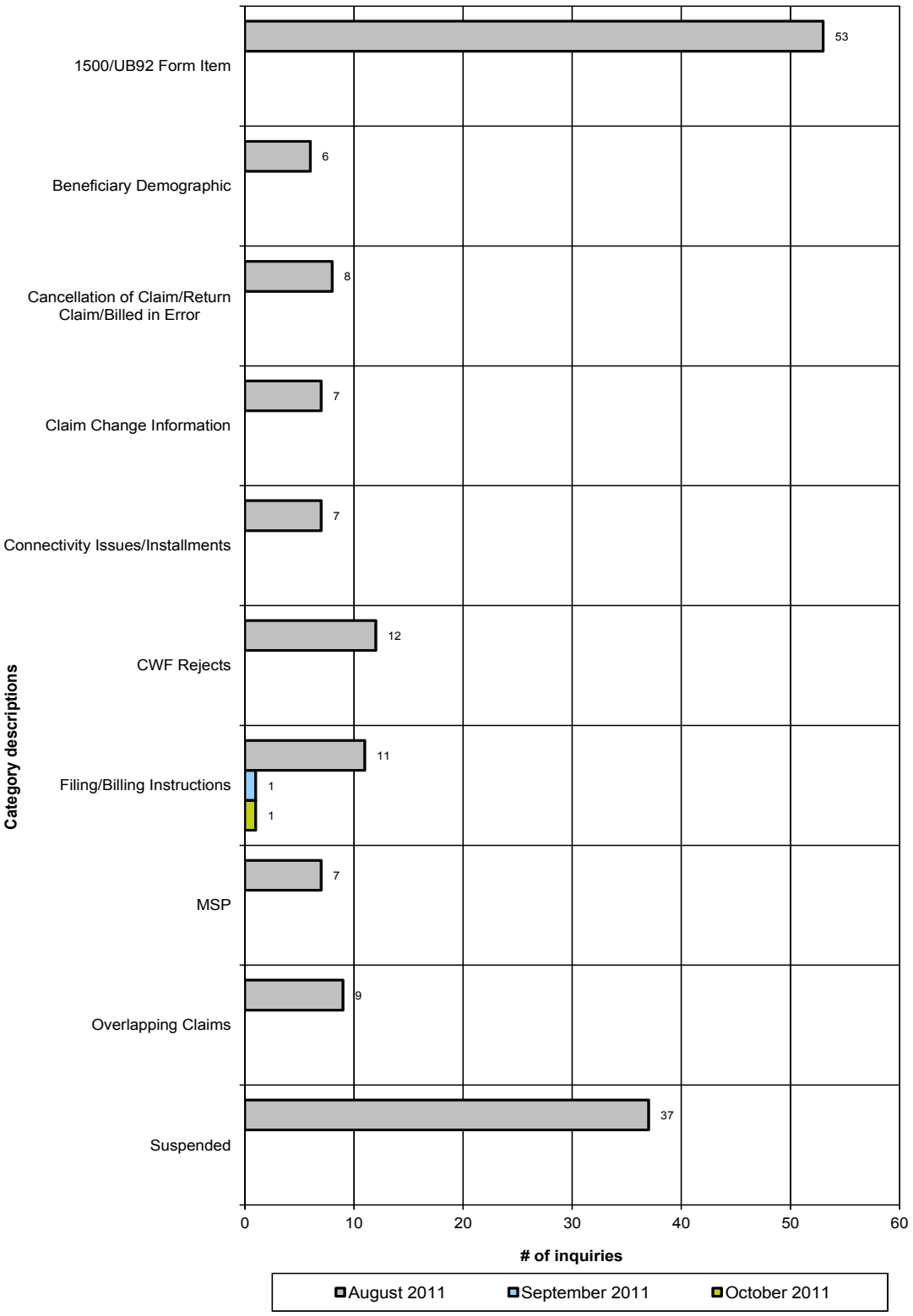
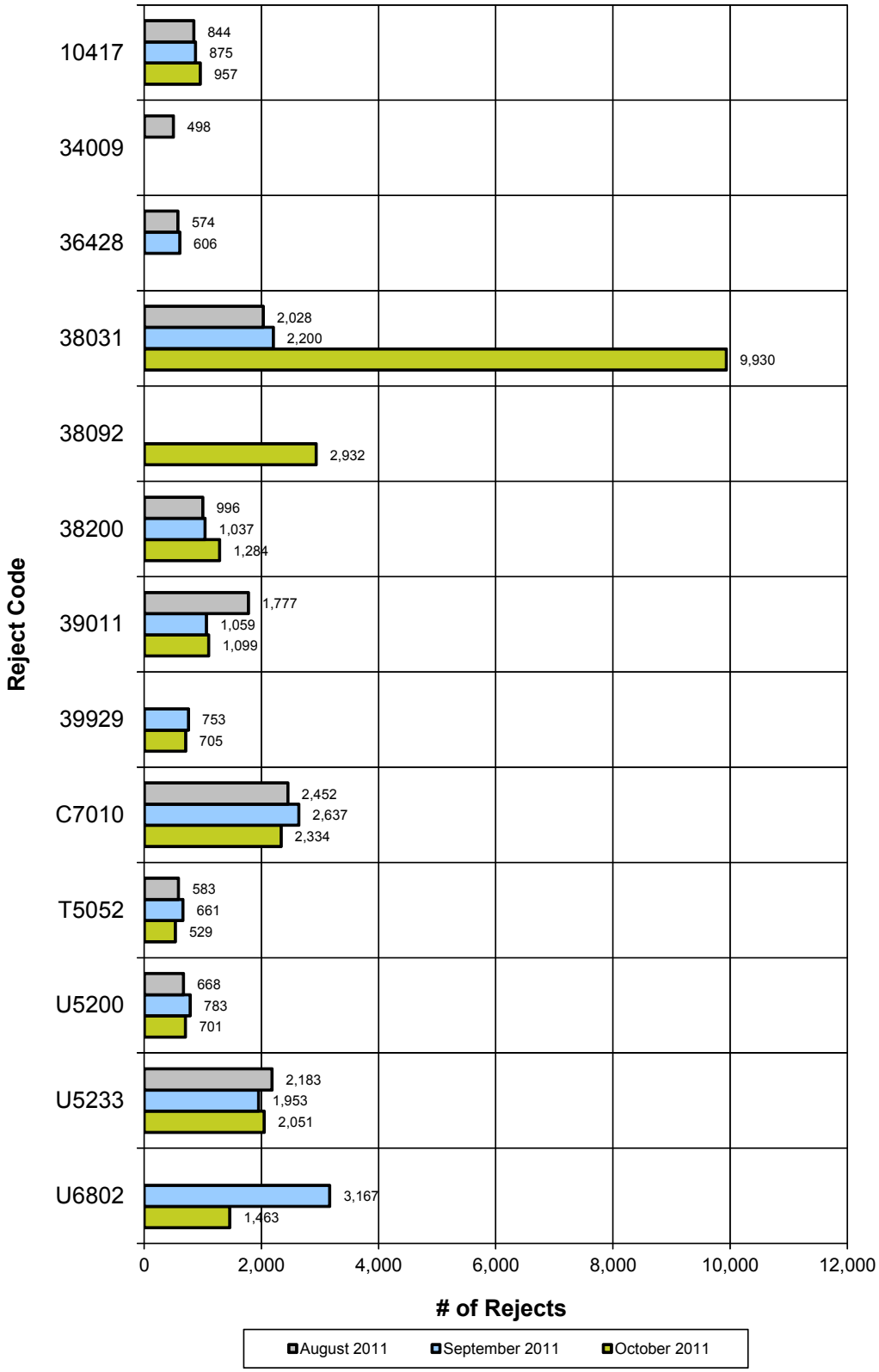
Inquiries...*continued*

U.S. Virgin Islands Part A top inquiries for August-October 2011

*Note: August includes Puerto Rico inquiries.



Florida Part A top rejects for August-October 2011



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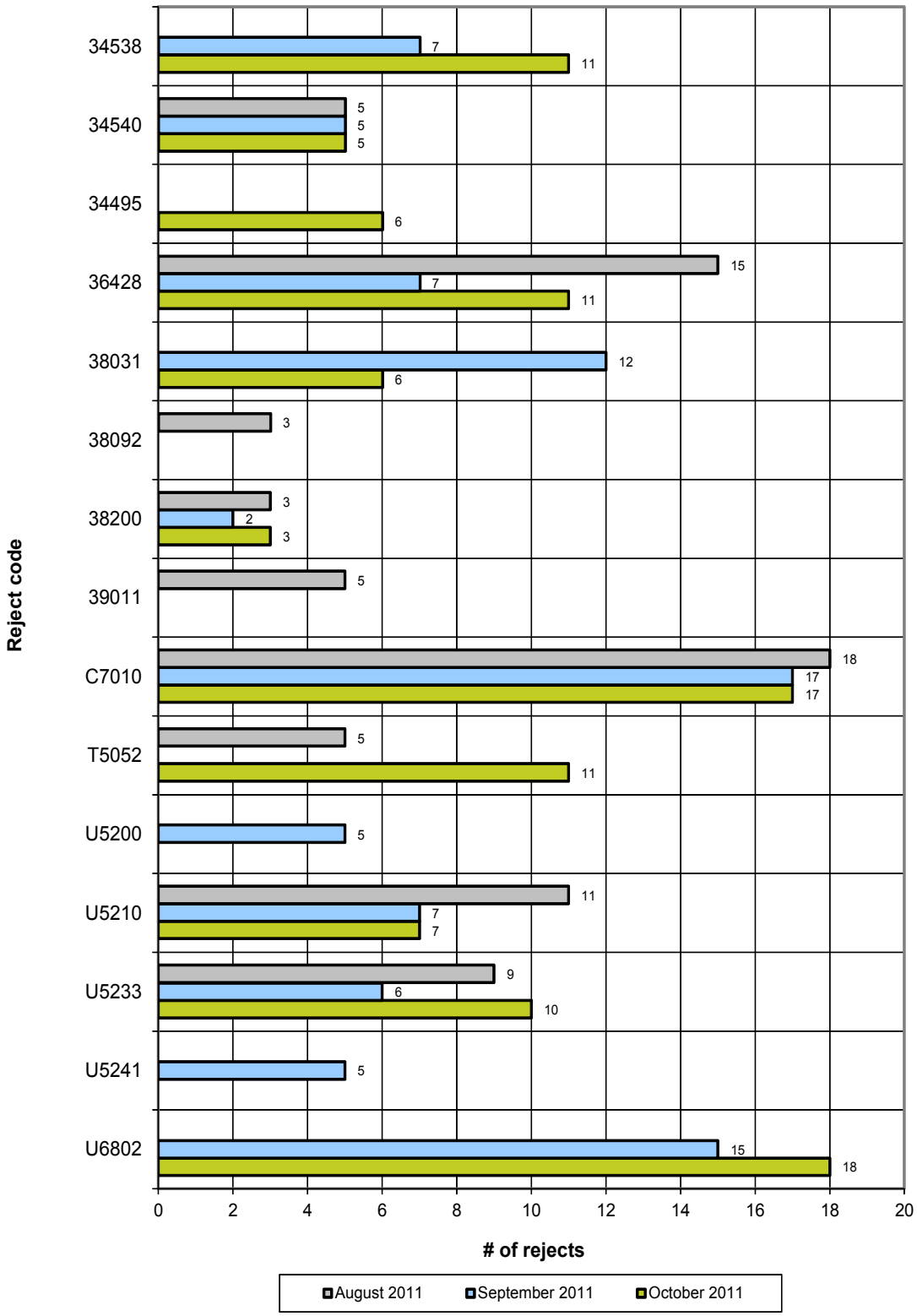
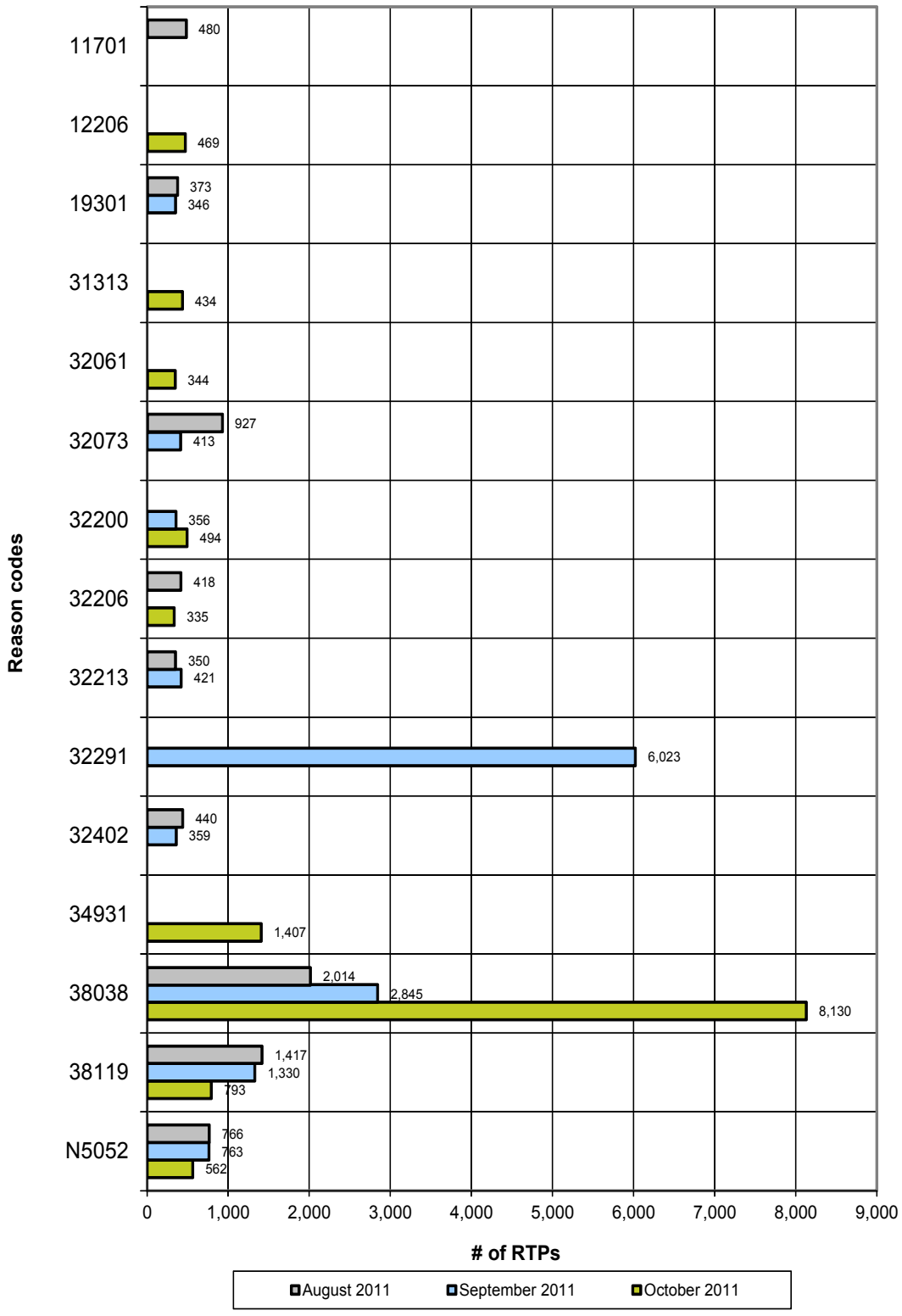
Rejects...*continued*

U.S. Virgin Islands Part A top rejects for August-October 2011



Florida Part A top return to providers (RTPs) for August-October 2011



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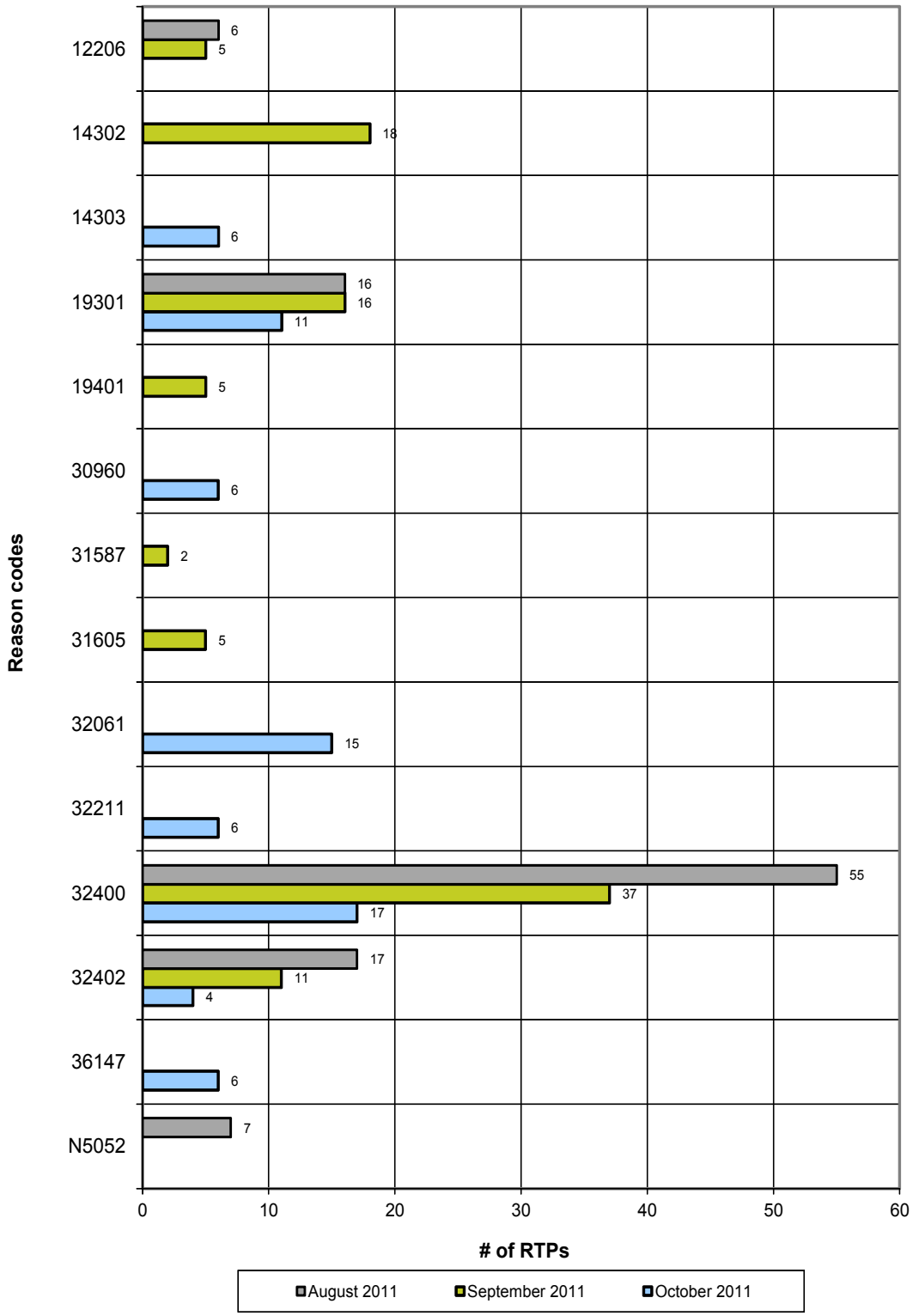
RTPs...*continued*

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



October 2011 quarterly provider specific files update

The October 2011 quarterly provider specific files (PSF) SAS and text data files are available. These files 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.

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

Source: CMS PERL 201110-25

CY 2011 outpatient prospective payment system Pricer file update

The outpatient prospective payment system (OPPS) Pricer Web page was recently updated to include the October 2011 update for outpatient provider data. Users may now access the October provider data update at *http://www.cms.gov/PCPricer/OutPPS/list.asp* by selecting 2011, and then downloading "4th Quarter 2011 Files" from the OPPS Pricer Web page.

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

Source: CMS PERL 201110-42

CMS finalizes 2012 Medicare home health payment changes

The Centers for Medicare & Medicaid Services (CMS) issued a final rule to update the home health prospective payment system (HH PPS) rates for calendar year (CY) 2012. Payments to home health agencies (HHAs) are estimated to decrease by approximately 2.31 percent or $430 million in CY 2012, the net effect of a 1.4 percent payment update, the wage index update, and the case-mix coding adjustment.

This final rule reflects the ongoing efforts of CMS to support Medicare beneficiary access to home health services while continuing to improve payment accuracy.

The Affordable Care Act applies a 1 percentage point reduction to the CY 2012 home health market basket amount. As the CY 2012 market basket is equal to 2.4 percent, the payment update for HHAs in CY 2012 will be 1.4 percent.

CMS also reduced HH PPS rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. CMS has finalized a 3.79 percent reduction to the home health PPS rates for CY 2012 and an additional 1.32 percent reduction for CY 2013.

This rule also finalizes structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments. These changes are intended to increase payment accuracy and reduce the growth in aggregate case-mix that is unrelated to changes in patients' health status.

The final rule went on display on October 31, 2011, at the *Federal Register*. The rule can be located at: *http://www.ofr.gov/OFRUpload/OFRData/2011-28416_PI.pdf*.

More information about the HH PPS can be located at: *http://www.cms.gov/HomeHealthPPS/*.

Click here to read the entire CMS press release from October 31, 2011: *http://www.cms.gov/apps/media/press/release.asp?Counter=4142*.

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

Source: CMS PERL 201110-58

Wage index corrections for CY 2012 home health prospective payment system final rule

The Centers for Medicare & Medicaid Services has posted two corrections to the wage index for the calendar year (CY) 2012 home health prospective payment system final rule (CMS-1353-F). CMS is correcting the wage index values for core-based statistical area (CBSA) 12060 (Atlanta-Sandy Springs-Marietta, GA) and for CBSA 26980 (Iowa City, IA). For CY 2012, the wage index for CBSA 12060 should be 0.9575 and the wage index for CBSA 26980 should be 1.0070. The corrected wage index files have been posted in the Spotlights section at *http://www.cms.gov/center/hha.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 201111-29

CY 2012 and after – payments to home health agencies that do not submit required quality data

Provider types affected

Home health agencies (HHAs) submitting claims to Medicare contractors, (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for home health services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7459 which revises the instructions, regarding required HHA quality data, to include the reporting of Home Health Consumer Assessment of Health Provider and Systems (HHCAHPS) data.

Caution – what you need to know

The addition of HHCAHPS data to the reporting requirement adds consumer satisfaction information to Centers for Medicare & Medicaid Services (CMS) databases and will improve the information available to the public via the HH Compare website. This reporting comes under the pay-for-reporting authority created by the Deficit Reduction Act in 2005, and the policy was finalized in the 2010 HH PPS final regulation.

Go – what you need to do

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

Background

The Social Security Act (Section 1895(b)(3)(ii)(V); see *http://www.ssa.gov/OP_Home/ssact/title18/1895.htm*) requires that each HHA submit data for the measurement of health care quality. In calendar year (CY) 2007 and each subsequent year, if a HHA does not submit the required data, their payment rates for the year are reduced by two percentage points.

The Deficit Reduction Act (DRA) of 2005 (see *https://www.cms.gov/DeficitReductionAct/*) added a pay-for-reporting requirement to payments for Medicare HH services, effective January 1, 2007. For payments in CYs 2007 through 2011, this requirement was limited to the reporting of Outcomes and Assessment Information Set (OASIS) data. Effective for payments in CY 2012 and after, the requirement also includes submission of HHCAHPS data. For payments in CY 2012 and after, documentation of HHCAHPS compliance may include any of the following:

- For CY 2012 only, evidence that the HHA participated in a HHCAHPS dry run for at least one month in third quarter 2010 (July, August, September 2010) and submitted the HHCAHPS dry run data to the HHCAHPS data center by 11:59 p.m. EST on January 21, 2011.
- Evidence that the HHA continuously collected data and submitted data to the HH CAHPS data center during the required timeframe. For CY 2012, the required period of data collection includes

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Home...*continued*

the dry run data in the third quarter 2010, the fourth quarter 2010 (all the months of October, November and December 2010), and the first quarter 2011 (all the months of January, February, and March 2011). For CY 2013 and after, the required period of data collection includes all months from April 1 of the prior year through March 31 of the current year.

- For HHAs with less than 60 HHCAHPS eligible patients in the year prior to the current reporting year, evidence that the HHA filed the Participation Exemption Request Form, on the form that can be found at *http://www.homehealth.org* by the deadline date specified in that year's HH prospective payment system final rule.

CR 7459 revises the *Medicare Claims Processing Manual* (Chapter 10, Section 120 (Payments to Home Health Agencies That Do Not Submit Required Quality Data)) to reflect the addition of HHCAHPS reporting, and the revised Section 120 is included as an attachment to CR 7459. The following requirements outline the significant changes for contractors from the revisions to the manual.

CR 7459 instructs your Medicare contractors to:

- Send notification letters to HHAs that indicate whether the HHA was non-compliant with regard to OASIS reporting, HHCAHPS reporting, or both no later than 10 business days from the receipt of a Technical Direction Letter (TDL) from CMS that provides the list of HHAs potentially subject to reductions;
- Use the model language provided in the revised *Medicare Claims Processing Manual*, Chapter 10, Section 120 when issuing notification letters and dispute determination letters; and
- Insert a CMS-provided statement of findings with regard to OASIS compliance, HHCAHPS compliance, or both in the model language of dispute determination letters.

Additional information

The official instruction, CR 7459, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2249CP.pdf*.

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

MLN Matters® Number: MM7459
Related Change Request (CR) #: CR 7459
Related CR Release Date: July 1, 2011
Effective Date: October 3, 2011
Related CR Transmittal #: 2249CP
Implementation October 3, 2011

CY 2012 blood clotting factor furnishing fee limit is now available

The Centers for Medicare & Medicaid Services (CMS) has posted the calendar year (CY) 2012 blood clotting factor furnishing fee at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/20_ClotFactorFurnishFee.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 201110-24

Rural health clinic and federally qualified health center payment rate increases

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for rural health center (RHC) and federally qualified health center (FQHC) services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7533 which provides instructions for the calendar year (CY) 2012 Payment Rate Increases for RHC and FQHC services.

Background

In accordance with the Social Security Act (Section 1833(f) at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*), the Centers for Medicare & Medicaid Services (CMS) is increasing the CY payment rates for RHCs and FQHCs effective for services on or after January 3, 2012, through December 31, 2012 (i.e., CY 2012) as follows:

- The RHC upper payment limit per visit is increased from $78.07 to $79.48 effective January 1, 2012, through December 31, 2012 (i.e., CY 2012). The 2012 rate reflects a 1.8 percent increase over the 2011 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI).
- The FQHC upper payment limit per visit for urban FQHCs is increased from $126.22 to $128.49 effective January 1, 2012, through December 31, 2012 (i.e., CY 2012), and the maximum Medicare payment limit per visit for rural FQHCs is increased from $109.24 to $111.21 effective January 1, 2012, through December 31, 2012 (i.e. CY 2012). The 2012 FQHC rates reflect a 1.8 percent increase over the 2011 rates in accordance with the rate of increase in the MEI.

Medicare contractors will not retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, they have the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

Additional information

The official instruction, CR 7533 issued to your A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2343CP.pdf*.

If you have any questions, please contact your 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: MM7533
Related Change Request (CR) #: 7533
Related CR Release Date: November 4, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2343CP
Implementation Date: January 3, 2012

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Rural health clinic claims hold

The Centers for Medicare & Medicaid Services (CMS) has identified a claim processing problem impacting rural health clinic (RHC) claims where claims submitted with more than one preventative service results in double reimbursement. CMS is holding RHC claims, type of bill 71x, submitted with more than one of the preventative services noted in change request (CR) 7208 found at *http://www.CMS.gov/transmittals/downloads/R2122CP.pdf*. As soon as a system fix is in place and successfully tested, these claims will be released for processing. CMS appreciates your patience and apologize for any inconvenience this may cause.

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

Source: CMS PERL 201110-46

Payment rate changes for the 2012 Medicare physician fee schedule

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period that updates payment policies and rates for physicians and nonphysician practitioners (NPPs) for services paid under the Medicare physician fee schedule (MPFS) in calendar year (CY) 2012. More than one million providers of vital health services to Medicare beneficiaries – including physicians, limited license practitioners such as podiatrists, and NPPs such as nurse practitioners and physical therapists – are paid under the MPFS. CMS projects that total payments under the MPFS in CY 2012 will be approximately $80 billion.

CMS is required to issue a final rule that reflects current law. Under current law, providers will face steep across-the-board reductions in payment rates, based on a formula – the sustainable growth rate (SGR) – that was adopted in the Balanced Budget Act of 1997. Without a change in the law from Congress, Medicare payment rates to providers paid under the MPFS will be reduced by 27.4 percent for services in CY 2012 – less than the 29.5 percent reduction that CMS had estimated in March of this year because Medicare cost growth has been lower than expected. This is the eleventh time the SGR formula has resulted in a payment cut, although the cuts have been averted through legislation in all but CY 2002. The Obama administration is committed to fixing the SGR and ensuring these payment cuts do not take effect.

In an effort to ensure Medicare is paying accurately for physician services and more closely managing the payment system, CMS has expanded the potentially misvalued code initiative in the CY 2012 final rule. This year, CMS is focusing on the codes billed by physicians in each specialty that result in the highest Medicare expenditures under the MPFS to determine whether these codes are overvalued. In the past, CMS has targeted specific codes for review that may have affected a few procedural specialties (e.g., cardiology, radiology, nuclear medicine); however, CMS has not taken a look at the highest expenditure codes across all specialties. This effort results in increased payments for primary care services that have historically been undervalued by the fee schedule.

CMS is also making changes in how it adjusts payment for geographic variation in the costs of practice. The Affordable Care Act and the Medicare and Medicaid Extensions Act made some temporary adjustments that were in place for two years while CMS and the Institute of Medicine (IOM) began to comprehensively study these issues.

The final rule with comment period will appear in the November 28, 2011, *Federal Register*. CMS will accept comments on those provisions that are subject to comment until Tuesday, January 3, 2012, and will respond in the MPFS for CY 2013.

For more information, visit *http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp*.

Read the entire CMS press release issued November 1, at *http://www.cms.gov/apps/media/press/release.asp?Counter=415*.

Also, please see additional CMS fact sheets issued November 1, which may be found at:

- *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4153*
- *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4154*
- *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4155*

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

Source: CMS PERL 201110-59

CARC used for therapy claims subject to the multiple procedure payment reduction

Provider types affected

Providers who bill Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (A/B MACs)) for therapy services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7564, which revises the remittance advice coding used when claim payments are subject to a multiple procedure payment reduction. Medicare contractors will use the following claim adjustment reason code (CARC) on the remittance advice for service lines for which they have applied the multiple procedure payment reduction (MPPR) code 59: Processed based on multiple or concurrent procedure rules.

This new code will make payment adjustments due to the MPPR more easily recognized on your remittance advices. This article contains no new policy. Be sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 7050, "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services," on December 21, 2010. CR 7050 implemented a MPPR to the practice expense (PE) payment of select therapy services paid under the Medicare physician fee schedule. MM7050, which explains that instruction, is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7050.pdf*. That instruction required the use of CARC 45 for the MPPR action. However, CARC 45 is also used for other payment adjustments and if both the MPPR and another reduction were applied to the same line item on a claim, CARC 45 would not readily distinguish the MPPR from the other reduction.

This article explains that Medicare contractors are instructed to use CARC 59, defined as "Processed based on multiple or concurrent procedure rules, (For example multiple surgery or diagnostic imaging, concurrent anesthesia)," on the remittance advice for service lines for which they have applied the MPPR methodology described in CR 7050.

Additional information

The official instruction, CR 7564, issued to your FI, RHHI, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2328CP.pdf*.

If you have any questions, please contact your FI, RHHI, 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: MM7564
Related Change Request (CR) #: 7564
Related CR Release Date: October 27, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2328CP
Implementation Date: April 2, 2012

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.

January 2012 quarterly ASP drug pricing files and revisions to prior files

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B 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) 7624 which instructs your Medicare contractors to download and implement the January 2012 average sales price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised October 2011, July 2011, April 2011, and January 2011 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 January 3, 2012, with dates of service January 1, 2012, through March 31, 2012.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c); see *http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf*) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis. The ASP methodology is based on quarterly data submitted to the CMS by manufacturers. CMS will supply 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 OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4, Section 50; see *http://www.cms.gov/manuals/downloads/clm104c04.pdf*.

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

Files	Effective for dates of service
January 2012 ASP and ASP NOC	January 1 - March 31, 2012
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

Additional information

The official instruction, CR 7624, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2331CP.pdf*.

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

MLN Matters® Number: MM7624
Related Change Request (CR) #: CR 7624
Related CR Release Date: October 27, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2331CP
Implementation Date: January 3, 2012

Influenza vaccine payment allowances – update for 2011-2012 season

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7575 in order to update payment allowances, effective September 1, 2011, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP). Be sure your billing staffs are aware of this update.

Background

CR 7575 provides the payment allowances for the following seasonal influenza virus vaccines: *Current Procedural Terminology (CPT)* codes *90654, 90655, 90656, 90657, 90660*, and *90662* and Healthcare Common Procedure Coding System (HCPCS) codes Q2035, Q2036, Q2037, Q2038, and Q2039 when payment is based on 95 percent of the AWP. The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year.

Effective for dates of service on or after September 1, 2011, (except payment is based on reasonable cost where the vaccine is furnished in a hospital outpatient department, a rural health clinic, or a federally qualified health center), the Medicare Part B payment allowance for:

- *CPT 90655* is $15.705;
- *CPT 90656* is $12.375;
- *CPT 90657* is $6.653;
- HCPCS Q2035 (Afluria®) is $11.543;
- HCPCS Q2036 (Flulaval®) is $8.784;
- HCPCS Q2037 (Fluvirin®) is $13.652; and
- HCPCS Q2038 (Fluzone®) is $13.306.

Note: The Medicare Part B payment allowance for HCPCS Q2039 (flu vaccine adult - not otherwise classified) will be determined by your local Medicare contractor.

Payment for *CPT 90654* (*flu vaccine, intradermal, preservative free (Fluzone ID®)*), for *CPT 90660 (FluMist®, a nasal influenza vaccine)*, or *CPT 90662 (Fluzone high-dose®)* may be made if your local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. Effective for dates of service on or after September 1, 2011, when payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for *CPT 90654* is $18.383, for *CPT 90660* is $22.316, and for *CPT 90662* is $30.923.

CPT 90654 is a valid code effective January 1, 2011. However, the product was not FDA approved until May 9, 2011. Therefore, the code is non-payable for Medicare purposes from January 1, 2011, until May 8, 2011. For any claims containing dates of service May 9, 2011, through August 31, 2011, Medicare contractors shall price the vaccine. Effective for dates of service on and after September 1, 2011, CMS has established a price for *CPT 90654*.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Note: Medicare contractors will not automatically adjust claims processed prior to implementation of CR 7575. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 7575 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2345CP.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: MM7575 Revised
Related Change Request (CR) #: 7575
Related CR Release Date: November 9, 2011
Effective Date: September 1, 2011
Related CR Transmittal #: R2345CP
Implementation Date: No later than January 27, 2012

CY 2012 fee schedule update for DMEPOS

Provider types affected

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

Provider action needed

Stop – impact to you

Updates and information in CR 7635 can impact reimbursement for your claims for DMEPOS items or services.

Caution – what you need to know

This article, based on change request (CR) 7635, advises you of the calendar year (CY) 2012 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the *Background* section below. These changes are effective for DMEPOS provided on or after January 1, 2012.

Go – what you need to do

You should make that sure your billing staffs are aware of these changes.

Background and key points of CR 7635

Payment on a fee schedule basis is required for durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act (the Act); and for parenteral and enteral nutrition (PEN) by 42 CFR, Section 414.102.

In accordance with these statutes and regulations, the DMEPOS fee schedules are updated annually; and the process for this update is documented in the *Medicare Claims Processing Manual*, Chapter 23 Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule at *http://www.cms.gov/manuals/downloads/clm104c23.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7635, from which this article is taken, provides instructions regarding annual the DMEPOS fee schedule annual update for 2012.

Fee schedule files

The DMEPOS fee schedule file will be available on or after November 16, 2011, for state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.hhs.gov/DMEPOSFeeSched/*.

Healthcare Common Procedure Coding System (HCPCS) codes added

The following new codes are effective as of January 1, 2012:

- A9272 which has no assigned payment category;
- A5056 and A5057 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0988 in the capped rental (CR) category;
- L5312, L6715, and L6880 in the prosthetics and orthotics category; and
- E2358, E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 in the inexpensive/routinely purchased (DME) payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2012 DMEPOS fee schedule update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2012 through June 30, 2012. The new codes are not to be used for billing purposes until they are effective on January 1, 2012.

Please note that the HCPCS codes listed as new codes in this CR may not be final and are subject to change

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DMEPOS...*continued*

pending release of the CY 2012 HCPCS file.

For gap-filling purposes, the 2011 deflation factors by payment category are listed in the following table:

Factor	Category
0.485	Oxygen
0.488	Capped Rental
0.490	Prosthetics and Orthotics
0.621	Surgical Dressings
0.676	Parenteral and Enteral Nutrition

HCPCS codes deleted

The following codes are being deleted from the HCPCS effective January 1, 2012, and are therefore being removed from the DMEPOS fee schedule files:

- E0571
- L1500, L1510, L1520, L3964, L3965, L3966, L3968, L3969, L3970, L3972, L3974, L4380, L5311, L7266, L7272, L7274, and L7500.

Specific coding and pricing issues

CMS has learned that the current language in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60.3(Gap-filling DMEPOS Fees), that describes the longstanding methodology for calculating gap-filled fee schedule amounts, can be misinterpreted.

For this reason, CR 7635 revises the first paragraph of this section by replacing the phrase “previous data base period” with “fee schedule data base year,” and later in the same sentence replacing the phrase “database year” with “fee schedule database year.” These revisions closely approximate the original gap-fill instructions as they appeared in the *Medicare Carriers Manual*, Part 3 (Claims Process), Section 5102 (Fee Schedules For Durable Medical Equipment and Orthotic/Prosthetic Devices). In addition, CR 7635 revises this section to include the addition of the 2011 deflation factors, as noted above.

CR 7635 also announces other coding and pricing changes, effective January 1, 2012:

1. New HCPCS codes: E2626, E2627, E26268, E 2629, E2630, E2631, E2632, and E2633 (for wheelchair accessories for shoulder elbow arm supports) are re-designated from codes L3964-L3974 and the fee schedule amounts will be directly assigned from the deleted codes to the new codes.
2. The fee schedule amounts for shoe modification HCPCS codes A5503 through A5507 are being adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the original fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2012, the base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2010 and the fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change.

KE modifier update

To ensure appropriate modifier processing when submitting claims for HCPCS code E0776 (IV Pole), suppliers should bill using the following modifiers depending upon the type of pump that the IV pole is used with:

- For use with infusion pumps – submit E0776RR, E0776NU, or E0776UE;
- For use with parenteral pumps – submit E0776RRBAKE, E0776NUBAKE, or E0776UEBAKE;
- For use with enteral pumps – submit E0776RRBA, E0776NUBA or E0776UEBA; or
- For use with enteral pumps by beneficiaries that permanently reside in round I rebid competitively bid areas – submit E0776RRBAKG, E0776NUBAKG or E0776UEBAKG.

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DMEPOS...*continued*

Similarly, when submitting claims for a replacement HCPCS code E2373 (power wheelchair accessory, hand or chin control interface, compact remote joystick) suppliers should bill using the following modifiers depending upon the associated base wheelchair:

- For use with a power wheelchair HCPCS code that was bid in round I of the DMEPOS competitive bidding program – submit E2373KCRR, E2373KCNU or E2373KCUE;
- For use with a power wheelchair HCPCS code that was not bid in round I of the DMEPOS competitive bidding program – submit E2373KCRRKE, E2373KCNUKE or E2373KCUEKE; or
- For beneficiaries that permanently reside in round I rebid competitively bid areas when used with a power wheelchair HCPCS code that was bid in the round I rebid of the DMEPOS competitive bidding program – submit E2373KCRRKK, E2373KCNUKK or E2373KCUEKK.

Note: The above billing instructions supersede the E0776 and E2373 KC billing instructions furnished in Transmittal 1630, CR6270, dated November 7, 2008.

Attachment B to CR 7635 contains a list of the HCPCS codes that were selected in 2008 for round I of the DMEPOS competitive bidding program. For beneficiaries who permanently reside in round I rebid competitive bid areas, a list of the round 1 rebid competitively bid items is available in the single payment amount charts located at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Single%20Payment%20Amounts* on the Competitive Bidding Implementation Contractor (CBIC) website.

CY 2012 fee schedule update factor

For CY 2012, the update factor of 2.4 percent is applied to the applicable CY 2011 DMEPOS fee schedule amounts.

In accordance with section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2012 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2011, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 1.2 percent and the CPI-U percentage increase is 3.6 percent. Thus, the 3.6 percentage increase in the CPI-U is reduced by the 1.2 percentage increase in the MFP resulting in a net increase of 2.4 percent for the MFP-adjusted update factor.

2011 update to labor payment rates

2012 fees for HCPCS labor payment codes K0739, L4205, L7520 are increased by 3.6 percent effective for dates of service on or after January 1, 2012 through December 31, 2012, and those rates are as follows:

State	K0739	L4205	L7520		State	K0739	L4205	L7520
AK	$26.47	$30.16	$35.48		NC	$14.05	$20.94	$28.43
AL	14.05	20.94	28.43		ND	17.51	30.10	35.48
AR	14.05	20.94	28.43		NE	14.05	20.92	39.64
AZ	17.37	20.92	34.98		NH	15.08	20.92	28.43
CA	21.56	34.38	40.07		NJ	18.96	20.92	28.43
CO	14.05	20.94	28.43		NM	14.05	20.94	28.43
CT	23.47	21.41	28.43		NV	22.39	20.92	38.75
DC	14.05	20.92	28.43		NY	25.88	20.94	28.43
DE	25.88	20.92	28.43		OH	14.05	20.92	28.43
FL	14.05	20.94	28.43		OK	14.05	20.94	28.43
GA	14.05	20.94	28.43		OR	14.05	20.92	40.88
HI	17.37	30.16	35.48		PA	15.08	21.54	28.43
IA	14.05	20.92	34.03		PR	14.05	20.94	28.43

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DMEPOS...*continued*

State	K0739	L4205	L7520		State	K0739	L4205	L7520
ID	14.05	20.92	28.43		RI	16.75	21.56	28.43
IL	14.05	20.92	28.43		SC	14.05	20.94	28.43
IN	14.05	20.92	28.43		SD	15.70	20.92	38.00
KS	14.05	20.92	35.48		TN	14.05	20.94	28.43
KY	14.05	26.81	36.35		TX	14.05	20.94	28.43
LA	14.05	20.94	28.43		UT	14.09	20.92	44.27
MA	23.47	20.92	28.43		VA	14.05	20.92	28.43
MD	14.05	20.92	28.43		VI	14.05	20.94	28.43
ME	23.47	20.92	28.43		VT	15.08	20.92	28.43
MI	14.05	20.92	28.43		WA	22.39	30.69	36.45
MN	14.05	20.92	28.43		WI	14.05	20.92	28.43
MO	14.05	20.92	28.43		WV	14.05	20.92	28.43
MS	14.05	20.94	28.43		WY	19.59	27.91	39.64
MT	14.05	20.92	35.48					

2012 national monthly payment amounts for stationary oxygen equipment

CR 7635 implements the 2012 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2012. As required by statute, the payment amount must be adjusted annually, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE).

The updated national 2012 monthly payment amount of $176.06 for stationary oxygen equipment codes is included in the DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2012 maintenance and servicing payment amount for certain oxygen equipment

CR 7635 also updates the 2012 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792 Maintenance and Servicing Payments for Certain Oxygen Equipment, which you can find at *http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf* and MM6990 Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010, which you can find at *https://www.cms.gov/MLNMattersArticles/downloads/MM6990.pdf*.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2011 maintenance and servicing fee is adjusted by the 2.4 percent MFP-adjusted covered item update factor to yield a CY 2012 maintenance and servicing fee of $67.51 for oxygen concentrators and transfilling equipment.

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DMEPOS...*continued*

Additional information

You can find the official instruction, CR 7635, issued to your carrier, DME MAC, FI, A/B MAC, or RHHI by visiting *http://www.cms.gov/Transmittals/downloads/R2340CP.pdf*. You will find the updated *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements, Section 60.3 (Gap-filling DMEPOS Fees) as an attachment to that CR.

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

MLN Matters® Number: MM7635
Related Change Request (CR) #: CR 7635
Related CR Release Date: November 4, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2340CP
Implementation Date: January 3, 2012

Changes to Medicare overpayment notification process

The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare overpayment notification process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare overpayments:

- Initial demand letter (first letter)
- Follow-up letter (second letter)
- Intent to refer letter (third letter)

CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that this is not efficient since most providers respond to the initial demand letter and pay the debt.

Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged.

If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

Source: CMS PERL 201111-22

Take advantage of FCSO's exclusive PDS report

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

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

Note: This article was revised on November 7, 2011, to reflect changes made to CR 7499. In this article, the implementation dates (see above), the CR release date, transmittal number, and the Web address for accessing CR 7499 were revised. All other information is the same. This information was previously published in the August 2011 *Medicare A Connection*, page 37.

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 Health Insurance Claim (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/R993OTN.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 Revised
Related Change Request (CR) #: CR 7499
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R993OTN
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 9, 2012 for supplier claims submitted to DME MACs

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

Fiscal year 2012 inpatient PPS PC Pricer updates

The fiscal year (FY) 2012 inpatient prospective payment system (INP PPS) PC Pricer has been updated on the Centers for Medicare & Medicaid Services (CMS) website. If you use the FY 2012 INP PPS PC Pricer, please go to the CMS Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp*, and download the latest version of the FY 2012 PC Pricer. This PC Pricer is for claims dated from October 1, 2011, to September 30, 2012. The update is dated November 8, 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 201111-06

Hospital routine services 'under arrangement' requirement

On August 18, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2012 inpatient prospective payment system (IPPS) final rule. The final rule included a provision limiting the circumstances under which a hospital may furnish services "under arrangement." Under the revised policy, only therapeutic and diagnostic services may be furnished outside of the hospital under arrangement; "routine services" (for example, bed, board, and nursing services) must be provided by the hospital. Under the policy, routine services that are furnished in the hospital to its inpatients are considered as being provided by the hospital. If services are provided outside of the hospital, the services are considered as being provided under arrangement.

CMS recognizes that hospitals may need more time to restructure existing arrangements and establish operational protocols necessary to comply with the requirement that only therapeutic and diagnostic services may be furnished outside of the hospital under arrangement and that "routine services" must be provided by the hospital. CMS expects that during FY 2012, hospitals will work towards ensuring compliance with the new requirements. CMS will continue to work with these hospitals to communicate the requirements of this provision and to provide continued guidance. Beginning with the FY 2013, all hospitals will need to be in full compliance with the modified under arrangement provisions.

Source: TDL 12038

Diagnosis code update for add-on payments for blood clotting factor administered to hemophilia inpatients

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for inpatient services provided to Medicare beneficiaries with hemophilia.

Provider action needed

This article is based on change request (CR) 7553 which provides updates to diagnosis codes required in order to allow add-on payments under the inpatient prospective payment system (IPPS) for blood clotting factor administered to hemophilia inpatients. Be sure your billing staffs are aware of the updates.

Background

The September 1, 1993, Inpatient Prospective Payment System (IPPS) Final Rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM diagnosis code for hemophilia is included on the bill.

Change request 7553 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 3 (Inpatient Hospital Billing, Section 20.7.3 (Payment for Blood Clotting Factor Administered to Hemophilia Inpatients)) with the following diagnosis code changes in order to allow add-on payments under the IPPS:

continued on next page

Clotting...*continued*

Add – effective October 1, 2011

Effective for discharges on or after October 1, 2011, payment may be made if one of the following diagnosis codes is reported:

ICD-9-CM code	Descriptor
286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors

Add – effective October 1, 2013

Effective for discharges on or after October 1, 2013, payment may be made if the following ICD-10 diagnosis code is reported:

ICD-10 code	Descriptor
D6831	Hemorrhagic disorder due to intrinsic circulating anticoagulants

Terminate – effective September 30, 2011

Effective for discharges as of September 30, 2011, the add-on payment will not be made for:

ICD-9-CM code	Descriptor
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants

Note: The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will not be updated until April 2, 2012. Therefore, providers that include diagnosis codes 286.52, 286.53 or 286.59 on inpatient claims with discharge dates after October 1, 2011, prior to the April 2012 implementation will not receive the add-on payment. Providers may contact their Medicare contractors to have any affected claims adjusted once CR 7553 is implemented. Your Medicare contractor(s) will not search claims history but will adjust affected claims when brought to their attention.

Additional information

The official instruction, CR 7553, issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2332CP.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: MM7553
Related Change Request (CR) #: 7553
Related CR Release Date: October 28, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2332CP
Implementation Date: April 2, 2012

Policy and payment changes for outpatient care in hospitals and ambulatory surgical centers

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period (final rule) that will update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2012. In addition to establishing payment rates for calendar year (CY) 2012, the final rule expands the measures to be reported under the hospital outpatient quality reporting program, creates a new quality reporting program for ASCs, and strengthens the hospital value-based purchasing (hospital VBP) program that will affect payments to hospitals for inpatient stays beginning Oct. 1 2012.

CMS projects that total payments to more than 4,000 hospitals – which includes general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals – paid under the outpatient prospective payment system (OPPS) in CY 2012 will be approximately $41.1 billion. CMS also projects that payments to approximately 5,000 Medicare-participating ASCs paid under the ASC payment system will be approximately $3.5 billion for CY 2012.

"The CMS is committed to the goal of improving the quality and safety of care in all settings for all patients," said CMS Administrator Donald M. Berwick, M.D. "Using the tools made available under the Affordable Care Act, CMS is moving aggressively to reform the payment and health care delivery systems to provide better care at lower costs through improvement."

The final rule also establishes an electronic reporting pilot that will allow additional hospitals, including critical access hospitals (CAHs), to report clinical quality measures in CY 2012 for purposes of participating in the Medicare electronic health record incentive program.

Provisions affecting payments to hospital outpatient departments

The final rule will increase payment rates under the OPPS by 1.9 percent in CY 2012. This increase is based on the projected hospital inpatient market basket percentage increase of 3.0 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) minus the multifactor productivity adjustment of 1.0 percentage points and minus a 0.1 percentage point adjustment, both of which are required by the Affordable Care Act.

The final rule also provides a payment adjustment for designated cancer hospitals as required by the Affordable Care Act. This payment adjustment is expected to increase payments to cancer hospitals by 11.3 percent (or approximately $71 million) over what they would have otherwise been paid.

The final rule will increase payment rates under the OPPS by 1.9 percent in CY 2012.

In response to concerns that Medicare's requirement for direct physician supervision of outpatient hospital therapeutic services could hinder access for beneficiaries specifically in rural areas, the final rule establishes an independent advisory review process to consider requests that specific outpatient services be subject to a level of supervision other than direct supervision. Under this process, CMS will seek recommendations from Ambulatory Payment Classification (APC) Advisory Panel about appropriate supervision requirements. This panel was created to provide technical advice and recommendations to CMS about assigning items and services furnished in hospital outpatient departments to appropriate payment classifications. CMS will add two small rural PPS hospital members and two CAH members to represent their interests to the panel so that all hospitals subject to the supervision rules for payment of outpatient therapeutic services will be represented. Since CAHs are not paid under the OPPS, CAH representatives would not participate in deliberations about APC assignments.

"The CMS is committed to ensuring that beneficiaries who are treated in small rural hospitals have access to high quality, safe therapeutic services in outpatient departments," said Jonathan Blum, deputy administrator and director for CMS's Center for Medicare. "We believe the process we have adopted will provide meaningful and transparent input from stakeholders to assist CMS in establishing appropriate supervision requirements."

In other provisions, the final rule will:

- Pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals, other than new drugs and biologicals that have pass-through status, at the average sales price (ASP) plus 4 percent.
- Pay for partial hospitalization (PHP) services in hospital-based PHPs and community mental health centers (CMHCs) based on the unique

continued on next page

Outpatient...*continued*

cost-structures of each type of program. For both types of providers, CMS is proposing to finalize our proposal to update the four PHP per diem payment rates based on the median costs calculated using the most recent claims data for each provider type.

- Increase the number of measures for reporting in CY 2012 and CY 2013 for purposes of the CY 2014 and CY 2015 payment determinations, and would modify the process for selecting hospitals for validating reported chart-abstracted measures that was adopted for CY 2012 in the CY 2011 OPPS rule.

Provisions affecting payments to ambulatory surgical centers

The final rule increases payment rates to ASCs by 1.6 percent in CY 2012. This reflects a consumer price index for all urban consumers estimated at 2.7 percent, minus a 1.1 percent productivity adjustment required by the Affordable Care Act.

The final rule also establishes a quality reporting program for ASCs and adopts five quality measures, including four outcome measures and one surgical infection control measure beginning in CY 2012 for the CY 2014 payment determination. The final rule adds two structural measures for reporting beginning in CY 2013 for the CY 2015 and CY 2016 payment determinations – one for safe surgery checklist use, and one for ASC facility volume data on selected ASC surgical procedures.

Provisions affecting the hospital value-based purchasing program

The hospital VBP, which was required by section 3001(a) of the Affordable Care Act, was initially established in a final rule published in May 2011. The final rule contained the measures, performance standards, and scoring methodology that would be used to determine the value-based incentive payments to hospitals in FY 2013. The final rule announced today addresses the program requirements for the FY 2014 program. These changes include: adding one clinical process measure to guard against infections due to urinary catheters; and, establishing the weighting, performance periods, and performance standards for the clinical process, patient experience, and outcomes measures for FY 2014.

The final rule with comment period for the OPPS and the ASC payment system can be downloaded from: *http://www.ofr.gov/inspection.aspx*.

It will appear in the November 30, 2011, Federal Register. CMS will accept comments on issues open for comment by January, 3, 2012, and will respond to them in the CY 2013 rule.

The addenda to the final rule for the OPPS are available at: *http://www.cms.gov/HospitalOutpatientPPS*.

The addenda to the final rule for the ASC payment system are available at: *http://www.cms.gov/ASCpayment/*.

A CMS fact sheet (November 1, 2011) providing more details on the final rule can be found at: *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4145*.

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

Source: CMS PERL 201110-61

Payment for multiple surgeries in a method II critical access hospital

Provider types affected

Physicians, providers, and method II critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7587 which implements the multiple procedure payment reduction policy for CAH method II providers. CR 7587 updates the *Medicare Claims Processing Manual* (Chapter 4, Section 250). CR 7587 is for clarification purposes only and does not introduce any policy changes.

Background

Medicare uses the payment policy indicators on the Medicare physician fee schedule (MPFS) to determine if a multiple procedure is authorized for a specific Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) code.

Physicians and non-physician practitioners billing on type of bill (TOB) 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue code 96x, 97x, or 98x) based on the MPFS supplemental file.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100 percent for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50 percent of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. Claims lines containing modifier 22 are excluded from the multiple surgery payment methodology.

When the multiple surgery and/or special endoscopic payment methodologies are applied, the remittance advice notice will contain:

- Claim adjustment reason code 59 – “Processed based on the multiple or concurrent procedure rules” and
- Group code “CO” contractual obligation.

Endoscopies

If multiple endoscopies are billed, special rules for multiple endoscopic procedures apply. Medicare contractors will perform the following actions when multiple HCPCS/*CPT* codes with a payment policy indicator of “3” (Special rules for multiple endoscopic procedures), with the same date of service, are present:

1. Identify if the billed codes share the same endoscopic base code (using the physician fee schedule payment policy indicator file).
2. Pay the full value of the highest valued endoscopy (if the same base is shared), plus the difference between the next highest and the base endoscopy.

   Example: In the course of performing a fiber optic colonoscopy (*CPT* code *45378*), a physician performs a biopsy on a lesion (code *45380*) and removes a polyp (code *45385*) from a different part of the colon. The physician bills for codes *45380* and *45385*. The value of codes *45380* and *45385* have the value of the diagnostic colonoscopy (*45378)* built in. Rather than paying 100 for the highest valued procedure (*45385*) and 50 for the next (*45380*), pay the full value of the higher valued endoscopy (*45385*), plus the difference between the next highest endoscopy (*45380*) and the base endoscopy (*45378*).

   Medicare contractors:

   - Assume the following fee schedule amounts for these codes: *45378* - $255.40; *45380* - $285.98; *45385* - $374.56; and

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Multiple...*continued*

- Pay the full value of *45385* ($374.56), plus the difference between *45380* and *45378* ($30.58), for a total of $405.14.

Note: If an endoscopic procedure with an indicator of "3" (Special rules for multiple endoscopic procedures) is billed with other procedures that are not endoscopies (procedures with an indicator of '2' (Standard payment adjustment rules for multiple procedures)), the standard multiple surgery rules apply.

3. Apply the following rules where multiple endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures (indicator of '2' (Standard payment adjustment rules for multiple procedures)):

Procedure performed	Rules applied
Two unrelated endoscopies (e.g., *46606* and *43217*)	Apply the usual multiple surgery rules.
Two sets of unrelated endoscopies (e.g., *43202* and *43217*; *46606* and *46608*)	1. Apply the special endoscopy rules to each series, then 2. Apply the multiple surgery rules. (Consider the total payment for each set of endoscopies as one service)
Two unrelated endoscopies and a third, unrelated procedure	Apply the multiple surgery rules.
Two related endoscopies and a third, unrelated procedure	1. Apply the special endoscopic rules to the related endoscopies, then 2. Apply the multiple surgery rules. (Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.)

You can review the multiple surgery and special endoscopic pricing rules in the *Medicare Claims Processing Manual* (Chapter 12 (Physicians/Non-physician Practitioners), Section 40.6 (Claims for Multiple Surgeries)); see *https://www.cms.gov/manuals/downloads/clm104c12.pdf*). In addition, Chapter 12, Section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22 (Increased Procedural Services). Providers should be aware that CAH claims billed with modifier 22 may be subject to medical review.

Note: Contractors will not search for and adjust claims that have been paid prior to the implementation date, but will adjust claims brought to their attention.

Additional information

The official instruction, CR 7587, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2333CP.pdf*.

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

MLN Matters® Number: MM7587
Related Change Request (CR) #: CR 7587
Related CR Release Date: October 28, 2011
Effective Date: April 1, 2012
Related CR Transmittal #: R2333CP
Implementation Date: April 2, 2012

Prepayment medical review of inpatient hospital claims

Hospitals, surgeons, admitting physicians, and practitioners ordering or performing services related to inpatient admissions affected

Throughout 2011, First Coast Service Options Inc. (FCSO) has conducted an aggressive provider outreach approach and performed significant prepayment medical record reviews to support the Centers for Medicare & Medicaid Services' (CMS) goals of reducing the national Medicare paid claims error rate. Unfortunately, the number of comprehensive error rate testing (CERT) findings show that error rates related to inpatient admissions are not improving. After execution of comprehensive data analysis, FCSO concluded that the Part A error rate is driven by high-dollar Medicare severity-diagnosis-related-group (MS-DRG) medical necessity denials involving surgical procedures and short stay MS-DRG admissions. Therefore, Part A MS-DRG (DRG for short) claims will become the primary focus for increased prepayment medical record review. Only providers in Florida will be the subject of increased prepayment review; providers in Puerto Rico and the U.S. Virgin Islands will not be affected.

Provider impact: Prepayment medical review of certain inpatient DRG claims and post-payment review of related Part B services in MAC J9 (excluding Puerto Rico and the U.S. Virgin Islands).

FCSO, the Medicare administrative contractor (MAC) for jurisdiction 9 (J9), is currently in the process of implementing a staggered approach to begin performing 100% prepayment medical review of Florida inpatient hospital claims for the DRGs listed below by January 1, 2012. The review of these DRGs will affect **both** the Part A hospital surgery claim **and** related Part B services.

- 226 – Cardiac defibrillator implant without (w/o) cardiac catheter with (w/) major complications or comorbitities (MCC)
- 227 – Cardiac defibrillator implant w/o cardiac catheter w/o MCC
- 242 – Permanent cardiac pacemaker implant w/ MCC
- 243 – Permanent cardiac pacemaker implant w/ CC
- 244 – Permanent cardiac pacemaker implant w/ CC or MCC
- 245 – Automatic implantable cardiac defibrillator (AICD) generator procedures
- 247 – Percutaneous cardiovascular procedure w/ drug eluding stent w/o MCC
- 251 – Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC
- 253 – Other vascular procedures w/CC
- 264 – Other circulatory system or procedures
- 287 – Circulatory disorders except acute myocardial infarction (AMI), w/cardiac catheter w/o MCC
- 458 – Spinal fusion except cervical w/spinal curve, malign, or 9+ fusions w/o CC
- 460 – Spinal fusion except cervical w/o MCC
- 470 – Major joint replacement or reattachment of lower extremity w/o MCC
- 490 – Back and neck procedures except spinal fusion w/CC/MCC or disc device/neurostimulator

FCSO will continue to perform 30 percent prepayment medical review for **DRG 313** (chest pain) and **DRG 552** (medical back) services. As of November, 1, 2011, 10 percent prepayment medical review was initiated for **DRG 392** (esophagitis, gastroenteritis, and miscellaneous digestive w/o MCC) and **DRG 641** (nutritional miscellaneous metabolic disorder w/o MCC).

Effective January 1, 2012, FCSO also will perform post-payment review of the admitting physician's and /or surgeon's Part B services related to inpatient admissions that are denied either because they do not meet the level of care criteria as services performed could have been performed in a less intensive setting (i.e., outpatient), or documentation did not support the medical necessity of the procedure.

As Part A CERT errors significantly decrease for the DRGs identified in this prepayment error prevention strategy, prepayment medical review of those DRGs will be decreased or discontinued. Also, as individual providers' performance shows consistent compliance with documentation requirements and results in low error rates, those providers will be removed from prepayment medical review of the applicable DRG code(s).

FCSO will continue to provide education and feedback on the prepayment review process and will partner with associations, medical societies, and provider groups throughout Florida in order to successfully lower the error rates.

Source: FCSO's Program Integrity and Provider Outreach and Education departments

Skilled nursing facility claims hold

The Centers for Medicare & Medicaid Services (CMS) has identified a claim processing problem impacting skilled nursing facility (SNF) type of bills 18x and 21x containing Healthcare Common Procedure Coding System (HCPCS) code AAAxx and revenue code 0022. CMS is holding these claims. As soon as a system fix is in place and successfully tested, these claims will be released for processing. CMS appreciates your patience and apologize for any inconvenience this may cause.

Source: CMS PERL 201110-45

Systems issue impacting SNFs that bill electronically using HIPPS codes

The Centers for Medicare & Medicaid Services (CMS) recently developed a new change of therapy (COT) other Medicare required assessment (OMRA) for the skilled nursing facility (SNF) prospective payment system (PPS) and developed a mechanism to allow providers to report a resumption of therapy on an end of therapy (EOT) OMRA. In addition, several new assessment indicators (AIs) were created to identify that a COT OMRA was completed and to distinguish between cases where an EOT OMRA is performed with the resumption items completed and cases where an EOT OMRA is completed without the resumption items completed. The new AIs were introduced in Chapter 6, Section 6.4, of the new *Minimum Data Set (MDS) Manual* located at: *http://www.cms.gov/NursingHomeQualityInits/downloads/MDS30RAIManual.zip*.

As a result of these new AIs, CMS must add approximately 1,500 new Health Insurance Prospective Payment System (HIPPS) codes to the fiscal intermediary shared system (FISS). The HIPPS master list located at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp* contains these new codes.

An unforeseen claims processing system issue surfaced for claims that are submitted electronically. The correction for this issue will take place on December 5, 2011. In the meantime, providers may submit claims that contain these HIPPS codes directly via FISS direct data entry (DDE) screens or hold these claims until after the system fix is implemented on December 5, 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 201111-35

Skilled Nursing Facility Prospective Payment System fact sheet revised

The *Skilled Nursing Facility Prospective Payment System* fact sheet (ICN 006821) has been revised. It includes background and elements of the skilled nursing facility prospective payment system.

Source: CMS PERL 201111-25

2012 minimum data set (MDS) 3.0 national conference

The Centers for Medicare & Medicaid Services 2012 MDS national conference is a two-day conference that will be held twice. A conference will be held on March 6-7, 2012, and repeated on March 8-9, 2012, at the Hyatt Regency St. Louis at the Arch in St. Louis, Missouri.

Conference registration will begin November 14, 2011, and close on December 30, 2011. Please visit the *CMS MDS 3.0 Training Conference Information Web page* for additional information.

Source: CMS PERL 201111-27

Implementation of changes in ESRD payment for CY 2012

Provider types

Affected end-stage renal disease (ESRD) facilities submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7617, which informs Medicare contractors about the changes necessary for ESRD payments for calendar year (CY) 2012.

Caution – what you need to know

CR 7617 implements:

- The second year of the ESRD Prospective Payment System (PPS) 4-year transition;
- The calendar year 2012 rate updates for the composite rate portion of the blended payment amount and the ESRD PPS rate; and
- Changes to the outlier policy and consolidated billing requirements under the ESRD PPS.

Go – what you need to do

Be sure billing staff knows of this update.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA), section 153(b), available at *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331* required the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD bundled PPS, effective January 1, 2011. The CY 2011 ESRD PPS final rule, published on August 12, 2010 (75 FR 49030 through 49214) and CR 7064, entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," implemented the ESRD PPS, which included consolidated billing requirements. The article related to CR 7064 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*.

For CY 2012, in addition to updating the ESRD PPS payment amount, CMS must continue to update the composite rate for purposes of determining the composite rate portion of the blended payment amount during the ESRD PPS 4-year transition (CYs 2011 - 2013). CY 2012 implements the second year of the transition where the ESRD facilities that are receiving payment under the transition will be paid a blended amount that will be based on 50 percent of the basic case-mix adjusted composite payment amount and 50 percent of the ESRD PPS payment amount. ESRD facilities that elected to be reimbursed 100 percent based on the ESRD PPS will continue to be reimbursed 100 percent based on the ESRD PPS payment amount. The Affordable Care Act, section 3401(h), provided that, for 2012 and each subsequent year, the Secretary of Health and Human Services will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (the Act), section 1886(b)(3)(B)(xi)(II). The ESRDB market basket increase factor reduced by the productivity adjustment will update the composite rate portion of the blended rate and the ESRD PPS payment rate portion of the blended rate under the transition and under the full ESRD PPS.

CY 2012 implements the second year of the transition, where ESRD facilties under the transition will be paid a blended amount based on 50 percent of the composite and ESRD PPS payment amounts.

Transition budget neutrality adjustment

Section 1881(b)(14)(E)(iii) of the Social Security Act requires that an adjustment to payments be made for renal dialysis services provided by ESRD facilities during the transition so that the estimated total payments under the ESRD PPS, including payments under the transition, equal the estimated total of payments that would otherwise occur under the ESRD PPS without such transition. Subsequent to the CY ESRD PPS final rule, CMS published an Interim Final Rule on April 6, 2011 (76 FR 18930), entitled, "Changes in the End-Stage Renal Disease Prospective Payment System Transition Budget Neutrality Adjustment," which revised the ESRD transition budget neutrality adjustment from a 3.1 percent reduction to zero percent for renal dialysis services furnished on April 1, 2011 through December 31, 2011. For CY 2012, CMS will continue to apply a zero percent reduction to both the blended payments made under the transition and payments made under the 100 percent ESRD PPS for renal dialysis services furnished January 1, 2012 through December 31, 2012.

Body surface area (BSA) payment adjustment

Under the ESRD PPS, CMS retained the BSA case-mix adjustment factor for adult patients from the basic case-mix adjusted composite payment system. For CY 2011, CMS used a national average of 1.84 to compute the BSA for the composite rate portion of the blended payment and a national average of 1.87

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Payment...*continued*

for the ESRD PPS. For CY 2012 and in subsequent years, CMS will use one national average of 1.87 for computing the BSA under the composite rate portion of the blended payment during the transition and under the ESRD PPS.

ESRD PPS outlier policy

Section 1881(b)(14)(D)(ii) of the act requires that the ESRD PPS include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care. The Code of Federal Regulations (CFR), section 413.237(a)(1), provides that ESRD outlier services are those ESRD-related services that were or would have been considered separately paid under Medicare Part B, or would have been separately payable drugs under Medicare Part D (excluding ESRD-related oral-only drugs), prior to January 1, 2011. A listing of the ESRD PPS outlier services is available at *http://www.cms.gov/ESRDPayment/30_Outlier_Services.asp#TopOfPage*.

For CY 2012, CMS is making the following policy changes to the ESRD PPS outlier policy:

- Effective January 1, 2012, CMS is eliminating the issuance of a list of former separately billable Part B drugs and biologicals that would be eligible for outlier payments, because of the number of Part B drugs and biologicals that may be considered ESRD-related eligible outlier service drugs,
- For CY 2012, CMS is making two modifications to the computation of the separately billable Medicare allowable payment (MAP) amounts used to calculate outlier payments, i.e.,:
  1) Subsequent to the publication of the CY 2011 ESRD PPS final rule, CMS' clinical review of the 2007 ESRD claims used to develop the ESRD PPS revealed that ESRD facilities routinely used alteplase and other thrombolytic drugs for access management purposes. Drugs and biologicals that are used as a substitute for any composite rate drug or are used to accomplish the same effect are covered under the composite rate. CMS has recalculated the average outlier services MAP amounts to exclude these composite rate drugs.
  2) Subsequent to the publication of the CY 2011 ESRD PPS final rule, CMS learned that testosterone and anabolic steroids may be used for anemia management. Because drugs used for anemia management in ESRD patients were or would have been considered separately billable under Medicare Part B, these drugs would be outlier eligible drugs under CFR, section 413.237(a)(1). Consequently, CMS has recomputed the outlier service MAP amounts to include these drugs.
- In order to compute the outlier payment for laboratory tests, the 50 percent rule is required for the tests that comprise the automated multi-channel chemistry (AMCC) tests. The AMCC panel tests are identified in the *Medicare Benefit Policy Manual*, Chapter 11, section 30.2.2, and an explanation of the 50 percent rule can be found in the *Medicare Claims Processing Manual*, Chapter 16, section 40.6. In the interest of administrative simplification, CMS is excluding the AMCC laboratory tests from the definition of eligible outlier services and from the computation of outlier payments. The 50 percent rule would continue to apply to AMCC laboratory tests for classification as either composite rate or separately billable for the purpose of computing the composite rate portion of the ESRD PPS blended payment for ESRD facilities that are receiving payments under the ESRD PPS transition.
- Prior to the ESRD PPS, antibiotics, when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis, were considered to be composite rate drugs, and, when used for in-facility patients, they were considered to be separately payable. Therefore, for CY 2011, antibiotics used by home patients were not eligible for outlier payment. CMS does not believe that it is appropriate to have this distinction between how antibiotics are classified as composite rate drugs versus drugs that are separately payable. Therefore, CMS is allowing antibiotics when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis to be separately billable under the composite rate portion of the ESRD blended payment amount and eligible for outlier payment for claims with dates of service on or after January 1, 2012.

ESRD-related laboratory tests

In the CY 2011 ESRD PPS final rule, CMS finalized a specific list of routine ESRD-related laboratory tests included as part of consolidated billing (Table F: ESRD-Related Laboratory Tests of the Appendix). CR 7497, entitled, "Independent Laboratory Billing of Automated Multi-Channel Chemistry (AMCC) Organ Disease Panel Laboratory Tests for Beneficiaries who are not Receiving Dialysis for Treatment of End Stage Renal Disease (ESRD)," sunset the requirement for independent laboratories to bill separately for each

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Payment...*continued*

individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. Because organ disease panels consist of AMCC laboratory tests that are ESRD-related laboratory services, it is important for CMS to ensure that these laboratory tests remain in the ESRD PPS bundle. An article related to CR 7497 is available at *http://www.cms.gov/mlnmattersarticles/downloads/MM7497.pdf*.

CMS is adding the "Assay of protein by other source," which is identified by the *Current Procedural Terminology (CPT)* code *84157* to the listing of items and services subject to consolidated billing for the ESRD PPS. This listing can be found at *http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage*. The "Assay of protein by other source" was a composite rate service under the basic case-mix adjusted composite rate system and, consequently, is considered a renal dialysis service under the ESRD PPS.

ESRD PPS policy summary for CY 2012

Calendar year (CY) 2012 rate updates

For CY 2012, CMS will make the following updates to the composite rate portion of the blended payment amount for the second year of the ESRD PPS 4-year transition:

1. The CY 2011 Part D per treatment add-on amount (that is, $0.49) will be added to the CY 2011 composite rate in order to update the Part D amount for CY 2012 ($138.53 + $0.49 = $139.02).
2. The composite rate (with the addition of the CY 2011 Part D per treatment add-on amount of $0.49) will be updated by the ESRDB market basket reduced by a productivity adjustment which results in an increase of 2.1 percent ($139.02 x 1.021 = $141.94). Therefore, the unadjusted composite rate for CY 2012 is $141.94.
3. The drug add-on will remain at zero to the composite rate for CY 2012.
4. The wage index adjustment will be updated to reflect the latest available wage data. The wage index is available at *http://www.cms.gov/ESRDPayment/*.
5. The wage index floor will be reduced from 0.6000 to 0.5500, then after applying a budget neutrality adjustment of 1.002830, the wage index floor will be 0.5520 for CY 2012.
6. CMS will use the latest national average (that is, 1.87) to calculate the body surface area (BSA) adjustment for CY 2012 and subsequent years. This indicates that the national average of 1.87 will be used for computing the BSA under the composite rate portion of the blended payment during the transition.
7. CMS will allow an antibiotic when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis to be separately billable under the composite rate portion of the ESRD blended payment amount for claims with dates of service on or after January 1, 2012.
8. CMS is including alteplase and other thrombolytic drugs and biologicals used for access management purposes as part of the composite rate drugs, therefore these drugs will not be paid separately under the composite rate portion of the ESRD blended payment amount for claims with dates of service on or after January 1, 2012.

For CY 2012, CMS will make the following updates to the ESRD PPS base rate and wage index:

1. The ESRD PPS base rate will be updated by the ESRDB market basket reduced by a productivity adjustment which results in an increase of 2.1 percent ($229.63 x 1.021 = $234.45). Therefore, the unadjusted ESRD PPS base rate for CY 2012 is $234.45.
2. The wage index adjustment will be updated to reflect the latest available wage data.
3. The wage index floor will be reduced from 0.600 to 0.550. There will be no application of a budget neutrality adjustment to the wage index floor for the full ESRD PPS payments or for the ESRD PPS portion of the blended payment under the transition.
4. The wage index budget neutrality adjustment factor will be applied to the ESRD PPS base rate subsequent to the application of the ESRDB market basket minus productivity adjustment ($234.45 X 1.001520 = $234.81).

Transition budget neutrality adjustment

For CY 2012, for the transition budget-neutrality adjustment, CMS will continue a zero percent reduction to all payments made to ESRD facilities; that is, the zero percent adjustment would be applied to both the blended payments made under the transition and payments made under the 100 percent ESRD PPS for renal dialysis services furnished January 1, 2012 through December 31, 2012.

Outlier policy changes

For CY 2012, CMS will make the following updates to the average outlier service MAP amount per treatment:

continued on next page

Payment...*continued*

1. For adult patients, the average outlier service MAP amount per treatments is $78.00.
2. For pediatric patients, average outlier service MAP amount per treatment is $45.44.

For CY 2012, CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $141.21 for adult patients.
2. The fixed dollar loss amount is $71.64 for pediatric patients.

For CY 2012, CMS will make the following changes to the list of outlier services:

1. All ESRD-related Part B drugs and biologicals will be removed from the outlier list. Therefore, all ESRD-related non-composite rate Part B drugs and biologicals with an ASP rate will be included in the outlier calculation. This includes antibiotics when used in the home to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis.
2. The ESRD-related drugs that had been Part D drugs which are based on the most recent prices retrieved from the Medicare prescription drug plan finder will be updated to reflect the most recent mean unit cost. The list of ESRD-related drugs that had been Part D drugs and are included in the ESRD base rate in CY 2012, will also be updated to reflect the most recent list of ESRD-related Part D drugs that are eligible for outlier payment.
3. The mean dispensing fee of the national drug codes (NDC) qualifying for outlier consideration is revised to $1.59 per NDC per month for claims with dates of service on or after January 1, 2012.
4. The AMCC laboratory tests are excluded from the definition of eligible outlier services and will therefore be removed.

Consolidated billing changes

CMS is adding the following organ disease panels (identified by HCPCS) to the list of laboratory items and services subject to consolidated billing for the ESRD PPS for dates of service on or after January 1, 2012:

- *80047 – Basic metabolic panel (calcium, ionized),*
- *80048 – Basic metabolic panel (calcium, total),*
- *80051 – Electrolyte panel,*
- *80053 – Comprehensive metabolic panel,*
- *80061 – Lipid panel,*
- *80069 – Renal function panel, and*
- *80076 – Hepatic function panel.*

CMS is also adding the "*Assay of protein by other source*," which is identified by the *CPT* code *84157* to the list of items and services subject to consolidated billing for the ESRD PPS effective for dates of service on or after January 1, 2012. Additional Information

The official instruction, CR 7617, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R150BP.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: MM7617 Revised
Related Change Request (CR) #: 7617
Related CR Release Date: November 16, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R150BP
Implementation Date: January 3, 2012

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.

Minor ESRD facility billing change after January 1, 2012

End-stage renal disease (ESRD) facilities will no longer be required to report modifiers V8 and V9, which indicate the presence or lack of presence of an infection, for claims submitted on or after Sunday, January 1, 2012. The Centers for Medicare & Medicaid Services (CMS) will be obtaining this information through means other than the claim record. Contractors have been notified of the change in this reporting requirement.

Source: CMS PERL 201111-17

Clarification and revisions for claims submitted for ESRD patients

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare ESRD beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7593 which includes several revisions and clarifications regarding instructions published for the end-stage renal disease prospective payment system (ESRD PPS) and the ESRD quality incentive program (ESRD QIP).

Caution – what you need to know

These clarifications and revisions include 1) A clarification on the onset of dialysis adjustment for ESRD claims, 2) A revision to ESRD claims reporting the drug Vancomycin, 3) A revision to hospitals reporting emergency related laboratory services, 4) A clarification of ESRD claims reporting the Kt/V value, and 5) A revision to ESRD claim requirements for reporting hematocrit and hemoglobin readings for all ESRD patients.

Go – what you need to do

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

Background

CR 7593 includes several revisions and clarifications regarding the instructions published for the ESRD PPS and the ESRD QIP as follows:

1. Clarification of the onset of dialysis adjustment for ESRD claims

The 2011 final rule for the ESRD PPS, published on August 12, 2010, implemented a case-mix adjusted bundled PPS, effective January 1, 2011. In this rule, the Centers for Medicare & Medicaid Services (CMS) finalized a payment adjustment for dialysis treatments furnished to adults for onset of dialysis. This adjustment is applied to each dialysis treatment that is furnished to adult patients who are eligible to receive Medicare coverage during their first 120 calendar days of dialysis. This adjustment is determined by the dialysis start date in the Common Working File as provided on the CMS Form 2728 (ESRD medical evidence report medicare entitlement and/or patient registration form) completed by the provider and certified by the practitioner.

Subsequent to the publication of the ESRD PPS final rule, there has been confusion as to how often the onset of dialysis adjustment can apply. The onset of dialysis is a one-time adjustment.That is, payment for the onset of dialysis is only provided during the initial 120 calendar days from when an ESRD beneficiary began their maintenance dialysis. The onset of dialysis adjustment does not restart and apply when a patient receives dialysis at a different facility or when dialysis resumes after a failed kidney transplant.

Effective April 1, 2012, Medicare system changes will be implemented to support the existing policy.

2. Revision to ESRD claims reporting Vancomycin

CR 7064 (Transmittal 2134; End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services) implemented the ESRD PPS.

CR 7064 provided ESRD consolidated billing requirements for certain Part B services included in the ESRD facility bundled payment. See the MLN article corresponding to CR 7046 at *https://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*. All drugs reported on the ESRD facility claim that do not have an “AY” (Item or service furnished to an ESRD patient that is not for the treatment of ESRD) modifier are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and, therefore, separate payment is not made to ESRD facilities. However, subsequent to the publication of the calendar year (CY) 2011 ESRD PPS final rule and CR 7064, CMS received numerous comments indicating that Vancomycin is indicated for both ESRD and non-ESRD conditions. After consultation with CMS medical advisors, CMS concurs with this assessment.

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Claims...*continued*

Effective January 1, 2012, ESRD facilities have the ability to receive separate payment for ancomycin furnished on or after January 1, 2012, by placing the "AY" modifier on the claim when Vancomycin is furnished to treat non-ESRD related conditions. The ESRD facility is required to indicate (in accordance with International Classifications of Diseases, Ninth Revision (ICD-9) guidelines) the diagnosis code for which the Vancomycin is indicated. CMS contractors are advised to reprocess ESRD claims with dates of service from January 1, 2012, through March 31, 2012, containing Vancomycin with the "AY" modifier.

3. Revision to hospitals reporting emergency related laboratory services

CR 7471 (Transmittal 2266; Implementation of Changes to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Outlier Payment Policy and Changes to the ESRD PPS Consolidated Billing Requirements for Laboratory Services Furnished in a Hospital Emergency Room or Department) implemented a bypass of the ESRD PPS consolidated billing requirements for ESRD-related laboratory services furnished to ESRD patients in an emergency room or emergency department on the same date of service as the emergency visit.

Subsequent to the issuance of CR 7471, CMS found that there are situations where an ESRD-related laboratory service may be furnished to an ESRD patient in an emergency room or emergency department on a different date of service. For example, the patient may have gone to the emergency room at 10:30 p.m. one evening but did not receive laboratory testing until 1 a.m. the next day. This instruction will allow for identifying and reporting of emergency related laboratory services not performed on the same date of service as the emergency visit.

Effective April 1, 2012, CMS is requiring that hospitals append an "ET" (emergency services) modifier to ESRD-related laboratory tests furnished to ESRD patients on a day other than the date of the emergency room or emergency department visit to indicate that the laboratory test was furnished in conjunction with the emergency visit. Appending the "ET" modifier indicates that the laboratory service being furnished on a day other than the emergency visit is related to the emergency visit. Therefore, at the time the laboratory test was ordered, the ordering physician was unable to determine if it is being ordered for reasons of treating the patient's ESRD.

4. Clarification of ESRD claims reporting the Kt/V value

CR 7460 (Transmittal 2262; Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims) provided instructions for calculating the Kt/V value for reporting on the claim. See the MLN Matters article corresponding to CR 7460 at *https://www.cms.gov/MLNMattersArticles/downloads/MM7460.pdf*. When reporting a value of 8.88 the date of a Kt/V reading is not required. However the standard system will require a date until April 1, 2012. Facilities that do not have a date to report may use any date within the billing period until April when the date will no longer be required.

Effective January 1, 2012, when reporting a value of 8.88 the date of a Kt/V reading is not required. However, the standard system will require a date until April 1, 2012. System changes will be implemented to no longer require a date be reported when the value being reported is 8.88.

5. Revision to ESRD claim requirements for reporting a hematocrit or hemoglobin

CR 7460 (Transmittal 2262; Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims) provided requirements for ESRD facilities to report a hematocrit or hemoglobin reading all ESRD claims. See the MLN Matters article corresponding to CR 7460 at *https://www.cms.gov/MLNMattersArticles/downloads/MM7460.pdf*. However, CR 7460 did not provide instructions in the event a facility does not have a hematocrit or hemoglobin reading to report. As a result, this instruction will require that a facility that does not have a hematocrit or hemoglobin to report must submit a default value of 99.99 to indicate no reading was available. In compliance with the CMS long-standing policy that requires that a hematocrit or hemoglobin be reported when an erythropoiesis stimulating agent (ESA) is administered, the value 99.99 may not be used.

Effective April 1, 2012, when a facility does not have a hematocrit or hemoglobin to report, the facility shall report a value of 99.99 with either the value code 48 (Hemoglobin reading) or value code 49 (hematocrit reading). Failure to report either a hematocrit or hemoglobin reading on an ESRD claim will result in the claim being returned to the provider. When billing for an ESA the value 99.99 will not be acceptable.

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Claims...*continued*

Additional information

The official instruction, CR 7593, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2361CP.pdf*.

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

MLN Matters® Number: MM7593
Related Change Request (CR) #: CR 7593

Related CR Release Date: November 25, 2011
Effective Date: Effective January 1, 2012 and April 1, 2012 as indicated in the *Background* Section
Related CR Transmittal #: R2361CP
Implementation Date: April 2, 2012

Changes to the ESRD PPS outlier payment policy and consolidated billing requirements for laboratory services furnished in an ER

Provider types affected

Providers and suppliers submitting claims to Medicare contractors ((fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for laboratory services provided to Medicare ESRD beneficiaries in a hospital emergency room or department.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7471 which provides revisions to the end-stage renal disease (ESRD) prospective payment system (PPS) outlier services and a consolidated billing (CB) bypass for laboratory services billed with an emergency room service.

Caution – what you need to know

For calendar year (CY) 2012, the Centers for Medicare & Medicaid Services (CMS) is making the following policy changes to the ESRD PPS outlier policy. CMS is 1) eliminating the Part B drug-specific list to allow all non-composite rate ESRD-related drugs with a HCPCS and an ASP rate to be eligible for the outlier payment; and 2) eliminating, as of January 1, 2012, the requirement that hospitals append an AY modifier to laboratory tests that are billed as part of an emergency room or department visit.

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 (MIPPA; Section 153(b)) required the implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011. Change Request (CR) 7064 (Transmittal R2134CP dated January 14, 2011,) implemented the bundled PPS effective January 1, 2011. Medicare regulations (42 CFR 413.237(a)(1)) provides that ESRD outlier services are those ESRD-related services that 1) were or would have been considered separately billable under Medicare Part B, or 2) would have been separately payable drugs under Medicare Part D (excluding ESRD-related oral-only drugs), for renal dialysis services furnished prior to January 1, 2011.

You can find

- MIPPA, Section 153(b), at *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331*,
- The MLN Matters article corresponding to CR7064 (Transmittal R2134CP dated January 14, 2011,) at *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf* on the Centers for Medicare & Medicaid Services (CMS) website, and
- 42 CFR 413.237(a)(1) at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=772c4252601164de94c95be51f45cc43;rgn=div2;view=text;node=20100812%3A1.30;idno=42;cc=ecfr;start=1;size=25*.

Subsequent to the publication of the ESRD PPS final rule, CMS concluded that any CMS prepared lists of drugs and biologicals recognized as outlier services may be difficult to keep up-to-date. Because of the large number of Part B drugs and biologicals that may be considered ESRD-related eligible outlier service drugs, effective January 1, 2012, CMS is eliminating the issuance of a list of former Part B drugs and biologicals that would be eligible for outlier payments. As a result, all ESRD-related Part B drugs

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Laboratory...*continued*

and biologicals reported with a Healthcare Common Procedure Coding System (HCPCS) code that is on the average sales price (ASP) List will be included for outlier payments (with the exception of composite rate drugs).

In an emergency room or emergency department, diagnostic laboratory testing is ordered according to the illness the patient is presenting, and it may not be feasible for the ordering physician to know at the time the laboratory test is being ordered if it is being ordered for reasons of treating the patient's ESRD. Emergency rooms or emergency departments will not be required to append an AY modifier to these laboratory tests when submitting claims with dates of service on or after January 1, 2012.

Note: Allowing laboratory testing to bypass CB edits in the emergency room or department does not mean that ESRD facilities should send patients to the emergency room or department for routine laboratory testing or for the provision of renal dialysis services that should be provided by ESRD facilities.

Additional information

The official instruction, CR 7471, issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2281CP.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: MM7471
Related Change Request (CR) #: CR 7471
Related CR Release Date: August 19, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2281CP
Implementation Date: January 3, 2012

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Medicare finalizes the provisions for the ESRD prospective payment system (CMS-1577-F)

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

CMS is projecting that payment rates for dialysis treatments will increase by 2.1 percent, representing a projected inflation (or ESRD market basket) increase of 3.0 percent, less a projected productivity adjustment of 0.9 percent. CMS estimates that payments to ESRD facilities in 2012 will total $8.3 billion.

CMS is also finalizing the quality incentive program (QIP) that will adjust payment rates to individual facilities based on how well they meet specified performance standards. Please refer to the *end-stage renal disease (ESRD) quality initiative* Web page for more information.

This rule also finalizes provisions that are not related to the ESRD PPS and QIP. These include proposing a one-year extension of certain payment rate increases for both ground and air ambulance services, and proposing to establish a 3-year minimum lifetime for equipment to be considered durable for purposes of payment under the benefit category for durable medical equipment, prosthetics, orthotics, and supplies.

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

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

Source: CMS PERL 201110-60

Educational Events

Upcoming provider outreach and educational events – December 2011

Bimonthly Medicare Part A ACT: Medicare changes and hot issues

When: Tuesday, December 6
Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

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

2011-2012 seasonal influenza (flu) resources for health care professionals

Provider types affected

This article is for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

What you need to know

- Keep this special edition *Medicare Learning Network* (*MLN*) Matters article and refer to it throughout the 2011 - 2012 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

Flu seasons are unpredictable and can be severe. Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people.1 Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) Medicare provides coverage of the seasonal influenza virus vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for contracting influenza. Vaccination is recommended for all individuals aged 6 months and older. While everyone should get a seasonal influenza vaccine each influenza season, it's especially important that certain groups get vaccinated either because they are at high risk of having serious influenza-related complications or because they live with or care for people at high risk for developing influenza-related complications. For more information, refer to the most recent recommendations at *http://www.cdc.gov/flu/protect/keyfacts.htm*.

Vaccinate early to protect against the flu

The Centers for Disease Control (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff.

Get the flu vaccination – not the flu

Remember – the influenza vaccine plus its administration are covered Part B benefits. Note that the influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

1. MLN seasonal influenza related products for health care professionals
   - MLN Matters® article MM7575: Influenza Vaccine Payment Allowances – Annual Update for 2011-2012 Season – this article contains

continued on next page

Flu...*continued*

information on the payment allowances for influenza vaccines for the 2011-2012 season. You can view this article at *http://www.cms.gov/MLNMattersArticles/Downloads/MM7575.pdf*.

- *Quick Reference Information: Medicare Part B Immunization Billing* – this educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf*. This product is also available in hardcopy as part of the *Quick Reference Information Resources* hardcopy booklet.
- *The Guide to Medicare Preventive Services, Fourth Edition* – this guide is designed to provide education on Medicare's preventive benefits. Available as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf* .
- *Preventive Immunizations Brochure* – this brochure is designed to provide education on Medicare's influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine benefits. Available in print and as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- *Quick Reference Information: Preventive Services* – this educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*. – this product is also available in hardcopy as part of the *Quick Reference Information Resources* hardcopy booklet.
- *Quick Reference Information Resources: Medicare Preventive Services* – this booklet is designed to provide education on coverage, coding and billing criteria for Medicare-covered preventive services. It includes the following four quick reference information charts: *Preventive Services, Medicare Immunization Billing, The ABCs of Providing the Initial Preventive Physical Examination* and *The ABCs of Providing the Annual Wellness Visit*. Available in hardcopy only.

  Note: To order hardcopy products, please visit the MLN Preventive Services Educational Products Web page at *https://www.cms.gov/MLNProducts/35_PreventiveServices.asp* and select "MLN Product Ordering Page" in the "Related Links Inside CMS" section.
- *MLN* Preventive Services Educational Products Web page – this *Medicare Learning Network*® (*MLN*) Web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. View this page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp* .

2. Other CMS resources

- Seasonal influenza vaccines pricing is at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp*.
- Prevention general information overview is at *http://www.cms.gov/PrevntionGenInfo*.
- CMS immunizations page is at *http://www.cms.gov/immunizations*.
- CMS frequently asked questions are available at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*.
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 – immunizations available at *http://www.cms.gov/manuals/downloads/bp102c15.pdf*.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services available at *http://www.cms.gov/manuals/downloads/clm104c18.pdf*.
- Medicare Part B drug average sales price payment amounts influenza and pneumococcal vaccines pricing found at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp*.
- *2011-2012 Immunizers' Question & Answer Guide to Medicare Part B and Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations* available at *http://www.cms.gov/Immunizations/Downloads/20112012ImmunizersGuide.pdf*.
- Immunizations Web page at *http://www.cms.gov/immunizations*.

3. Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2011 – 2012 flu season:

- Advisory Committee on Immunization Practices are at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- American Lung Association's Influenza (Flu) Center is at *http://www.lungusa.org*. This

continued on next page

Flu...*continued*

website provides a flu clinic locator at *http://www.flucliniclocator.org*. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- Centers for Disease Control and Prevention – *http://www.cdc.gov/flu*;
- Flu.gov – *http://www.flu.gov*;
- Food and Drug Administration – *http://www.fda.gov*;
- Immunization Action Coalition – *http://www.immunize.org*;
- Indian Health Services – *http://www.ihs.gov/*;
- National Alliance for Hispanic Health – *http://www.hispanichealth.org* ;
- National Foundation For Infectious Diseases – *http://www.nfid.org/influenza* ;
- National Library of Medicine and NIH Medline Plus – *http://www.nlm.nih.gov/medlineplus/immunization.html*;
- National Network for Immunization Information – *http://www.immunizationinfo.org/*;
- National Vaccine Program – *http://www.hhs.gov/nvpo*;
- Office of Disease Prevention and Health Promotion – *http://odphp.osophs.dhhs.gov*;
- Partnership for Prevention – *http://www.prevent.org*; and
- World Health Organization – *http://www.who.int/en*.

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

MLN Matters® Number: SE1136
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

1 Flu.gov. 2011. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2011 [cited 16 September 2011]. Available from the World Wide Web: http://www.flu.gov/individualfamily/about/index.html.

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Now available – question and answer guide to coverage of influenza and pneumococcal vaccinations

The *2011-2012 Immunizers' Question & Answer Guide to Medicare Part B & Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations* is now available on the immunizations section of the Centers for Medicare & Medicaid Services (CMS) website at *http://www.CMS.gov/immunizations*. The CMS immunizations page features a *mini-poster* that reminds everyone that flu vaccination is covered for Medicare beneficiaries and for children eligible for Medicaid and CHIP.

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

Source: CMS PERL 201110-21

Tobacco-Use Cessation Counseling Services document available in downloadable and hardcopy formats

The *MLN* would like to remind you that the publication *Tobacco-Use Cessation Counseling Services*, which is designed to provide education on tobacco-use cessation counseling services, is now available in both downloadable and hardcopy formats. To place an order for a hardcopy version, 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 201110-22

November is National Diabetes Month and Diabetic Eye Disease Month

Please join the Centers for Medicare & Medicaid Services (CMS) this November during National Diabetes Month and Diabetic Eye Disease Month in raising awareness about diabetes, diabetic eye disease, the importance of early disease detection, and the related preventive health services covered by Medicare.

Diabetes can lead to severe complications such as heart disease, stroke, vision loss, kidney disease, nerve damage, and amputation among others, and it's a significant risk factor for developing glaucoma. People with diabetes are more susceptible to many other illnesses such as pneumonia and influenza and are more likely to die from these than people who do not have diabetes. Among U.S. residents aged 65 years and older, 10.9 million (or 26.9 percent) had diabetes in 2010. Currently, 3.6 million Americans age 40 and older suffer from diabetic eye disease. Education and early detection are major components to combating this disease.

What can you do?

Help protect the health of your Medicare-covered patients by informing them that Medicare covers several diabetes-related preventive services for eligible beneficiaries including diabetes screening tests, diabetes self-management training, medical nutrition therapy, diabetes supplies, glaucoma screening, and vaccinations for pneumonia and influenza. Advise them that the early detection and treatment of diabetes can prevent or delay many associated illnesses and complications. Encourage utilization of these important preventive services as appropriate. And remember, many of these services require an order or referral for coverage by Medicare. Please ensure that you provide your Medicare patients with the appropriate documentation so they can receive the services needed to help prevent, treat, and manage the disease.

For more information:

- *The Guide to Medicare Preventive Services (see Chapter 6)*
- *Medicare Preventive Services Quick Reference Information Chart*
- *Diabetes-Related Services Fact Sheet*
- *The Glaucoma Screening Brochure*
- *Medicare.gov – Diabetes Screening, Supplies and Self Management Training website*
- *National Diabetes Fact Sheet, 2011*
- *National Diabetes Education Program (NDEP) Healthcare Professionals website*

Thank you for joining with CMS to help increase awareness and educate about diabetes and diabetic eye disease, and the diabetes-related preventive health services now covered by Medicare.

Source: CMS PERL 201111-24

Updates from the *Medicare Learning Network®*

Medicare Preventive Services Series Part 1 Web-based training course revised

This Web-based training (WBT) is designed to provide education on Medicare-covered preventive services. It includes information on Medicare coverage of seasonal influenza, pneumococcal, and hepatitis B vaccines. To access the WBT, please visit the *MLN®* Overview page at *http://www.CMS.gov/MLNGenInfo* and click on "Web-Based Training (WBT) Courses" in the "Related Links Inside CMS" section.

Bone Mass Measurements document available in downloadable and hardcopy format

The *MLN®* would like to remind you that the publication "Bone Mass Measurements" which is designed to provide education on the bone mass measurement benefit, methods of bone measurement (bone density), coverage information, and risk factors, is available in both downloadable and hardcopy formats. To place an order for a hardcopy version, visit the *MLN®* General Information Web page at *http://www.CMS.gov/MLNGeninfo/*, scroll down 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 201110-30

'Medicare Preventive Services Series Part 3 Web-Based Training Course' revised

The "Medicare Preventive Services Series Part 3 Web-Based Training Course" (WBT) is designed to provide education on Medicare-covered preventive services. It includes information on Medicare coverage of screening mammography, screening Pap test, pelvic examination, colorectal cancer screening, prostate cancer screening, bone mass measurements, and glaucoma screening. To access the WBT, please visit the *Medicare Learning Network®* (*MLN*) overview page at *http://www.CMS.gov/MLNGenInfo*, then click on "Web-Based Training (WBT) Courses" in the "Related Links Inside CMS" section.

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

Source: CMS PERL 201111-14

Podcasts from the July 21 IPPE and AWV national call now available

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

The Centers for Medicare & Medicaid Services has released the following two podcasts from the Thursday, July 21 national provider call, "The ABCs of the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)":

- Podcast 1 of 2: Welcome and IPPE Overview
- Podcast 2 of 2: AWV

The podcasts are now available at *http://www.CMS.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1249934*. The two audio podcasts with corresponding written transcripts, as well as the full audio and written transcript of the call can be accessed by scrolling to the "Downloads" section at the bottom of the 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 201111-09

Comprehensive Outpatient Rehabilitation Facility fact sheet revised and available in downloadable format

The *Comprehensive Outpatient Rehabilitation Facility* fact sheet (ICN 904085) has been revised and is now available in downloadable format. It includes the following information: background; core comprehensive outpatient rehabilitation facility (CORF) services; optional CORF services; place of treatment requirements; physical therapy, occupational therapy, and speech-language pathology plan of care (POC) requirements; respiratory therapy POC requirements; and payment for CORF services.

Source: CMS PERL 201110-30

Rural Health Clinic fact sheet revised and available in downloadable format

The revised *Rural Health Clinic* fact sheet (ICN 006398) is now available in downloadable format. It includes the following information: background, rural health clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation.

Source: CMS PERL 201110-30

April 2011 Medicare Quarterly Provider Compliance Newsletter revised

The April 2011 issue of the *Medicare Quarterly Provider Compliance Newsletter*, available at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf*, has been revised to amend an entry in the "Recovery Audit Finding: Untimed Codes – Excessive Units" section under "Guidance on How Providers Can Avoid These Problems" on page 10. All other information remains the same. 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.

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

Source: CMS PERL 201110-22

Medicare Quarterly Provider Compliance Newsletter released

The *October 2011 "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 1]" (ICN 907163)* has been released. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. It highlights the top issues of the particular quarter. You may also 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 201111-14

Get connected with the *Medicare Learning Network®*

Want to stay informed about the latest new and revised *MLN* products and services? Subscribe to the *MLN* educational products electronic mailing list. For more information about the *MLN* and how to register for this service, visit *http://www.CMS.gov/MLNProducts/downloads/MLNProducts_listserv.pdf* and start receiving updates.

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Source: CMS PERL 201110-22

New *MLN* fact sheets regarding the Medicare Shared Savings Program

Accountable Care Organizations: What Providers Need to Know fact sheet, ICN 907406 – this downloadable fact sheet is designed to provide education on Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program. It includes a definition of an ACO, and information on how to participate in an ACO, how shared savings will work, how this program is aligned with other quality initiatives and how ACOs help doctors coordinate care.

Improving Quality of Care for Medicare Patients: Accountable Care Organizations fact sheet, ICN 907407 – this downloadable fact sheet is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

Advance Payment Accountable Care Organization (ACO) Model fact sheet, ICN 907403 – this downloadable fact sheet is designed to provide education on the advance payment model for ACOs. It includes a summary of the advance payment ACO model, background, and information on the structure of payments, recoupment of advance payments, eligibility, and the application process.

Medicare Shared Savings Program and Rural Providers fact sheet, ICN 907408 – this downloadable fact sheet is designed to provide education on how the Medicare Shared Savings Program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals and how this program impacts them.

Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program fact sheet, ICN 907404 – this downloadable fact sheet is designed to provide education on the provisions of the final rule that implements the Medicare Shared Savings Program with ACOs. It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs.

Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program fact sheet, ICN 907405 – this downloadable fact sheet is designed to provide education on the methodology for determining shared savings and losses under the Medicare Shared Savings Program. It includes an overview of the program, a description of the two tracks providers can choose, and a description of how Medicare determines the shared savings or loss.

Source: CMS PERL 201111-03

ABN resources from the *Medicare Learning Network®*

Items and Services That Are Not Covered Under the Medicare Program booklet (ICN 906765) – this booklet, which is available in downloadable format, includes information about the four categories of items and services that are not covered under the Medicare program and applicable exceptions to exclusions and the advance beneficiary notice of noncoverage (ABN).

Advance Beneficiary Notice of Noncoverage Part A and Part B booklet (ICN 006266) – this booklet, which is available in downloadable and hardcopy format, is designed to provide education on the ABN. It includes information on when an ABN should be used and how it should be completed.

Source: CMS PERL 201110-53

New MSP provisions Web-based training course released

The Medicare secondary payer (MSP) provisions Web-based training (WBT) course is designed to provide general education on when Medicare may or may not pay first. It includes an overview of the MSP provisions, common payment situations, Medicare conditional payments, and the role of the coordination of benefits contractor. To access the WBT, please visit the *MLN®* overview page at *http://www.CMS.gov/MLNGenInfo* and click on "Web-Based Training (WBT) Courses" in the "Related Links Inside CMS" section.

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

Source: CMS PERL 201110-30

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
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)
DME, 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

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

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 A *Connection*

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