Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers January 2012

In this issue

Health care professionals selected for the new innovation advisors program to improve care for patients

The Centers for Medicare & Medicaid Services (CMS) announced that it has selected 73 individuals from 27 states and the District of Columbia for its innovation advisors program.

A list of innovation advisors can be found at *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4240*.

The initiative, launched by the CMS Innovation Center in October 2011, will help health professionals deepen skills that will drive improvements to patient care and reduce costs. After an initial orientation phase, innovation advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Funding for this initiative was made possible by the Affordable Care Act.

“There has been an incredible groundswell of interest in becoming an innovation advisor. It’s clear that doctors, hospitals and health care providers are enthusiastic about implementing the Affordable Care Act and strengthening our health care system,” said CMS Acting Administrator Marilyn Tavenner.

The 73 individuals were selected from 920 applications through a competitive process, and include clinicians, allied health professionals, health administrators and others. By attending in-person meetings as well as remote sessions to expand their skills and applying what they learn, the advisors will be able to deepen their knowledge in health care economics and finance, population health, systems analysis, and operations research.

“We’re looking to these innovation advisors to be our partners – we want them to discover and generate new ideas that will work and help us bring them to every corner of the United States,” said CMS Innovation Center Director Rick Gilfillan, M.D.

Among other duties, the advisors will be expected to support the Innovation Center in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost.

Each innovation advisor’s home organization will receive a stipend of up to $20,000. The stipend will support an individual’s activities while serving as an innovation advisor.

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

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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.

Innovation...*continued*

More information about the innovation advisors program, including a fact sheet and list of participants and their home organization, can be found at: *http://innovations.cms.gov/initiatives/innovation-advisors/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 201201-04

President Obama signs the Temporary Payroll Tax Cut Continuation Act of 2011

New law includes physician update fix through February 2012

On Friday, December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 Medicare physician fee schedule is now scheduled to take effect on March 1, 2012, the administration remains strongly opposed to letting this cut take effect. As he has repeatedly made clear, President Obama is committed to a permanent solution to eliminating the sustainable growth rate's cut. We will continue to work with Congress to achieve this goal.

The Centers for Medicare & Medicaid Services (CMS) has also recently implemented several important changes for Medicare providers and beneficiaries, and it would like to remind physicians and practitioners of some of these key changes for 2012. For many of your patients, Medicare costs will go down. Medicare cost-sharing for Part B services will decline in some cases and, for the first time, the Part B deductible will decrease, by $22, to $140.

Additionally, health care professionals will be paid more to provide certain important services for people with Medicare. CMS has increased the payment amount for the initial and annual wellness visit – which has no cost sharing for patients – to account for the introduction of health risk assessment (HRA). CMS believes it is important to balance the comprehensiveness of the HRA with the potential burden on patients and health professional time constraints. As such, in 2012, CMS will allow for variation in the content of the HRA.

The Medicare Part D prescription drug program has also been enhanced for 2012, with the coverage gap being further reduced as it is phased-out over the next several years. These improvements to the drug benefit from the Affordable Care Act have already saved millions of seniors nearly $2 billion.

CMS wishes to remind physicians and practitioners about the primary care incentive program. Again in 2012, primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants may be eligible to receive an incentive payment equal to 10 percent of their allowed charges for primary care services under Medicare Part B. This incentive is paid in addition to any physician incentive payments for services furnished in Health Professional Shortage Areas. Please remember that if a practitioner has reassigned his or her benefits to another entity, such as a group practice, Medicare will pay that entity and not the individual practitioner.

The Affordable Care Act created the Center for Medicare and Medicaid Innovation that offers physicians, practitioners and other health care leaders the opportunity to propose innovative payment and service delivery models to lower costs, improve quality, and improve health. More information can be found at *www.innovations.cms.gov*.

Below please find summaries of key provisions of the TPTCCA along with some information about how these changes may affect providers and provider billing.

Physician payment update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect on January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes

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Payroll...*continued*

to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. CMS is currently developing the 2012 Medicare Physician Fee Schedule (MPFS) to implement the zero percent update. As previously advised, Medicare claims administration contractors will be holding new, January 2012 claims for up to 10 business days in order to effectively test and implement the new 2012 MPFS. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected. Finally, Medicare contractors will be posting the new rates on their websites no later than January 11, 2012.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense, and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index, through February 29, 2012. As with the physician payment update, this change will be accomplished through a revised 2012 MPFS.

Extension of physician fee schedule mental health add-on payments

For calendar year 2011, certain mental health services' payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services, through February 29, 2012. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2012 MPFS.

Extension of Medicare Modernization Act section 508 reclassifications

Section 302 of the TPTCCA extends section 508 reclassifications and certain special exception wage indexes for 2 months, from October 1, 2011, through November 30, 2011. For the period beginning on October 1, 2011, and ending on November 30, 2011, Section 302 also requires removing section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by section 302 of the TPTCCA shall be assigned a special wage index effective for only October and November 2011. We will apply the provision to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception wage index will be applicable from January 1, 2012, through February 29, 2012.

Extension of exceptions process for Medicare therapy caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,880. For occupational therapy services, the limit is $1,880. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Extension of moratorium on independent laboratory billing for the technical component (TC) of physician pathology services furnished to hospital patients

In the final physician fee schedule regulation published in the *Federal Register* November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the technical component of a pathology service provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the technical component of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the most recent extension of the moratorium expired at the end of 2011, section 305 of the TPTCCA restores the moratorium through February 29, 2012. Therefore, those independent laboratories that are eligible may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was furnished. This policy is effective for claims with dates of service on or after January 1, 2012, through February 29, 2012.

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Payroll...*continued*

Extension of ambulance add-on payments

The provisions that were extended by section 306 of the TPTCCA are:

1. The three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas;
2. The provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and
3. The provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through February 29, 2012. As previously advised, Medicare claims administration contractors will be holding new, January 2012 ambulance claims for up to 10 business days in order to effectively implement the new 2012 ambulance fee schedule. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected.

Extension of outpatient hold harmless provision

Section 308 of the TPTCCA extends the outpatient hold harmless provision, effective for dates of service on and after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Extension of minimum payment for bone mass measurement

Section 309 of the TPTCCA extends through February 29, 2012, the 2011 payment rate for bone mass measurement. Similar to the zero percent update and other provisions, this extension will be reflected in the revised 2012 MPFS.

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

Source: CMS PERL 201201-01

Quarterly provider update

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

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

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

2012 annual participation enrollment program extension

Attention health professionals

The Centers for Medicare & Medicaid Services (CMS) is anticipating congressional action to avert the negative update for the 2012 Medicare physician fee schedule. Therefore, CMS is extending the 2012 annual participation enrollment period through February 14, 2012. The enrollment period now runs November 14, 2011, through February 14, 2012.

However, the effective date for any participation status change during the extension remains January 1, 2012, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are post-marked on or before February 14, 2012.

Source: CMS PERL 201112-47

All Medicare provider and supplier payments to be made 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 (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 Centers for Medicare & Medicaid Services' (CMS) revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified and will be required to submit the CMS-588 EFT form with their provider enrollment revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official..

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 201201-36

CMS announces delays in the implementation of two demonstration projects due to provider feedback

On November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) announced the prepayment review and prior authorization for power mobility devices (PMD) demonstration and the recovery audit prepayment review demonstration. These demonstrations were scheduled to begin January 1, 2012. However, CMS received many comments/suggestions regarding these demonstrations and is carefully considering these comments. Therefore, CMS will delay implementation of these demonstrations. CMS will provide at least 30-day's notice before the demonstrations begin.

However, the Part A to Part B rebilling demonstration will begin January 1, 2012, as scheduled.

Please continue to check *http://go.cms.gov/cert-demos* for updated information.

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

Source: CMS PERL 201112-59

Recovery audit program: MAC-issued demand letters

Note: This article was revised on January 9, 2012, to reflect the revised CR 7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR 7436 were revised. All other information is the same. This information was previously published in the August 2011 *Medicare A Connection*, Page 38.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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

Additional information

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

To see the official instruction (CR 7436) issued to your Medicare contractor, see *http://www.cms.gov/Transmittals/downloads/R202FM.pdf*.

MLN Matters® Number: MM7436 Revised
Related Change Request (CR) #: 7436
Related CR Release Date: January 6, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R202FM
Implementation Date: January 3, 2012

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.*

Register now for DMEPOS competitive bidding

If you are a supplier interested in participating in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program and have registered an authorized official (AO) but not a backup authorized official (BAO), the Centers for Medicare & Medicaid Services (CMS) strongly recommends that a BAO register no later than Thursday, January 12, 2012. It is important to do it now so that the BAO will be able to assist the AO with approving end user (EU) registration. The establishment of a BAO is encouraged, if your company has someone that can occupy the BAO role, to avoid any disruption in the bidding process once the 60-day bid window opens. The individual in the BAO role can also assume the AO role if for some reason the AO can no longer fulfill his or her bidding responsibilities; if there is no BAO and the AO leaves the company, all end users associated with the company will lose access to the bidding system.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "Individuals Authorized Access to CMS Computer Services (IACS) Reference Guide" posted on the competitive bidding implementation contractor (CBIC) website (*www.DMECompetitiveBid.com*). To register, visit the *CBIC website* and click on "Registration is Open" above the registration clock on the home page. You will also find a registration checklist and quick step guides on the *CBIC website*. Please note that suppliers with multiple locations typically must register only one Provider Transaction Access Number (PTAN) that will submit the bid for all locations. If you have any questions about the registration process, please contact the CBIC customer service center at 877-577-5331.

The deadline has now passed for AO registration. If the AO for your company has not already registered and obtained a user ID and password, CMS cannot guarantee that he or she will be able to complete the registration process before the registration window closes on Thursday, February 9, 2012, at 9 p.m. Eastern Time. This should be of particular concern if the national supplier clearinghouse (NSC) record for your company is not current and accurate. AOs should register now to allow BAOs and EUs time to register. In addition, suppliers whose AOs do not register now run the risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the covered document review date (CDRD). As a result, CMS encourages you to register now.

Remember, the AO and BAO must be listed on the CMS-855S enrollment form as an AO. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as BAOs; the AO and BAOs can then designate other supplier employees as EUs. BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name, date of birth, and Social Security Number of the AO and BAOs must match exactly with what is on file with the NSC to register successfully.

Registration will close on Thursday, February 9, 2012, at 9 p.m. Eastern Time – no AOs, BAOs, or EUs will be able to register after registration closes.

Remember that the CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the home page of the *CBIC website*. For information about round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under the "Bidding Suppliers: Round 2 & National Mail-Order" menu on the CBIC website.

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

Source: CMS PERL 201201-13

DMEPOS competitive bidding announcements

The Centers for Medicare & Medicaid Services (CMS) has several announcements of interest to suppliers that are considering participating in the round 2 and national mail-order competitions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

- The competitive bidding implementation contractor (CBIC) has issued a new fact sheet providing anti-trust guidance for bidders. To view the fact sheet, please go to the CBIC website at *www.dmecompetitivebid.com* and select "Bidding Suppliers: Round 2 & National Mail-Order" and then choose "Fact Sheets."
- Four adjustable seat cushion codes have been removed from the round 2 standard wheelchair product category. CMS is in the process of deleting these codes from the educational materials on the CBIC website. A follow-up listserv notice will be sent when the updates to the educational materials are complete.
- The bid limits in the round 2 rebid preparation worksheets have been revised for 14 Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs (K0813 through K0829). The previous bid limits listed in the worksheet were erroneously based on 150 percent of the actual bid limits.
- CMS has made three clarifying updates to the list of glucose monitors on the 50 percent compliance form, a required bid document for the national mail-order competition:
    1. ASCENSIA AUTO DISC has been consolidated with ASCENSIA BREEZE 2. (ASCENSIA AUTO DISC is no longer manufactured but uses the same test strips as the ASCENSIA BREEZE 2.)
    2. FREESTYLE FLASH has been consolidated with FREESTYLE and FREESTYLE FREEDOM. (FREESTYLE FLASH is no longer manufactured but uses the same test strips as FREESTYLE and FREESTYLE FREEDOM.)
    3. PROTÉGÉ has been consolidated with SMARTEST. (PROTÉGÉ is no longer manufactured but uses the same test strips as SMARTEST.)
- CMS would like to remind potential bidders that four adjustable seat cushion codes (E2622 through E2625) have been removed from the round 2 standard wheelchairs product category. The competitive bidding implementation contractor (CBIC) has deleted these codes from the bidder education materials.

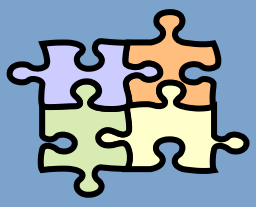
All of these updates are now available on the CBIC website, *www.dmecompetitivebid.com/*.

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

Source: CMS PERL 201201-12, 201112-53

Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at *http://medicare.fcso.com/Enrollment/PEStatus.asp*



Learn about the DMEPOS competitive bidding program with CMS' new on-demand webcasts

Several new educational webcasts for the round 2 and national mail-order competition of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program are now available on the competitive bidding implementation contractor (CBIC) website (at *www.DMECompetitiveBid.com*).

- "National Mail-Order Competition for Diabetic Supplies," covers rules that apply specifically to this competition and provides resources to assist you with bidding.
- "Program Rules," explains important rules detailed in the request for bids (RFB) instructions that you should understand before you prepare your bids. The webcast also provides resources to assist you with bidding.
- "How a Bid is Evaluated," goes over each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The webcast also provides resources to assist you with bidding.
- "Financial Documentation Requirements," goes over the rules and requirements for the financial documents that you must submit in addition to your online bid.

These webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and transcripts are also posted on the website. To view the webcasts, please go to the *CBIC website*, select "Bidding Suppliers: Round 2 & National Mail-Order," and choose "Education Events."

The Centers for Medicare & Medicaid Services (CMS) will be issuing one more webcast that will address how to submit a bid in the online bidding system, DBidS. CMS will announce its availability with an email update. If you have not already done so, please register on the *CBIC website* to receive this announcement and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9 a.m. to 9 p.m. ET, Monday through Friday, throughout the registration and bidding periods.

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

Source: CMS PERL 201201-44, 201201-38, 201201-25, 201201-14

Credit report/score requirements for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) has issued the following clarification to assist suppliers bidding in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. This information will also be posted on the competitive bidding implementation contractor (CBIC) website. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. ET during the registration and bidding periods.

Q. The request for bids instructions say that suppliers must submit a copy of a credit report with numerical score that was prepared within 90 days prior to the opening of the bid window. Does this mean I can't submit a credit report and score that is dated after bidding opens but before bidding closes?

A. No. Credit reports and scores must not be prepared earlier than 90 days prior to the opening of the bid window, but they can be prepared after bidding opens as long as they are received by the competitive bidding implementation contractor (CBIC) by the close of the bid window. When bidding opens, CMS will post the specific date that is 90 days prior to the opening of the bid window on the CBIC website. Credit reports and scores that are older than this date will not be accepted.

Source: CMS PERL 201201-43

Medicare Shared Savings Program video slideshows and podcasts

Do you want to learn more about the Medicare Shared Savings Program (Shared Savings Program) and how to apply? The Centers for Medicare & Medicaid Services (CMS) has posted new resources on the "Shared Savings Program CMS Teleconferences and Events" Web page at *http://www.cms.gov/sharedsavingsprogram/40_Events.asp*.

Medicare Shared Savings Program overview

A YouTube Video Slideshow Presentation

On December 7, John Pilotte, Director of the Performance-Based Payment Policy Group at CMS gave an overview of the Medicare Shared Savings Program, followed by a question and answer session. A video slideshow presentation of this call with audio and captioning is now available on the *CMS YouTube Channel*.

Medicare Shared Savings Program: "Application Process and Overview of the Advance Payment Model Application" national provider call

A YouTube Video Slideshow Presentation

Did you miss the November 15 national provider call on the "Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application"? The call presentation is available on the *CMS YouTube Channel* as a video slideshow. It includes the call audio and is captioned.

Podcasts

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 from the November 15 Shared Savings Program call are also available:

- Podcast 1 of 4: Introduction by Dr. Donald Berwick
- Podcast 2 of 4: Medicare Shared Savings Program application process
- Podcast 3 of 4: Advance payment model
- Podcast 4 of 4: Question and answer session

You can find links to these podcasts with corresponding written transcripts, as well as links to the YouTube video slideshow presentations, complete audio recording, and complete written transcript on the Shared Savings Program CMS Teleconferences and Events Web page at *http://www.cms.gov/sharedsavingsprogram/40_Events.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 201201-08

Medicare Shared Savings Program *2012 ACO Narrative Quality Measures Specifications Manual* and application crosswalks

The Centers for Medicare & Medicaid Services (CMS) has added new information to the Medicare Shared Savings Program (Shared Savings Program) website at *www.cms.gov/sharedsavingsprogram*.

A new Web page on quality measures and performance standards at *http://www.cms.gov/sharedsavingsprogram/37e_Quality_Measures_Standards.asp* has the latest information on Medicare accountable care organization (ACO) quality measures. The *2012 ACO Narrative Quality Measures Specifications Manual* provides guidance about the 33 required quality measures that are part of the quality performance standard.

Two crosswalks have been added to the Shared Savings Program Application Web page at *http://www.cms.gov/sharedsavingsprogram/37_Application.asp*. Organizations who submitted an application under the pioneer ACO model or have been participating in the physician group practice (PGP) transition demonstration, who would like to submit a Shared Savings Program application, scroll down the page for links to these two application crosswalks.

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

Source: CMS PERL 201201-06

Medicare Shared Savings Program and Rural Providers fact sheet available

The new *"Medicare Shared Savings Program and Rural Providers"* fact sheet (ICN 907408) 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.

Source: CMS PERL 201201-35

Incentive Programs

Available 2012 eRx incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2012 Electronic Prescribing (eRx) Incentive Program educational products to the eRx Web page at *http://www.cms.gov/ERxIncentive*.

To access the 2012 eRx Incentive Program educational products, visit the Spotlight section on the eRx incentive program Web page at *http://www.cms.gov/ERxIncentive/02_Spotlight.asp* for the listing of educational products and their corresponding section pages where they can be found.

- *2012 Electronic Prescribing (eRx) Incentive Program Measure Specifications and Release Notes* – provides guidance on the 2012 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the 2011 eRx measure specifications.
- *Claims-Based Reporting Principles for the 2012 Electronic Prescribing (eRx) Incentive Program* – provides guidance on the principles for reporting the eRx measure on claims for the 2011 eRx incentive program.
- *2012 Electronic Prescribing (eRx) Incentive Program CMS-1500 Claim Example* – a detailed sample of an individual NPI reporting the eRx measure on a CMS-1500 form
- *2012 Electronic Health Record (EHR) Measure Specifications for Electronic Prescribing (eRx) Incentive Program and Release Notes* – provides guidance on the 2012 EHR measure specifications for eRx and release notes. In addition, the specifications contain a detailed description of data element names and codes.
- *2012 Electronic Health Record (EHR) Downloadable Resource Table and Release Notes* – an Excel spreadsheet and release notes listing 2012 EHR information.
- *2012 Electronic Prescribing (eRx) Incentive Program GPRO Measure Specifications and Release Notes* – provides guidance on the specifications for the eRx measure for use in 2012 eRx GPRO and release notes.

Further information on the 2012 physician quality reporting system may be found in the final 2012 Medicare physician fee schedule rule with comment period that was published in the *Federal Register* on November 28, 2011.

Further information on the 2012 eRx incentive program may be found in the final 2012 Medicare physician fee schedule rule that was published in the *Federal Register* on November 28, 2011. The final rule can be found on the "Statute/Regulations/Program Instructions" section at *http://www.cms.gov/ERxIncentive/04_Statute_Regulations_Program_Instructions.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 201201-11

Upcoming dates for the Medicare EHR incentive program and information on the payment threshold for eligible professionals

As 2012 begins, the Centers for Medicare & Medicaid Services (CMS) wants to remind eligible professionals (EPs) participating in the Medicare electronic health record (EHR) incentive program of important approaching deadlines and what can still be completed in 2012 in order to receive an incentive payment for calendar year (CY) 2011.

Important Medicare EHR incentive program dates

On Saturday, December 31, 2011, the reporting year ended for EPs who participated in the Medicare EHR incentive program in 2011. What does this mean? For participating EPs, they must have completed their 90-day reporting period by the end of 2011.

However, EPs have until Wednesday, February 29, 2012, to actually register and attest to meeting meaningful use to receive an incentive payment for CY 2011 through the *Medicare & Medicaid EHR incentive program registration and attestation system.*

Payment threshold information

Wednesday, February 29, 2012, is also the deadline for EPs to submit any pending Medicare Part B claims from CY 2011, as CMS allows 60 days after Saturday, December 31, 2011, for all pending claims to be processed. This means that EPs have 60 days in 2012 to submit claims for allowed charges incurred in 2011.

Medicare EHR incentive payments to EPs are based on 75 percent of the Part B allowed charges for covered professional services furnished by the EP during the entire payment year. If the EP did not meet the $24,000 threshold in Part B allowed charges by the end of CY 2011, CMS expects to issue an incentive payment for the EP in April 2012 for 75 percent of the EP's Part B charges from 2011.

Note for Medicaid participants: Medicaid incentives will be paid by the states, but the timing will vary according to state. Please contact your state's Medicaid agency for more details about payment.

Want more information about the EHR incentive programs? Visit the *EHR Incentive Programs* website for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201201-31

Health professional shortage area (HPSA) bonus payment policy reminders

Provider types affected

This *Medicare Learning Network (MLN) Matters*® special edition article is intended for physicians and providers submitting claims to Medicare carriers, Medicare administrative contractors (A/B MACs), and/or fiscal intermediaries (FIs) for services furnished to Medicare beneficiaries in areas designated as geographic health professional shortage areas (HPSAs).

Provider action needed

Stop – impact to you

Physicians who furnish services to Medicare beneficiaries in areas designated as primary care geographic HPSAs by the Health Resources and Services Administration (HRSA) as of December 31, 2011, are eligible for a 10 percent bonus payment for services furnished from January 1, 2012, to December 31, 2012. If an area does not have a geographic primary care HPSA designation, but does have a geographic mental health HPSA designation, then only psychiatrists furnishing services to Medicare beneficiaries in the designated area are eligible for the ten percent bonus.

Caution – what you need to know

The physician must determine whether a service is furnished in a geographic primary care (or mental health) HPSA. Eligibility is determined annually based on the status of the designation, as of December 31 of the prior

continued on next page

HPSA...*continued*

year. That is, a physician who was eligible for the 10 percent bonus in 2011 may not be eligible for the bonus in 2012. A physician or provider that was not eligible for the 10 percent bonus in 2011 may be eligible for the bonus in 2012. Information about designated areas is available from HRSA. The following web pages may help you determine whether an area is a geographic primary care or mental health HPSA:

- The "Shortage Designation Advisor" page identifies areas located in an HPSA by entering a valid address. It is available at *http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx*.
- The "HPSA State & County Search" page identifies HPSA designation with a state and is available at *http://hpsafind.hrsa.gov/HPSASearch.aspx*.
- The "Geocoding System" page identifies census tracts by entering a valid address and is available at *http://www.ffiec.gov/Geocode/default.aspx*.

Go – what you need to know

The Centers for Medicare & Medicaid Services (CMS) publishes an annual list of ZIP codes that automatically receive the HPSA bonus. Only areas where the entire ZIP code falls within the designated area at the time the list is developed are listed. Services provided in eligible areas that are not listed for automatic bonus payment must use the AQ modifier to receive the bonus.

Only physicians who furnish services in areas designated as a geographic primary care HPSA, as of December 31, 2011, and whose ZIP code is not on the list should use the modifier. Only psychiatrists, who furnish services in areas that are not designated as primary care HPSAs, as of December 31, 2011, but are designated as a geographic mental health HPSA, should use the modifier if the ZIP code is not on the list for automatic payment.

Information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic payment of the bonus, is available at *http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp*. An *MLN Matters*® article, MM7517, on this issue can be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf*.

Additional information

For more information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic bonus payment, visit the HPSA/PSA physician bonuses Web page at *http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp*.

MLN Matters® article MM7517, titled, "2012 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf*.

The *MLN* fact sheet titled, "Health Professional Shortage Area," which is designed to provide education on the HPSA payment system, is available at *http://www.cms.gov/MLNProducts/downloads/HPSAfctsht.pdf*.

If you have questions, please contact your Medicare Carrier, 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: SE1202
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2012
Related CR Transmittal #: N/A
Implementation Date: January 1, 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.

Autologous cellular immunotherapy treatment of metastatic prostate cancer

Note: This article was revised on January 10, 2012, to reflect a revised change request (CR) 7431 issued on January 6, 2012. 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 CR7431 have been revised. All other information is the same. This information was previously published in the November 2011 *Medicare A Connection*, Pages 29-32.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

Make sure billing staff is aware of this article.

Background

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

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

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

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

The new HCPCS code Q2043 will:

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

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Immunotherapy...*continued*

- Have an effective date of **July 1, 2011**.

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 with the exception of its administration – the cost of Provenge® administration can 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 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).

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Immunotherapy...*continued*

- For Medicare Part B practitioner claims, payment for Provenge® is based on ASP + 6 percent.

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 firstt 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/R140NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2380CP.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: January 6, 2012
Effective Date: June 30, 2011
Related CR Transmittal #: R2380CP and R140NCD
Implementation Date: August 8, 2011

Update to Medicare deductible, coinsurance, and premium rates for 2012

Note: This article was revised on December 19, 2011, to reflect a revised CR 7567 issued on December 16, 2011. In the article, the CR release date, transmittal number, and the Web address for accessing CR7567 were revised. All other information is the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 26-27.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, 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) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2012. Be sure billing staffs are aware of these updates.

Background

2012 Part A – hospital insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Note: An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness. The 2012 inpatient deductible is $1,156.00. The coinsurance amounts are shown below in the following table:

Hospital coinsurance		Skilled nursing facility coinsurance
Days 61-90	Days 91-150 (Lifetime reserve days)	Days 21-100
$289.00	$578.00	$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary enrollees Part A premium schedule for 2012	
Base premium (BP)	$451.00 per month
Base premium with 10% surcharge	$496.10 per month
Base premium with 45% reduction	$248.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% reduction and 10% surcharge	$272.80 per month

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Rates...*continued*

2012 Part B – supplementary medical insurance (SMI)

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- Standard premium: $99.90 a month
- Deductible: $140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

Additional information

The official instruction, CR 7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R74GI.pdf*.

If you have any questions, please contact your carriers, 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: MM7567 Revised
Related Change Request (CR) #: CR 7567
Related CR Release Date: December 16, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R74GI
Implementation Date: January 3, 2012

Use of revised RARC N103 when denying services furnished to federally incarcerated beneficiaries

Provider types affected

Providers submitting claims to Medicare contractors (fiscal Intermediaries (FIs), carriers, A/B Medicare administrative contractors (MACs) and durable medical equipment MACs or DME MACs) for Medicare beneficiaries who are incarcerated in a federal facility.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7678 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending remittance advice remark code (RARC) N103 to include language that further explains the newly modified RARC N103—denying claims for services to federally incarcerated beneficiaries.

Caution – what you need to know

CR 7678 is limited to providers billing for services for beneficiaries while they are in federal, state, or local custody and the goal of this CR 7678 is to be more specific in explaining the accompanying adjustment.

Go – what you need to do

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

Background

The following exclusions presumptively apply to individuals who are incarcerated in a federal facility under federal authority:

- According to federal regulations at 42 Code of Federal Regulations (CFR) Section 411.4 Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service and no other person or organization has a legal obligation to provide or pay for the service;
- Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency; and
- Under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

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RARC...*continued*

Key points

When denying claims for services furnished to federally incarcerated Medicare beneficiaries, the newly modified RARC N103 will be used (in addition to remittance advice language already in use) and it reads as follows:

"Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a federal facility, or while he or she is in state or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt."

Additional information

The official instruction, CR 7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1012OTN.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: MM7678
Related Change Request (CR) #: 7678
Related CR Release Date: January 6, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R1012OTN
Implementation Date: July 2, 2012

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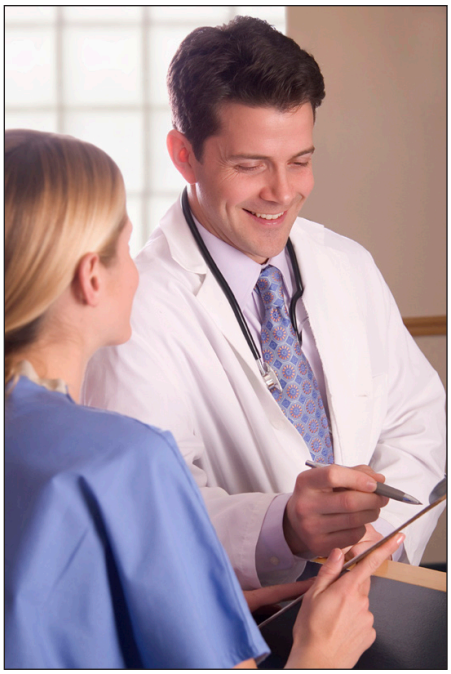
Services and items ordered or referred by other providers and suppliers

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.



Provider action needed

Stop – impact to you

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual National Provider Identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Caution – what you need to know

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

Go – what you need to do

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background

The Centers for Medicare & Medicaid Services (CMS) emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which

continued on next page

Referred...*continued*

the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Portable X-ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. Portable X-ray services ordered by any other practitioners will be denied.

MLN Matters® special edition article SE1011 provides further details about edits on the ordering/referring provider information on claims. The article is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf*.

Additional Information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/MedicareProviderSupEnroll* or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Contact_list.pdf*.

The *Medicare Learning Network*® (*MLN*) fact sheet titled, *Medicare Enrollment Guidelines for Ordering/Referring Provider*, is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *https://www.cms.gov/MLNMattersArticles/downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6417.pdf*.

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf*;

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6129.pdf*.

MLN Matters® Number: SE1201
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Implementation Date: N/A

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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

AJ9055: Cetuximab (Erbitux®) – revision to the LCD

LCD ID number: L28802 (Florida)
LCD ID number: L28804 (Puerto Rico/Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbitux®) was most recently revised on February 24, 2011. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include the new Food and Drug Administration (FDA) labeled indication:

- Recurrent locoregional disease or metastatic squamous cell carcinoma of the head and neck in combination with platinum-based therapy with 5-FU.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 173.12, 173.22, 173.32, and 173.42 were added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2012**, for services provided **on or after November 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

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

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here.*

AJ9263: Oxaliplatin (Eloxatin®) – revision to the LCD

LCD ID number: L28942 (Florida)
LCD ID number: L28963 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was most recently revised on March 19, 2009. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical necessity" section of the LCD to include the off-label indication of relapsed or refractory non-Hodgkin's lymphoma, including diffuse large B-cell lymphoma when used with other Food and Drug Administration (FDA) or Centers for Medicare & Medicaid Services (CMS) approved compendia supported chemotherapy regimens. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code range 202.80-202.88 was added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services provided **on or after January 25, 2012**. 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here.*

Stay on track and complete your version 5010 upgrade

As 2012 begins, it is important to keep your focus on compliance with version 5010 and beginning to plan for the transition to ICD-10.

The version 5010 deadline was on January 1, 2012; however, because of the *90-day enforcement discretion period* for all HIPAA covered entities upgrading to version 5010 (ASC X12 version 5010), the Centers for Medicare & Medicaid Services (CMS) will not initiate enforcement action until April 1, 2012. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades to be compliant.

CMS encourages you to continue internal testing as well as external testing of version 5010 transactions with trading partners to ensure compliance for version 5010. Although enforcement action will not be taken prior to April 1, 2012, it is important that you continue to move forward to meet version 5010 requirements as soon as possible. In addition to testing, if you have not yet created a plan for version 5010, you should do so in order to meet these compliance deadlines.

To find out about steps to take toward a successful upgrade, consult the new CMS fact sheet: *Version 5010: How Health Care Providers Can Ensure a Smooth Transition*.

Remember: Upgrading to version 5010 is a critical first step for the nationwide transition to ICD-10 that will take place on October 1, 2013. It is important that you finish this process, so that you can continue to prepare your organization for the ICD-10 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 201201-15

New ASC X12 version 5010 FAQs posted available – link corrected

Medicare fee-for-service (FFS) issued an announcement Wednesday, December 14 regarding its plan for the 90-day discretionary enforcement period for non-compliant Health Insurance Portability and Accountability Act (HIPAA) covered entities. The Centers for Medicare & Medicaid Services has published six frequently-asked questions (FAQs) related to this plan. These new FAQs can be found at *http://www.cms.gov/Versions5010andD0/Downloads/QandA_for_90_day_announcement.pdf*.

For more information on ASC X12 version 5010, National Council for Prescription Drug Program (NCPDP) D.0, and NCPDP 3.0; please visit *www.CMS.gov/Versions5010andD0*.

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

Source: CMS PERL 201201-02

Version 5010 benefits and resources

Version 5010 offers great improvement over version 4010/4010A; for example, version 5010:

- Greatly improves standardization of administrative data and supports both ICD-9 and ICD-10 codes sets
- Supports electronic submission of claims
- Provides greater specificity of clinical data and patient information, and
- Has a more logical structure, which will assist in faster code selection and improved ease of use.

Version 5010 resources

Please visit the *Version 5010* and *Latest News* pages on the CMS ICD-10 website for resources to assist with the version 5010 transition. Resources include:

- The following fact sheets can assist with making a smooth version:
  - *Version 5010: How Health Care Providers Can*
  - *Version 5010: Testing Readiness, What You Need to Know*
  - *FAQs: Versions 5010 and D.0 Transition Basics*
- Implementation handbooks tailored for:
  - *Large provider practices*
  - *Payers*
  - *Small hospitals*, and
  - *Small/medium provider practices*
- An interactive *widget* as well as printer friendly timelines for:
  - *Large provider practices*
  - *Small provider practices*
  - *Payers*, and
  - *Vendors*

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 201201-05

Have you transitioned to 5010?
***Don't wait** until it's too late ...*
Call FCSO EDI -- 888-670-0940, option-5

Medicare FFS Part A editing of the NDC

Effective December 21 Medicare fee-for-service (FFS) turned off the current ASC X12 version 5010 common edit and enhancements module (CEM) national drug code (NDC) validation edit for Medicare Part A. The specific NDC edit that was turned off requires that the NDC in loop ID 2410 LIN03 to be validated against the Food and Drug Administration's (FDA) NDC code list. A replacement NDC edit will be implemented in the Part A CEM for the January 2012 shared system quarterly release which will perform syntactical editing only of the NDC submitted in loop ID 2410 LIN03.

A similar announcement was disseminated for the deactivation of the Part B NDC edit on Monday, December 19. The Medicare Part B NDC edit was deactivated on Friday, December 9.

Background of the national drug code

The NDC is a unique product identifier used for drugs intended for human use and is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting or adjudication processes. The Drug Listing Act of 1972 requires registered drug establishments to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. Drug products are identified and reported using the NDC.

The NDC is a unique number expressed in three sections. This numeric identifier is assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The sections identify the labeler or vendor, the product (within the scope of the labeler), and the type of package (of this product). The ASC X12 TR3 documents stipulate that the 5-4-2 expression of NDC values must be used. However, the FDA does not have a version of the NDC in this (5-4-2) format. Therefore, the Centers for Medicare & Medicaid Services (CMS) has created a version of the NDC in the 11-byte numeric NDC derivative, which pads the product code (four positions) or package code (two positions) sections of the NDC with a leading zero thus resulting in a fixed length 5-4-2 configuration.

Source: CMS PERL 201112-55

Version 5010 and NCPDP D.0 cut over and impacts on crossover claims

On Monday, December 5 the Centers for Medicare & Medicaid Services (CMS) issued a special edition *MLN Matters* article (SE1137) titled "Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process." CMS issued this guidance for the benefit of physicians/practitioners, providers, and suppliers to help them understand why they were seeing greater instances of Medicare correspondence letters that made reference to error N22226 as the basis for why their patients' claims could not be crossed over.

CMS has since learned that concern exists in the provider community on whether billing of hardcopy CMS-1500 or UB04 claims or HIPAA version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. This is not true.

During the 90-day version 5010 non-enforcement period (Sunday, January 1, 2012, through Saturday, March 31, 2012), Medicare will have the systematic capability to perform up- or down-version conversion of incoming claim formats (ie. convert incoming hardcopy formats to HIPAA equivalent claim formats and convert incoming version 4010A1 claim formats to 5010 formats and vice versa), in accordance with external supplemental payer specifications concerning production claims format. This practice will discontinue, however, at the conclusion of the 90-day non-enforcement period, with the exception below. (This action is controlled by information that the common working file receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode.)

Note that physicians/practitioners, providers, and suppliers that have authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims using a hardcopy format should know that Medicare has the systematic capability to convert keyed claims into outbound-compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90-day non-enforcement period.

Source: CMS PERL 201201-28

Additional HIPAA 837 5010 transitional changes and further modifications to the COBA national crossover process

Note: This article was revised on January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims to the coordination of benefits agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB-04 hardcopy formats. All other information remains unchanged. This information was previously published in the December 2011 *Medicare A Connection*, Pages 47-48.

Provider types affected

This *MLN Matters*® special edition (SE) article is intended to alert physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What providers need to know

Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the national crossover process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production version 4010A1, HIPAA 837 claims to HIPAA versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all "clean" electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS' coordination of benefits contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

Note: The same premise will hold for inbound version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, version 5.2 batch format for receipt of crossover claims.

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226 –"4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims."
- N22230 –"NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims."

*To review the entire CR6658, visit *http://www.cms.gov/transmittals/downloads/R1844CP.pdf*.

*To review the entire CR6664, visit *http://www.cms.gov/transmittals/downloads/R1841CP.pdf*.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1. The patient's supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and
2. For a limited timeframe (likely 30 days after a supplemental payer cuts over to version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients' supplemental payers.

Key points

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC error reports with error codes N22226 through N22229, regardless of error percentage.
- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with "production" claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient's supplemental payer and include a specific "222" error code and accompanying description. *MLN Matters*® article

continued on next page

COBA...*continued*

MM3709 details the initial CMS instructions to contractors and may be reviewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf*.

- Complete details of the COBA error notification process are included in the official instruction issued to your Medicare contractor and may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf*.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional clarification of the crossover claims process

There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB-04 claims or HIPAA version 4010A1 or NCPDP version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or version 4010A1 or NCPDP 5.1 batch formats. **This assumption is incorrect, as explained below.**

During the 90 day non-enforcement period (January 1, 2012 – March 31, 2012), Medicare will have the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of Version 5010 COB claims in production; and
- Take incoming claims submitted by the provider community in the version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare's common working file (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90-day non-enforcement period.

Note: For physicians/practitioners, providers, and suppliers that have the authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims to Medicare using a hardcopy format, Medicare has the systematic capability to convert keyed claims into outbound compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90-day non-enforcement period.

Summary

During the 90-day non-enforcement period, Medicare has the ability to take incoming claims formats (hardcopy, version 4010A1, version 5010A1 or 5010A2, NCPDP 5.1 batch, or NCPDP D.0 batch) and transform them into alternative version HIPAA claim or NCPDP claim formats for COB purposes to address the "production" specifications of various supplemental payers. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of 90 day non-enforcement period.

Additional Information

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

If you have any questions about electronic data interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the "Downloads" section of the "Electronic Billing & EDI Transactions" Web page at *http://www.cms.gov/ElectronicBillingEDITrans/*.

MLN Matters® Number: SE1137 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
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Related CR Transmittal #: N/A
Implementation Date: N/A

Non-specific procedure code description requirement for HIPAA version 5010 claims

Provider types affected

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

What you need to know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required.

Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when non-specific procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all non-specific procedure codes.

Background

The HIPAA version 5010 implementation guide describes non-specific procedure codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name". If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional information

A complete listing of not otherwise classified (NOC) code set is available at *http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp*.

For 5010/D.O implementation information and deadlines, refer to *MLN Matters*® special edition article #SE1131, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf*.

If you are not ready, consider contacting your Medicare contractor to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare remit easy print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, change request (CR) 7392, "Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates," dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR 7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

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CMS requires adoption of HIPAA standards for electronic payments and remittance advice

Action

The Centers for Medicare & Medicaid Services (CMS) has announced an interim final rule (IFC) – with comment period (CMS-0024-IFC) – under which the Department of Health and Human Services (HHS) must adopt health care electronic funds transfers (EFT) and remittance advice transaction (RA) standards specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Section 1104 of the Patient Protection and Affordable Care Act of 2010 requires CMS to issue a series of regulations over the next five years that are designed to streamline health care administrative transactions, encourage greater use of standards by providers, and make existing standards work more efficiently. On July 8, 2011, CMS published the first regulation, an IFC that puts in place operating rules for two electronic health care transactions that make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer.

This regulation is the second in the series and establishes EFT standards that, when implemented by health plans, will save physician practices and hospitals between of $3 billion to $4.5 billion over the next ten years. Further environmental benefits from the use of an electronic payment in contrast to payments made by paper checks will result in an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over 10 years.

Future administrative simplification rules will address adoption of:

- A standard unique identifier for health plans;
- A standard for claims attachments; and
- Requirements that health plans certify compliance with all HIPAA standards and operating rules.

Background

Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996. HIPAA amended the Social Security Act (the Act) by adding Part C -- Administrative Simplification -- to Title XI of the Act, requiring the Secretary of the Department of Health and Human Services (DHHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Switching from paper checks to EFT will result in 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over 10 years.

Section 1104(b)(2)(A) of the Patient Protection and Affordable Care Act (Pub. L. 111 148) amended Section 1173(a)(2) of the Act by adding the electronic funds transfers (EFT) transaction to the list of electronic health care transactions for which the Secretary must adopt a standard under HIPAA.

In general, the savings and benefits related to use of EFT for business and consumer payments are well established. The most common savings are in paper, printing, and postage costs, as well as savings in staff time to manually process and deposit paper checks. Yet adoption and use of EFT by the health care industry has been low, resulting in administrative savings that go unrealized. The obstacles to greater use of EFT by the health care industry can be lessened by standardization of the EFT transaction. Beyond the material and administrative time savings for health care providers and health plans, the time and resources that physician practices and hospitals spend on billing and related tasks will be better spent on delivering health care to patients.

On December 3, 2010, the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards held a hearing and from it gathered a comprehensive review of the health care payment and remittance advice transaction for purposes of making a recommendation to the Secretary. Participants represented a cross section of the health care industry. On February 17, 2011, the NCVHS sent a letter to the Secretary that contained recommendations for adoption of a “health care EFT” standard.

Based on that recommendation, HHS is adopting two standards for the health care EFT that a health plan must comply with in order to transmit health care claim payments to providers via EFT. The first is a standard format for when a health plan orders, authorizes, or initiates an EFT with its financial institution. The second standard specifies the data content to be contained within the EFT.

The goal for adopting these standards is to ensure that a trace number that connects the payment to the electronic remittance advice is inputted into a

continued on next page

Standards...*continued*

standard EFT format and that is received without error by the health care provider. This can be best achieved by requiring that a single electronic file format (CCD+Addenda) be used by all health plans that transmit health care EFT to their financial institutions and by requiring that data elements are consistent and ordered according to clear implementation specifications.

Provisions of the IFC

HHS is adopting two standards for the health care EFT: The "CCD+Addenda" implementation specifications in the 2011 National Automated Clearing House Association (NACHA) Operating Rules & Guidelines and the "TRN Segment" implementation specifications in the X12 835 TR3 for the data content of the addenda record of the "CCD+Addenda.

Costs/benefits

Although all covered entities are required to comply with the adopted standards of HIPAA transactions, the health care EFT standards are expected to have the most substantial cost and benefit impacts on physician practices, hospitals, and commercial and government health plans.

CMS estimates that many health plans will have direct costs associated with implementing and using the health care EFT standards. However, those costs are expected to be comparably small software investments: Approximately $18 million to $28 million overall for all commercial health plans and $400,000 to $600,000 for Medicaid, the Children's' Health Insurance Program (CHIP), and the Indian Health Service (IHS). Over ten years, the savings could be as much as $40 million for commercial health plans and $31 million for Medicaid, CHIP, and IHS.

For physician practices and hospitals, there is little to no cost to implement the health care EFT standards, as providers are the receivers of the standardized transaction and not the senders. Overall, physician practices and hospitals should see savings of $3 billion to $4.5 billion over the next ten years as health plans implement the health care EFT standards.

CMS can also expect a modest environmental benefit from the use of an electronic payment in contrast to payments made by paper checks, including an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

Regulation effective date/ standards compliance date

The effective date of this regulation is January 1, 2012. Under the Affordable Care Act, HIPAA-covered entities must be in compliance with the standards (i.e., use the health care EFT standards) by January 1, 2014.

The rule (CMS-0024-IFC) is on display and may be viewed at *www.ofr.gov/inspection.aspx*. A news release on the rule may be viewed at *http://www.hhs.gov/news*.

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

Source: CMS PERL 201201-10

CARC, RARC, MREP, and PC Print update

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

Stop – impact to you

This article is based on change request (CR) 7683 which updates claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), Medicare remit easy print (MREP), and PC Print for Medicare.

Caution – what you need to know

Change request (CR) 7683 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare remit easy print (MREP) software. Be sure your billing staff is aware of these changes.

continued on next page

CARC...*continued*

Go – what you need to do

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that claim adjustment reason codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate remittance advice remark codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used. The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual “Stop Date” posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The regular code update change request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR7683, Medicare contractors must implement on the date specified on the WPC website. The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

The WPC website (at *http://www.wpc-edi.com/Reference*) has four listings available for both CARC and RARC:

1. **All:** All codes including deactivated and to be deactivated codes are included in this listing.
2. **To Be Deactivated**: Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
4. **Current:** Only currently valid codes are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare

Claim adjustment reason code (CARC):

A national code maintenance committee maintains the health care claim adjustment reason codes (CARCs).

continued on next page

CARC...*continued*

The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see *http://www.wpc-edi.com/Reference*.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than a future date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new CARCs were approved by the Code Committee in October, and must be implemented, if appropriate, by April 2, 2012.

New codes – CARC:

Code	Current narrative	Effective date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use group code PR).	March 1, 2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use group code OA).	March 1, 2012

Modified codes – CARC:

Code	Modified narrative	Effective date
141	Exact duplicate claim/service (Use with group code OA).	January 1, 2013

Deactivated codes – CARC:

Code	Current narrative	Effective date
141	Claim spans eligible and ineligible periods of coverage.	July 1, 2012

Remittance advice remark codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change.

CR 7683 contains no new, modified, or deactivated RARC codes.

Additional information

The official instruction, CR 7683, 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/R2372CP.pdf*.

continued on next page

CARC...*continued*

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: MM7683
Related Change Request (CR) #: CR 7683
Related CR Release Date: December 22. 2011
Effective Date: April 1, 2012
Related CR Transmittal #: R3372CP
Implementation Date: April 2, 2012

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FISS claims processing updates for ambulance services

Note: This article was revised on January 13, 2012, to reflect a revised change request (CR) on January 12, 2012. That CR revised the HCPCS codes requirements for emergency and non-emergency trips on or after April 12, 2012. On January 19, 2012, the article was revised to clarify that certain statements apply to institutional providers. The transmittal number, CR release date and web address for the CR was also changed. All other information remains the same. The information was previously published in the November 2011 *Medicare A Connection*, page 47.

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 institutional claims (i.e., paper UB-04, electronic 837I, or direct data entry (DDE) 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 (when A0428 is billed without modifier QL)) 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, A0434, and A0428 (when A0428 is billed with the modifier QL)).

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 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 (when A0428 is billed without modifier QL)) require an NPI in the Attending Physician field. Emergency trips on institutional claims (i.e., paper UB-04, electronic 837I, or direct data entry

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Ambulance...*continued*

(DDE) claims) do not require an NPI in the Attending Physician field (i.e., A0427, A0429, A0430, A0431, A0432, A0433, A0434, and A0428 (when A0428 is billed with the modifier QL)).

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/R2383CP.pdf*.

You may want to review *MLN Matters*® article MM7065 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7065.pdf*) that provides the procedure for reporting fractional mileage amounts on ambulance claims (other than on the UB04) effective for claims for dates of service on or after January 1, 2011. MM7065 also clarifies the requirements for using the UB-04 form when doing fractional billing, prior to August 1, 2011.

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 Revised
Related Change Request (CR) #: 7557
Related CR Release Date: January 12, 2012
Effective Date: For UB-04 Hardcopy Claims, August 1, 2011. For NPI requirement changes, April 1, 2012
Related CR Transmittal #: R2383CP
Implementation Date: April 2, 2012

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HCPCS code set update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at *www.cms.gov/medhcpcsgeninfo*. Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201201-18

New resources available to assist providers with ICD-10 transition

On January 16, 2009, the U.S. Department of Health and Human Services published final rules that mandated all organizations covered by Health Insurance Portability and Accountability Act (HIPAA) must upgrade to version 5010 by January 1, 2012, and transition to ICD-10 coding sets by October 1, 2013. As a result of the enforcement discretion period for version 5010, all organizations must complete their version 5010 upgrade by no later than March 31, 2012. Upgrading to version 5010 is an essential step that must be taken before the transition to ICD-10, and the deadline for the ICD-10 transition is quickly approaching.

To help with this transition, the Centers for Medicare & Medicaid Services (CMS) has developed a number of resources available on the CMS ICD-10 website.

Fact sheets

- *Ensuring a Smooth Transition to Version 5010*
- *ICD-10 Transition: An Introduction*
- *ICD-10 Basics for Medical Practices*
- *ICD-10 FAQs*
- *Talking to Your Vendors about the Transition to ICD-10*

Implementation widget

CMS' interactive *widget* outlines the steps to take to ensure compliance with version 5010 and ICD-10. CMS encourages you to download or share the widget and take advantage of printer-friendly versions of the timelines available for small provider practices, large provider practices, payers, and vendors.

Implementation timelines

Timelines are printer-friendly checklists that complement the widget. Timelines are available for:

- *Small providers*
- *Large providers*
- *Payers*
- *Vendors*

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.

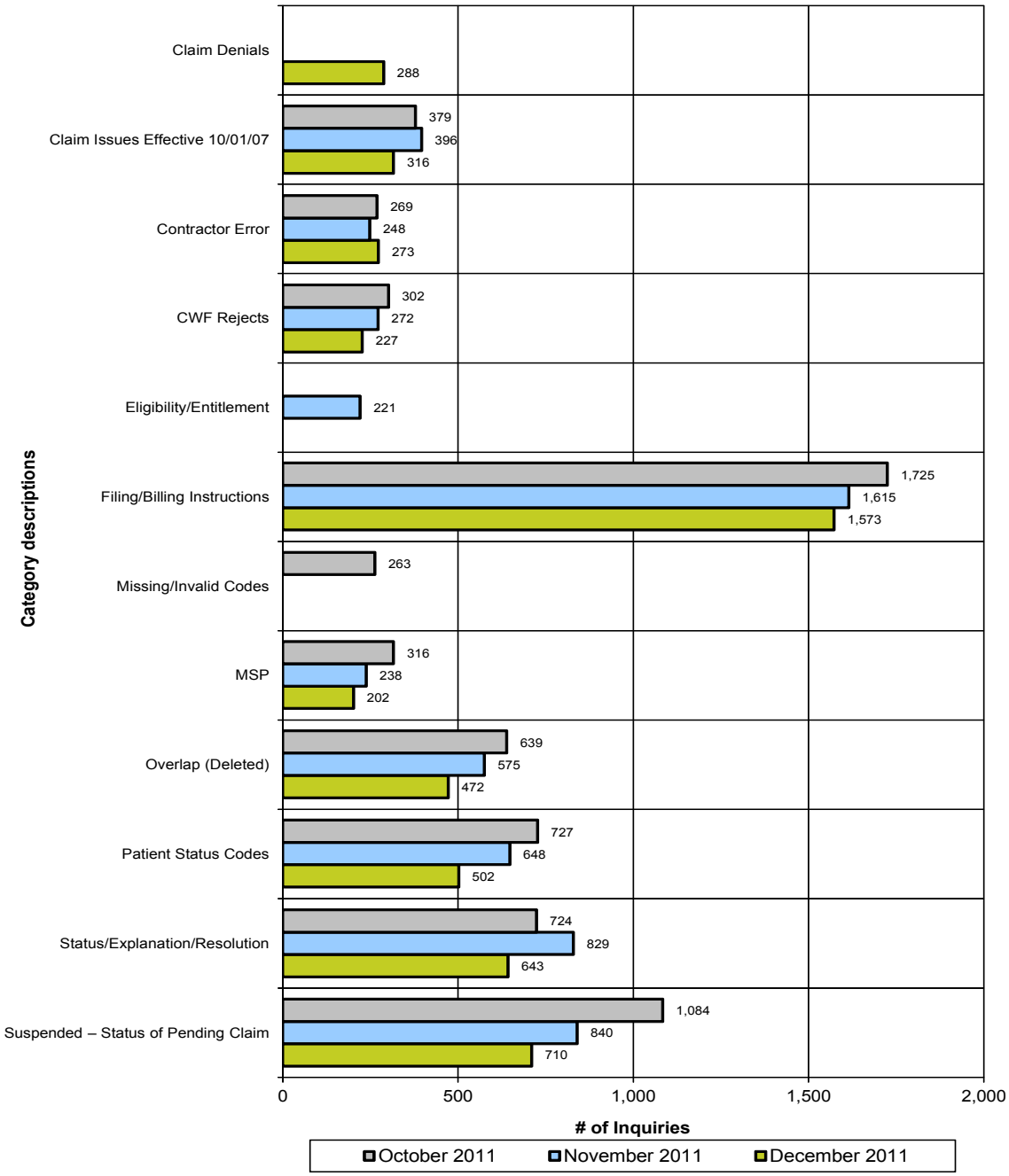
Source: CMS PERL 201201-40

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



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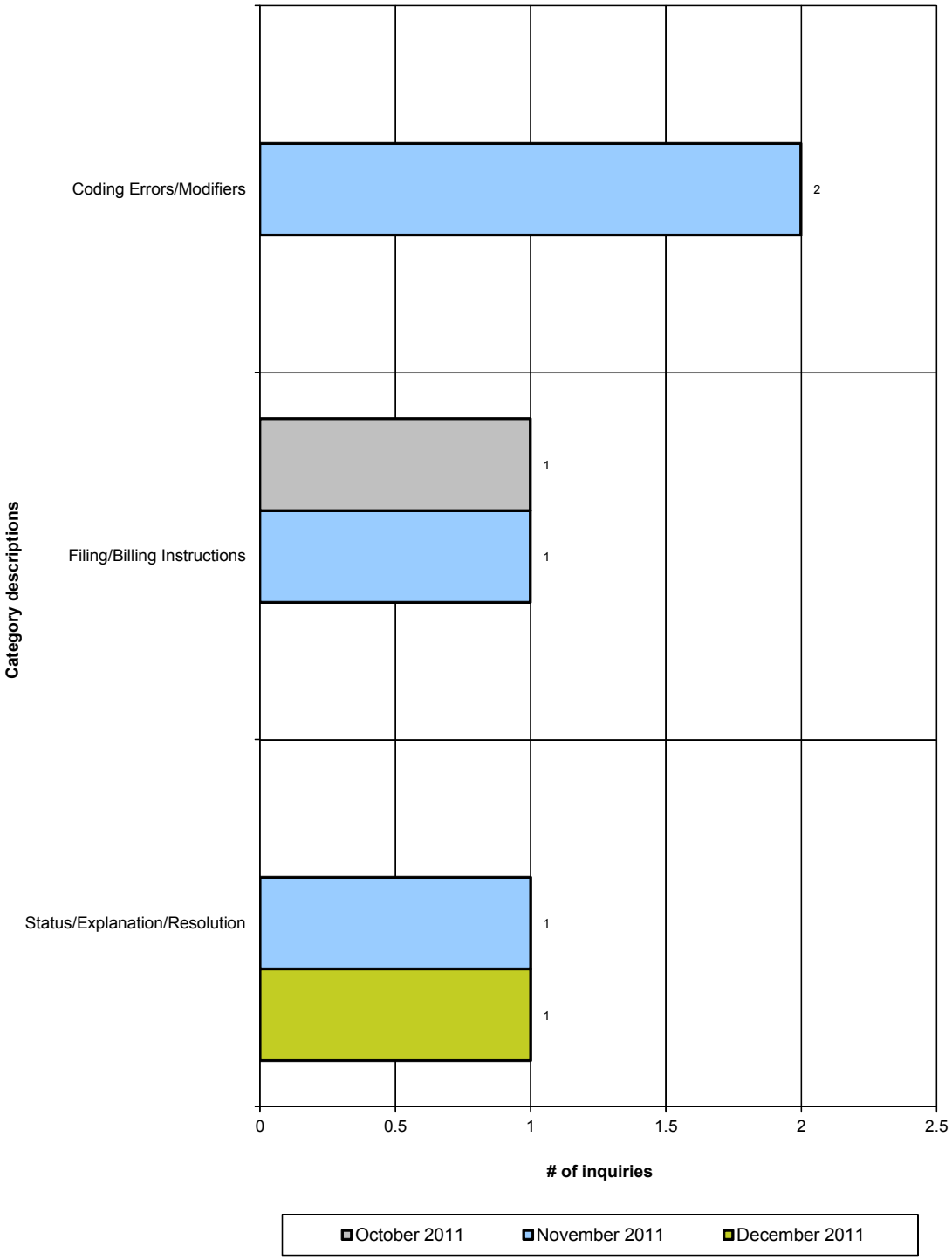
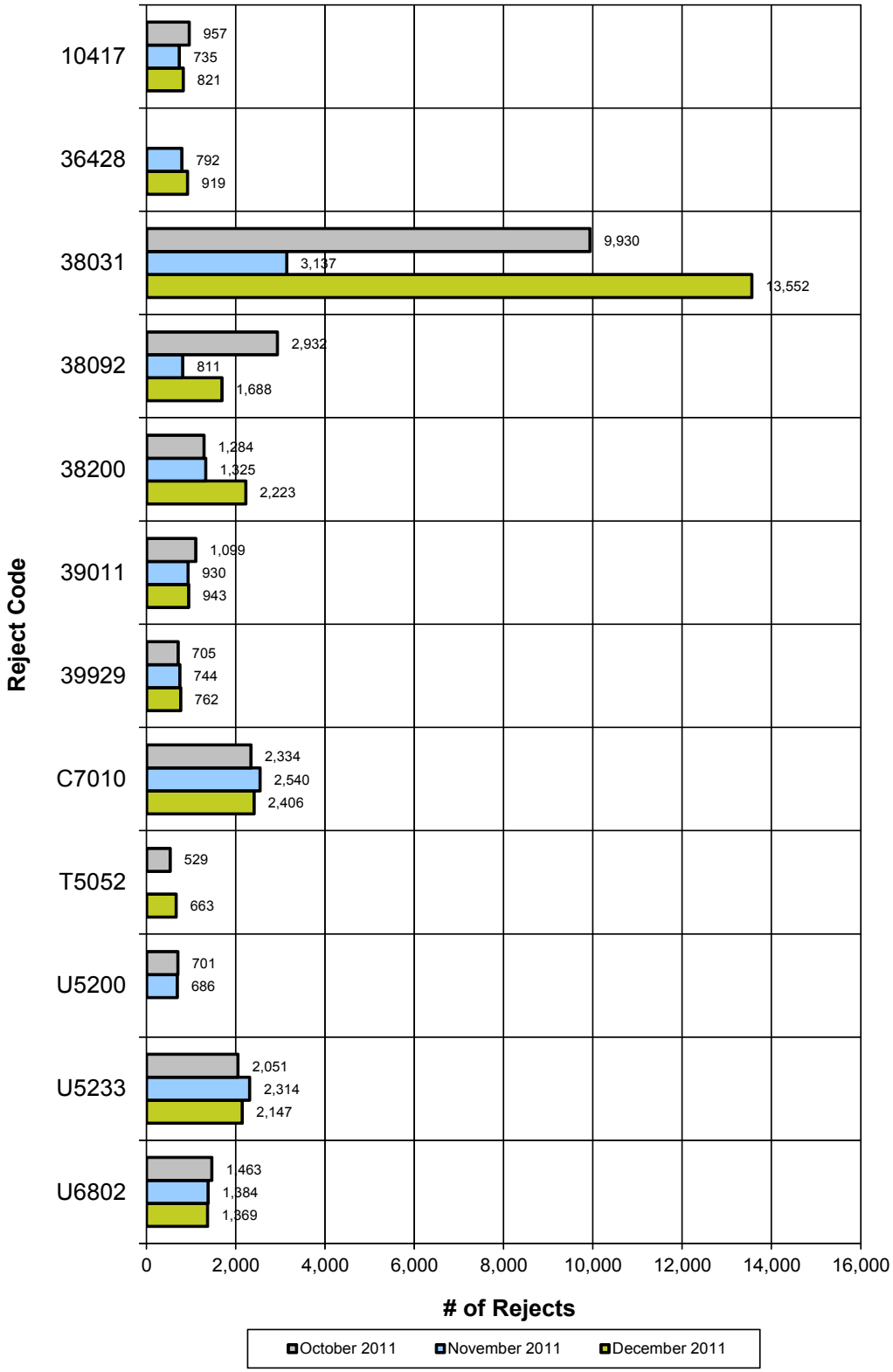
Inquiries...*continued*

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



Florida Part A top rejects for October-December 2011



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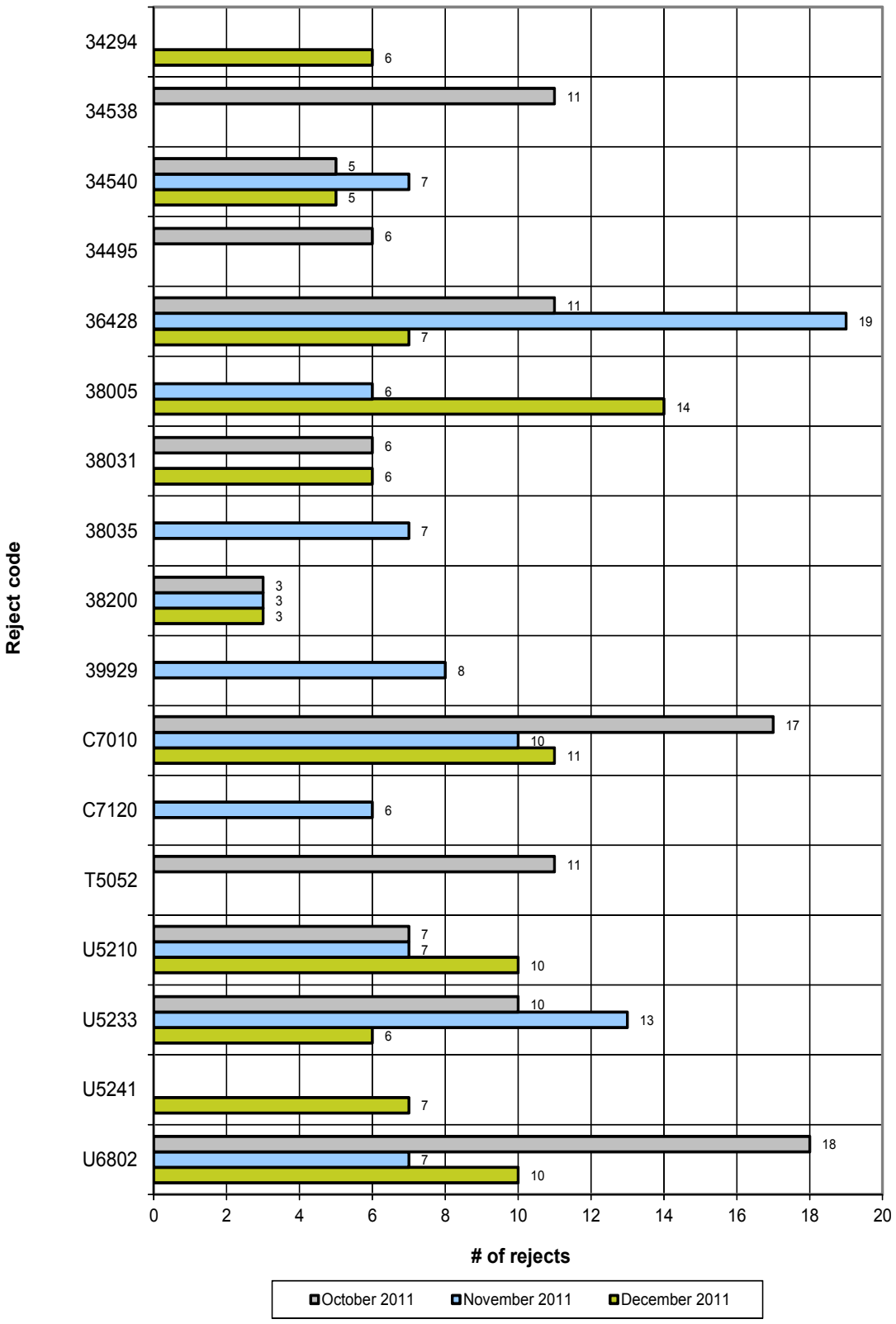
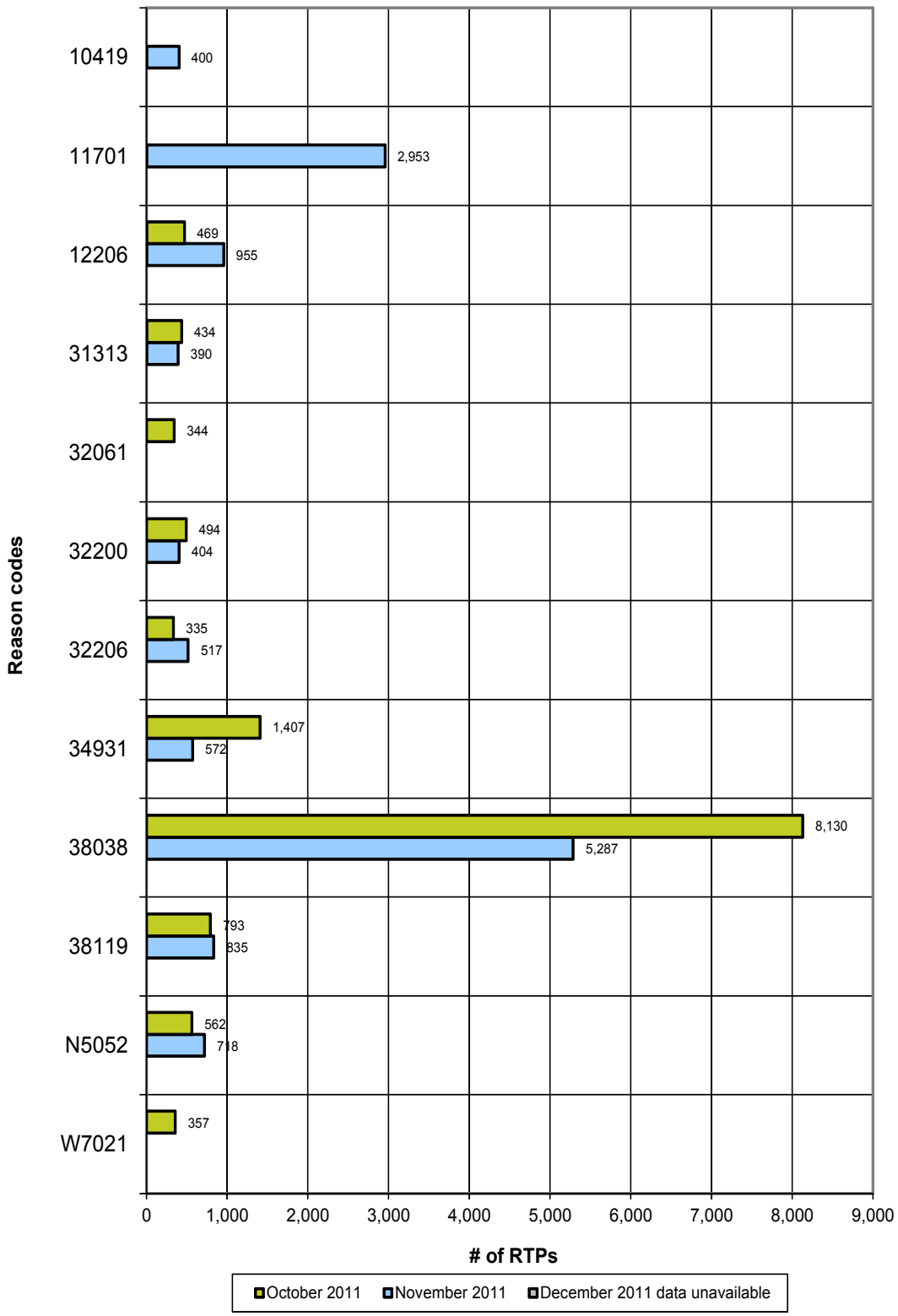
Rejects...*continued*

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



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



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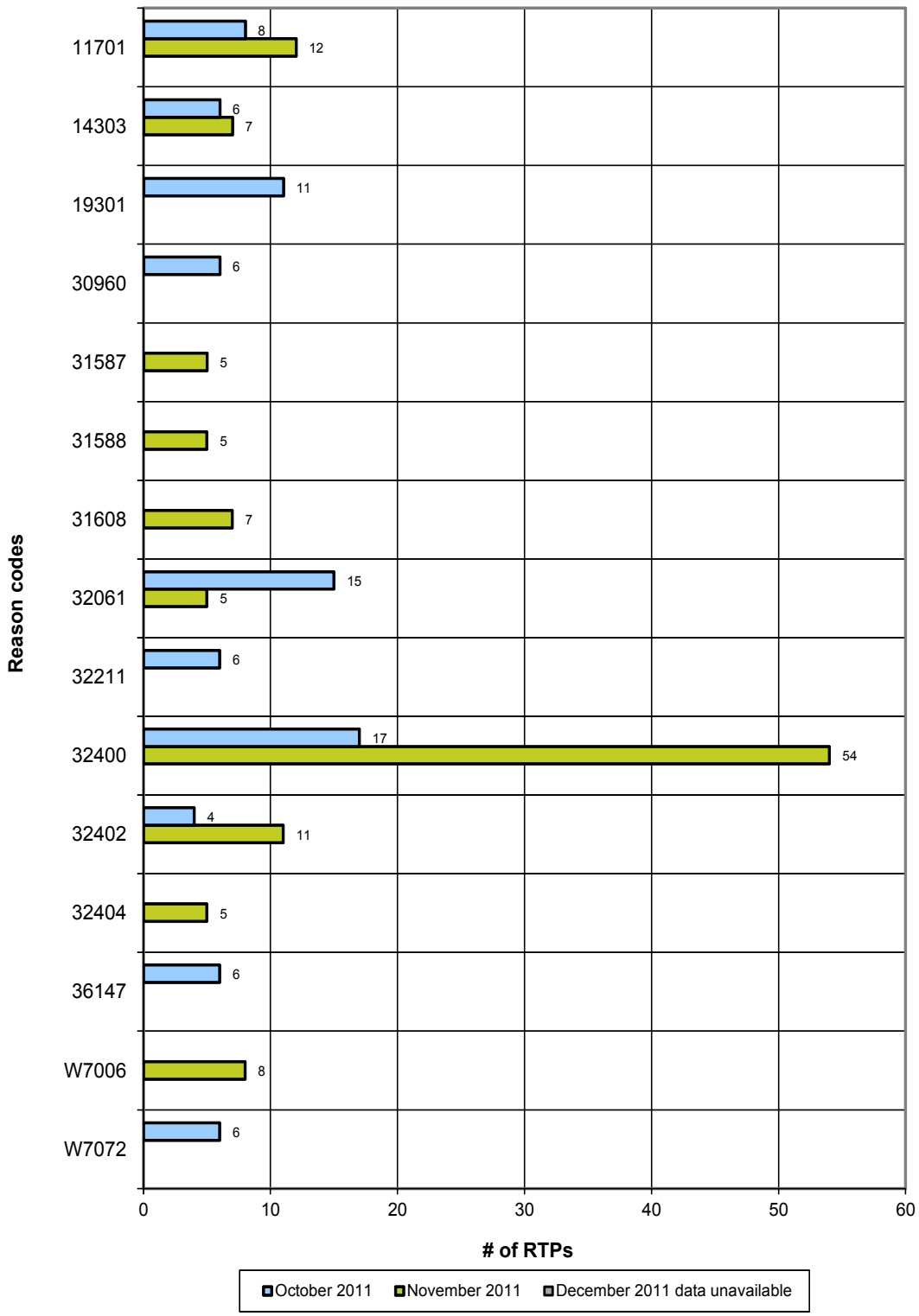
RTPs...*continued*

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



Bundling payments for services provided to outpatients who later are admitted as inpatients

Provider types affected

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

Provider action needed

Physicians, suppliers, and providers must insure that their billing staffs are aware of these new changes to the rules for services provided to outpatients who are later admitted as inpatient. The Centers for Medicare & Medicaid services (CMS) includes these changes in change request (CR) 7502.

Background

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) (Pub. L. 111-192) was enacted. Section 102 of this Act entitled, "Clarification of 3-Day Payment Window," clarified when certain nondiagnostic services furnished to Medicare beneficiaries in the three days (or, in the case of a hospital that is not a Subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the one day) preceding an inpatient admission should be considered "operating costs of inpatient hospital services" and therefore included in the hospital's payment under the hospital inpatient prospective payment system (IPPS). This policy is generally known as the "three-day payment window."

Under the three-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the inpatient claim for a Medicare beneficiary's inpatient stay, the technical portion of all outpatient diagnostic services and admission-related nondiagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

Prior to June 25, 2010, and the enactment of Public Law 111–192, the payment window policy for preadmission nondiagnostic services was rarely applied as the policy required an exact match between the principal ICD–9 CM diagnosis codes for the outpatient services and the inpatient admission. The requirement of the exact match resulted in very few services furnished in an entity that is wholly owned or operated by the hospital being subject to the policy. The statutory change to the payment window policy made by Public Law 111–192 significantly broadens the definition of nondiagnostic services that are subject to the payment window to include any nondiagnostic service that is clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

In accordance with Section 102(a)(1) of the PACMBPRA, for outpatient services furnished on or after June 25, 2010, the technical portion of all nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be included on the bill for the inpatient stay. Also, the technical portion of outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and the third calendar days (one calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay.

PACMBPRA did not change the requirement that the technical portion of all diagnostic services provided by the hospital (or entity wholly owned or wholly operated by the hospital) occurring on the date of an inpatient admission, or during the three calendar days (or one calendar day) immediately preceding the date of an inpatient admission must be billed with the inpatient admission.

Note: If the nondiagnostic services are unrelated to the inpatient hospital claims, that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission, the unrelated outpatient hospital nondiagnostic services are covered by Medicare Part B, and the wholly owned or wholly operated entity shall include the technical portion of the services in their billing.

Implementation of the three-day payment window policy in wholly owned or wholly operated entities

Wholly owned or wholly operated entities are subject to the three-day (or one-day) payment window policy when they furnish preadmission diagnostic services to a patient who is later admitted as an inpatient on the same day or within the preceding three calendar days (preceding one calendar day), or when they furnish preadmission nondiagnostic services to a patient, who is later admitted as an inpatient on the same day or within the preceding three calendar days (preceding one calendar day) for related medical care.

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Bundled...*continued*

When an entity that is wholly owned or wholly operated by a hospital furnishes a service subject to the three-day window policy, Medicare will pay the professional component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once the entity has received confirmation of a beneficiary's inpatient admission from the admitting hospital, they shall, for services furnished during the three-day window, append a CMS payment modifier to all claim lines for diagnostic services and for those nondiagnostic services that have been identified as related to the inpatient stay. Physician nondiagnostic services that are unrelated to the hospital admission are not subject to the payment window and shall be billed without the payment modifier.

Defining wholly owned and wholly operated entities

Wholly owned or wholly operated entities are defined in 42 CFR §412.2: "An entity is wholly owned by the hospital if the hospital is the sole owner of the entity." And, "an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity."

Payment methodology

CMS has established new payment modifier PD (diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within three days), and require that the modifier be appended to the entity's preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/CPT codes, which are subject to the three-day payment window policy. The wholly owned or wholly operated entity will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the three-day (or, when appropriate, one-day) payment window prior to the inpatient stay.

The modifier is available for claims with dates of service on or after January 1, 2012, and entities may begin to coordinate their billing practices and claims processing procedures with their hospitals to ensure compliance with the three-day payment window policy no later than for claims received on or after July 1, 2012.

When the modifier is present on claims for service CMS shall pay:

- Only the professional component (PC) for CPT/HCPCS codes with a technical component (TC)/PC split that are provided in the three-calendar day (or, one-calendar day) payment window; and
- The facility rate for codes without a TC/PC split.

Global surgical services and the three-day payment window policy

We note that the time frames associated with 10 and 90 day global surgical packages could overlap with the three-day (or one-day) payment window policy. The three-day payment window makes no change in billing surgical services according to global surgical rules, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the three-day window policy, as would occur if the surgery were performed within the three-day window. For example, a patient could have a minor surgery in a wholly owned or wholly operated entity and then, due to a complication, be admitted as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.

Additional Information

The official instruction, CR 7502 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2373CP.pdf*. Revised portions of the *Medicare Claims Processing Manual*, containing further details on this change, are attached to CR7502.

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: MM7502
Related Change Request (CR) #: 7502
Related CR Release Date: December 21, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2373CP
Implementation Date: January 3, 2012

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CY 2012 outpatient prospective payment system Pricer file update

The outpatient prospective payment system (OPPS) Pricer Web page was recently updated to include the calendar year (CY) January 2012 update for outpatient provider data. Users may now access the January provider data update at *http://www.cms.gov/PCPricer/OutPPS/list.asp* by selecting "2012," and then downloading "1st Quarter 2012 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 201201-37

Information for outpatient prospective payment system providers regarding the billing of *CPT®* code *33249*

The Centers for Medicare & Medicaid Services (CMS) has identified that an update to the integrated outpatient code editor (I/OCE) is necessary to allow payment for *Current Procedural Terminology®* (*CPT)* code *33249*. CMS has provided direction to Medicare claims administration contractors to hold outpatient prospective payment system (OPPS) claims containing *CPT®* code *33249*, effective Sunday, January 1, 2012, until the I/OCE has been updated with this payment information. The held claims should be released on or about Monday, February 6, 2012.

Source: CMS PERL 201201-29

January 2012 quarterly provider specific SAS and text data files are available

The January 2012 quarterly provider specific files (PSF) SAS data files 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 in the Downloads section at: *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp*, and the text data files are available in the Downloads section at: *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*. A new version of the text files has been added with name and address information at the end of the record. If you use the provider specific text or SAS file data, please go to the Web pages listed above and download the latest version of the PSF files.

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

Source: CMS PERL 201201-27

Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form.

Emergency update to the CY 2012 Medicare physician fee schedule database

Provider types affected

Physicians, non-physician practitioners, and providers who bill Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7737, which informs you that new Medicare physician fee schedule (MPFS) payment files have been created and are available to Medicare contractors.

- Payment files were issued to Medicare contractors based upon the CY 2012 Medicare physician fee schedule (MPFS) final rule, issued on November 1, 2011, and published in the *Federal Register* on November 28, 2011.
- CR 7737 amends those payment files to include corrections described in the CY 2012 MPFS final rule correction notice, as well as relevant statutory changes applicable January 1, 2012.

Background

Medicare physician fee schedule revisions and updates

Some physician work, practice expense, and malpractice relative value units (RVUs) published in the CY 2012 MPFS final rule have been revised to align their values with the CY 2012 MPFS final rule policies. These changes are discussed in the CY 2012 MPFS final rule correction notice and revised RVU values are found in Addendum B and Addendum C of the CY 2012 MPFS final rule correction notice.

In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2012 MPFS final rule correction notice.

Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2012 MPFS final rule correction notice public use data files, which are located at: *http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage*.

Changes to the physician work RVUs and payment indicators can be found in the attachment associated with CR7737, which is cited in the Additional Information section below. Changes to practice expense RVUs are reflected in Addendum B and Addendum C of the CY 2012 MPFS Final Rule Correction Notice.

Legislative changes subsequent to issuance of the CY 2012 MPFS final rule, specifically, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA), have led to the further revision of the values published in the CY 2012 MPFS final rule correction notice, including a change to the conversion factor. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 MPFS is now scheduled to take effect on March 1, 2012, the administration remains strongly opposed to letting this cut take effect. The Centers for Medicare & Medicaid Services (CMS) will work quickly to update MPFS payment rates in the event Congress passes legislation to prevent the negative update from going into effect. Please be on the alert for more information about the 2012 physician update as it becomes available.

Temporary Payroll Tax Cut Continuation Act of 2011

On December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This law contains a number of Medicare provisions, which extend current Medicare fee-for-service program policies, and, as previously mentioned, prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. A summary of the TPTCCA provisions relevant to the MPFS payment files are provided below.

Medicare physician payment update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect on January 1, 2012. **An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012.** While the physician fee schedule update will be zero percent, other changes to the relative

continued on next page

MPFS...*continued*

value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. Therefore, the conversion factor will not be unchanged in CY 2012 from CY 2011. The revised conversion factor to be used for physician payment as of January 1, 2012, is $34.0376. The calculation of the CY 2012 conversion factor is illustrated in the following table.

December 2011 conversion factor	TPTCCA of 2011 "Zero Percent Update"	CY 2012 RVU budget neutrality adjustment	CY 2012 conversion factor through February 29, 2012
$33.9764	0.0 percent (1.000)	0.2 percent (1.0018)	$34.0376

The revised CY 2012 MPFS payment files will reflect this conversion factor through February 29, 2012.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense (PE), and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index through February 29, 2012. This change is included in the revised CY 2012 MPFS payment files. Updated CY 2012 geographic practice cost indices (GPCI) are included in the attachment to CR7737. See the *Additional information* section below for information on accessing CR 7737.

Extension of MPFS mental health add-on

For calendar year 2011, certain mental health services' payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services through February 29, 2012. This five percent increase is reflected in the revised CY 2012 MPFS payment files. The lists of psychiatry *Current Procedural Terminology (CPT)* codes that represent the specified services subject to this payment policy are included in the attachment to CR 7737.

Extension of exceptions process for Medicare therapy caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier (Specific required documentation on file), when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,880. For occupational therapy services, the limit is $1,880. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached and also apply for services above the cap where the KX modifier is used.

Extension of payment for the technical component (TC) of certain physician pathology services

In the CY 2000 PFS final rule, published in the *Federal Register* on November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the TC of a pathology service provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the TC of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the most recent extension of the moratorium expired at the end of 2011, section 305 of the TPTCCA restores the moratorium through February 29, 2012. Therefore, those independent laboratories that are eligible may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was furnished. This policy is effective for claims with dates of service on or after January 1, 2012, through February 29, 2012.

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MPFS...*continued*

Extension of the minimum payment for bone mass measurement

Section 3111(a) of the Affordable Care Act changed the payment calculation for dual-energy X-ray absorptiometry (DXA) services described *CPT* codes *77080* (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)*) and *77082 (Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment)* for CYs 2010 and 2011. This provision required payment for these services at 70 percent of the product of the CY 2006 RVUs for these DXA codes, the CY 2006 conversion factor (CF), and the geographic adjustment for the relevant payment year. CMS provided for payment in CYs 2010 and 2011 under the physician fee schedule (PFS) for *CPT* codes *77080* and *77082* at the specified rates. Because this provision did not include CY 2012, the CY 2012 PFS final rule with comment period listed resource-based, rather than imputed, RVUs for *CPT* codes *77080* and *77082*. However, Section 309 of the TPTCCA extended the Affordable Care Act minimum payment for bone mass measurement for the first two months of CY 2012. For claims with dates of service on or after January 1, 2012, through February 29, 2012, *CPT* codes *77080* and *77082* will be paid at 70 percent of the product of the CY 2006 RVUs, the CY 2006 CF, and the geographic adjustment for the CY 2012. The revised CY 2012 work, PE, and malpractice RVUs for *CPT* codes *77080* and *77082* are shown below.

RVUs for DXA *CPT* Codes *77080* and *77082*, January 1 – February 29, 2012

CPT code	Modifier	Work RVU	Fully implemented non-facility PE RVU	Transitional non-facility PE RVU	Fully implemented facility PE RVU	Transitional facility PE RVU	Malpractice RVU
77080		0.23	2.50	2.50	N/A	N/A	0.14
77080	TC	0.00	2.42	2.42	N/A	N/A	0.13
77080	26	0.23	0.08	0.08	0.08	0.08	0.01
77082		0.13	0.63	0.63	N/A	N/A	0.05
77082	TC	0.00	0.58	0.58	N/A	N/A	0.04
77082	26	0.13	0.05	0.05	0.05	0.05	0.01

Additional information

The official instruction, CR 7737, issued to your FI, RHHI, carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1015OTN.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: MM7737
Related Change Request (CR) #: 7737
Related CR Release Date: January 20, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1015OTN
Implementation Date: No later than January 26, 2012

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Revised *Medicare Physician Fee Schedule f*act sheet

The *Medicare Physician Fee Schedule fact sheet (ICN 006814)* has been revised and is now available in downloadable format. It includes information on physician services, therapy services, Medicare physician fee schedule (PFS) payment rates, and the Medicare PFS rates formula.

Source: CMS PERL 201201-42

Inpatient claims with POA-exempt diagnosis codes are being RTP with reason code 34931

Change request (CR) 7680 updates the list of *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)* codes exempt from present on admission (POA) reporting for discharges on or after October 1, 2011. This CR is scheduled for implementation July 2, 2012.

Inpatient claims submitted with an ICD-9-CM code containing a POA exemption, effective October 1, 2011, are currently being returned to the provider (RTP) with reason code 34931, requesting a valid POA indicator. The Centers for Medicare & Medicaid Services (CMS) has created a workaround to resolve this issue by adding a POA indicator "W" to the affected ICD-9-CM code *instead* of leaving it blank.

Instructions for submitting claims containing a POA exempt ICD-9-CM code, effective October 1, 2011:

1. Facilities should check the POA exempt diagnosis code listings for 2011 and 2012.
   - *2011 list* (go to page 7)
   - *2012 list*
2. If the code is on **both** lists, do not add a POA code and leave the field **blank**.
3. However, if the diagnosis code is only on the 2012 list, apply the "W" in the field. The following diagnosis codes were added to the exempt list, effective October 1, 2011, and require the "W."

ICD-9-CM codes		
747.31	V13.81	V23.87
747.32	V13.89	V54.82
747.39	V15.9	V58.68
V12.21	V19.11	V88.21
V12.29	V19.19	V88.22
V12.55	V23.42	V88.29

   Note: Only the codes listed above require the "W" POA indicator. If the "W" indicator is incorrectly added to other diagnosis codes, the claim will be RTP with reason code 34931. If you are still receiving reason code 34931 after coding your claim as indicated above, CMS recommends you add the "W" for those exempt diagnosis codes until the April release.
4. If the code is not on either list (meaning it is not exempt); facilities should apply the appropriate *POA indicator*. (**Note:** POA indicator "1" should not be reported.)
5. Resubmit (or PF9 – DDE submitters) the claim.

Source: TDL 12137

Hospital Value-Based Purchasing Program fact sheet available in hardcopy

The *"Hospital Value-Based Purchasing Program"* fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on the hospital value-based purchasing program, and includes information on how Medicare will make incentive payments to hospitals in fiscal year (FY) 2013 based on performance and scoring of clinical process of care measures and patient experience of care dimensions. To order hardcopies of this fact sheet, visit *http://www.CMS.gov/MLNProducts* and click on "MLN Product Ordering Page" under "Related Links Inside CMS" at the bottom 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 201201-42

Claims reprocessing for Section 508 extension and special exception hospitals reclassifications

Section 302 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) extends Section 508 reclassifications and certain special exception wage indexes for two months, from October 1, 2011, through November 30, 2011. For the period beginning on October 1, 2011, and ending on November 30, 2011, Section 302 also requires removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by Section 302 of the TPTCCA shall be assigned a special wage index effective for only October and November 2011. The Centers for Medicare & Medicaid Services (CMS) will apply the provision to both inpatient and outpatient hospital payments. For hospital outpatient payments only, special exception hospitals and other reclassified hospitals that would have a higher wage index based on the removal of Section 508 and special exception hospitals' wage data will receive a special exception wage index from January 1, 2012, through February 29, 2012.

Inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) claims from Section 508 hospitals, IPPS special exception hospitals and IPPS non Section 508 hospitals affected by section 302 with discharge dates on or after October 1, 2011, through November 30, 2011, will be reprocessed no later than December 31, 2012, in accordance with the TPTCCA.

OPPS claims for hospitals reclassified for special exceptions and other affected reclassified hospitals that completed processing before the wage index was updated will be reprocessed by early February, 2012.

Please note that for OPPS hospitals, a Section 508 hospital that has geographic reclassification extended from October 1, 2011, to November 30, 2011, will revert to its previously scheduled October 1, 2011, reclassification or its home area wage index from December 1, 2011, to December 31, 2011. OPPS special exception hospitals and reclassified hospitals that benefit based on removal of Section 508 and special exception hospital data shall revert to the calendar year (CY) 2012 rule wage index, beginning March 1, 2012. IPPS hospitals shall revert to their wage index promulgated in the fiscal year (FY) 2012 rule located on our website at *http://www.CMS.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?itemID=CMS1250520*.

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

Source: CMS PERL 201201-21

Instructions to teaching hospitals for reporting the IRS refund of medical resident FICA taxes

Provider types affected

This article is for teaching hospitals that file cost reports with Medicare contractors (Medicare administrative contractors (MACs) or fiscal intermediaries (FIs)).

Provider action needed

This article is based on change request (CR) 7685 which informs teaching hospitals and Medicare contractors of the proper way of reporting Internal Revenue Service (IRS) refunds of Medicare FICA taxes on cost reports. Teaching hospitals must work with their Medicare contractor to make any necessary changes by January 30, 2012, to their fiscal year (FY) 2009 cost reports to be used in the FY 2013 wage index. See the *Background* section for further details regarding this requirement.

Background

On March 2, 2010, the IRS made an administrative determination that medical residents are exempt from FICA taxes based on the student exception for tax periods ending before April 1, 2005. Recently, the IRS began contacting hospitals, universities, and medical residents who filed FICA (Social Security and Medicare tax) refund claims for these periods. The purpose of these instructions is to instruct the contractors to inform teaching hospitals (defined in section I.B. below) of the proper way to report the FICA refund for medical residents on the Medicare cost report. The FICA refund must be reported in such a way that it does not impact a hospital's wage-related costs used to compute the wage index under the hospital inpatient prospective payment system (IPPS).

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FICA...*continued*

However, cost reimbursement principles for cost reporting purposes must be followed on worksheet A.

The FICA refund has two parts. Under Part I, the IRS will refund FICA and Medicare taxes to the hospitals for the employer's share. Under Part II, the IRS will refund FICA and Medicare taxes to the hospitals for the resident employee's share and the hospitals must return the refund to the residents employed by the hospital between approximately 1994 and 2005. Although both refunds apply for tax periods ending before April 1, 2005, hospitals are receiving these refunds during cost reporting periods that occur during FYs 2009, 2010, or 2011. It is important that a hospital's wage-related costs are properly reported in these fiscal years, so as not to impact the calculation of the IPPS wage index for FYs 2013, 2014, or 2015.

Cost reports ending on or after April 30, 2011 are to be filed on the Form 2552-10. CR7685 instructs your contractor to provide the following cost reporting instructions to the teaching hospitals that they service. For purposes of this instruction, a "teaching hospital" is defined as a hospital that completed worksheet E, Part A for IME and/or worksheet E-3, Part IV for direct GME (or worksheet E-4 if applicable) on its cost report that was most recently submitted as of the time of issuance of this CR.

I. FICA refund Part I – hospital employer's share

a. Cost reporting on Worksheet A:

For cost reporting purposes, on worksheet A of both Forms 2552-96 and 2552-10 of the Medicare cost report, the FICA employer's portion of the refund must follow Medicare reimbursement principles in accordance with 42 CFR §413.98. Refunds of the employer portion of FICA costs from previous periods are to be treated as a reduction of the current cost reporting employer portion of FICA costs. If the teaching hospital reported the FICA employer's portion of expense net of the FICA refund on worksheet A, column 2, no adjustment is necessary on worksheet A-8. However, if the teaching hospital did not report the employer's portion of the FICA expense net of the FICA refund on worksheet A, column 2, the teaching hospital shall ensure that the employer's portion of the FICA refund is identified as a revenue offset on worksheet A-8. The FICA employer portion of expenses is classified as an employee benefit and shall be reported on worksheet A, in the employee benefits cost center. The refund of the FICA employer's portion shall be offset against the expense reported on worksheet A. If the FICA employer's portion of expenses is directly assigned to individual cost centers other than employee benefits, the teaching hospital shall offset the refund, not to exceed the total current year FICA expense, against the employee benefits cost center, as the residual costs of this cost center will be allocated through step-down accordingly.

b. Wage-related cost for the wage index:

1. It is possible that teaching hospitals filing on the Form 2552-96 and receiving their employer's share of the FICA refund have subtracted the refund amount from their current year FICA expense on line 17 (FICA-Employer's Portion Only) of the Form 339. For wage index purposes, the FICA refund to a teaching hospital for its employer's share is not to be used to reduce the current year employer's portion of FICA expense on worksheet S-3, Part II and Form 339 of Form 2552-96. Therefore, the employer's portion of the FICA refund must be added back to line 17 of the Form 339 so that line 17 and worksheet S-3, Part II, reflect the full FICA employer's portion of the expense incurred for that year.

2. If a teaching hospital is filing on the Form 2552-10, then for wage index purposes, the employer's portion of the FICA refund must be excluded from line 17 of worksheet S-3, Part IV so that line 17 reflects the FICA employer's portion of the expense incurred for that year.

   After ensuring that the FICA employer's portion of the expense incurred for the cost reporting year is properly reflected on line 17 of the Form 339 or worksheet S-3, Part IV as applicable, a teaching hospital shall also ensure that the FICA employer's portion of the expense for the year is properly reflected in its allocation of wage-related costs to lines 13 through 20 of worksheet S-3, Part II of the respective cost report.

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FICA...*continued*

II. FICA refund Part II – hospital resident employee's share

a. If a teaching hospital has already reported the resident employee's share of the FICA refund as an accrued expense on worksheet A, column 2, then the teaching hospital shall ensure that a revenue offset equal to that accrued expense is submitted on worksheet A-8. A teaching hospital shall identify this offset on worksheet A-8 as the "Resident employee FICA refund." The amount is accrued as an expense on worksheet A and the offset on worksheet A-8 must net to zero.

b. If a teaching hospital has not reported the "Resident" employee's share of the FICA refund as an accrued expense on worksheet A, or has not filed a cost report in which the employee's portion of the FICA refund is received, then upon receipt of the refund, the proper reporting for such refund is an offset of the actual or accrued employee portion of the FICA refund expense, resulting in a net of zero.

III. Interest earned on FICA refunds

The interest income earned on the employee and employer portions of the FICA refund is considered non-capital related and shall be offset against the interest expense that will be incurred in refunding the residents as well as any additional non-capital related interest expense.

IV. Timeline and instructions for implementation

Teaching hospitals shall work with their contractors to make any necessary changes by January 30, 2012, to their FY 2009 cost reports (that is, cost reports beginning on or after October 1, 2008) to be used in the FY 2013 wage index, so that the wage index will be calculated correctly for the FY 2013 Inpatient PPS proposed rule. CR 7685 makes an exception to the December 5, 2011 deadline specified in CR 7450 to allow hospitals to submit revisions to the contractors after December 5, 2011, but only for the purpose of CR 7685 to properly report the FICA tax refund. CR 7450 is otherwise unchanged. Under CR 7685, teaching hospitals must submit the revisions to their FY 2009 cost reports to their contractors by January 30, 2012.

Additional information

CR 7685 may be viewed at *http://www.cms.gov/Transmittals/downloads/R1017OTN.pdf*. If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7685 Revised
Related Change Request (CR) #: 7685
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Related CR Transmittal #: R1017OTN
Implementation Date: January 30, 2012

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Acute Care Hospital Inpatient Prospective Payment System fact sheet revised

The *"Acute Care Hospital Inpatient Prospective Payment System"* fact sheet (ICN 006815) has been revised and is available in downloadable format. This fact sheet includes information on payment background, the basis for the acute care hospital inpatient prospective payment system payment, payment rates, and how payment rates are set.

Source: CMS PERL 201201-35

January 2012 update of the hospital outpatient prospective payment system (OPPS)

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7672 which describes changes to the OPPS to be implemented in the January 2012 OPPS update.

Caution – what you need to know

CR7672, from which this article is taken:

1. Describes changes to, and billing instructions for, various payment policies implemented in the January 2012 OPPS update; and
2. Implements several changes and clarifications in the manual requirements for the provision of hospital outpatient therapeutic services, finalized in the "Calendar Year (CY) 2012 OPPS/Ambulatory Surgical Center (ASC) Final Rule."

Go – what you need to do

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

Background

CR 7672 describes changes to and billing instructions for various payment policies implemented in the January 2012 OPPS update. The January 2012 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS Modifier, and revenue code additions, changes, and deletions identified in this CR.

The January 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 7668, "January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0." (You can find the associated *MLN Matters*® article at *http://www.cms.gov/MLNMattersArticles/downloads/MM7668.pdf*.)

Key changes to and billing instructions for various payment policies implemented in the October 2010 OPPS update are as follows:

Physician supervision

In the *Medicare Benefit Policy Manual*, Chapter 6 (Hospital Services Covered Under Part B), Section 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010), CMS is making several revisions to the standards governing the supervision of hospital or critical access hospital (CAH) outpatient therapeutic services.

Currently, CMS requires the direct supervision of outpatient therapeutic services except for nonsurgical extended duration therapeutic services, for which CMS allows general supervision during a portion of the service at the discretion of the supervising practitioner.

CR 7672 provides that (effective January 1, 2012) CMS may assign general or personal supervision for the duration of the service to certain hospital outpatient therapeutic services. To enable such assignment, CMS is defining those levels of supervision using the definitions that are used in the Medicare physician fee schedule.

CR 7672 also provides (as specified in CMS regulations), that in addition to providing direct supervision certain non-physician practitioners may also furnish the required general or personal supervision.

New device pass-through categories

The Social Security Act (the Act) (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at

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OPPS...*continued*

least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2012. Table 1, below, provides a listing of new coding, status indicator (SI), ambulatory payment classification (APC), and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New device pass-through code

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	APC for device offset from payment
C1886	01-01-12	H	1886	Catheter, ablation	Catheter, extravascular tissue ablation, any modality (insertable)	0415

Device offset from payment for C1886

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct, from pass-through payments for devices, an amount that reflects the portion of the APC payment amount determined to be associated with the cost of the device. (Please see 2005 *Federal Register*, Vol. 70, page 68627-8 at *http://www.gpoaccess.gov/fr/retrieve.html*).

CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), in APC 0415, Level II, Endoscopy, lower airway. The device offset from payment represents this deduction from pass-through payments for category C1886, when it is billed with a service included in APC 0415. The device offset amount for APC 0415, along with the device offsets for other APCs, is available under "Annual Policy Files" at *http://www.cms.gov/HospitalOutpatientPPS/*.

Revised device offset from payment for category C1840

Effective January 1, 2012, device pass-through category C1840 must be billed with procedure code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens), (see *New procedure code* section below) to receive pass-through payment. C9732 is assigned to APC 0234, Level IV Anterior Segment Eye Procedures. Therefore, as of January 1, 2012, device C1840 will be used with an APC 0234 service. The new device offset for CY 2012 for APC 0234, is available under "Annual Policy Files" at *http://www.cms.gov/HospitalOutpatientPPS/*.

New procedure code

CMS is establishing one new procedure code, effective January 1, 2012. Table 2 provides a listing of the descriptor and payment information for this new code.

Table 2 – new procedure code

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor
C9732	01-01-12	T	0234	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens

Billing instructions for C9732 and C1840

Pass-through category C1840 (Lens, intraocular (telescopic)), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012.

Note: These billing instructions supersede prior billing instructions for C1830 provided in the October 2011 update of the OPPS, Transmittal 2296, CR 7545.

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OPPS...*continued*

Billing for thermal anal lesions by radiofrequency energy

For CY 2012, the *CPT*® editorial panel created new *CPT* code *0288T* (*Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence)*) to describe the procedure associated with radiofrequency energy creation of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and *0288T* were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and *CPT* code *0288T* was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by *CPT* code *0288T*, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with *CPT* code *0288T* effective January 1, 2012. In addition, *CPT* code *0288T* is being reassigned from APC 0148 to APC 0150 effective January 1, 2012. This change will be reflected in the January 2012 OPPS I/OCE and OPPS Pricer. Table 3 below lists the final OPPS status indicator and APC assignment for HCPCS codes C9716 and 0288T.

Table 3 – CY 2012 OPPS status indicator and APC assignment for HCPCS codes C9716 and 0288T

HCPCS code	Short descriptor	CY 2012 SI	CY 2012 APC
C9716	Radiofrequency energy to anu	D	N/A
0288T	Anoscopy w/rf delivery	T	0150

Cardiac resynchronization therapy payment for CY 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures and pacing electrode insertion procedures when performed on the same date of service.

CMS also is implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by *CPT* code *33225* (*Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)*) is billed without one of the primary *CPT* codes for insertion of an implantable cardioverter defibrillator or pacemaker as specified in the 2012 *CPT* code book. CMS is adding new Section 10.2.2 to the *Medicare Claims Processing Manual*, Chapter 4, to reflect the implementation of this new composite service policy and claims processing edits for *CPT* code *33225*.

Billing for drugs, biologicals, and radiopharmaceuticals

Reporting HCPCS codes for all drugs, biologicals, and radiopharmaceuticals

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

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is CMS' standard rate-setting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

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

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

New CY 2012 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4.

Table 4 – New CY 2012 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 SI	CY 2012 APC
A9585	Injection gadobutrol, 0.1 ml	N	N/A
C9287	Injection, brentuximab vedotin, 1 mg	G	9287
C9366	EpiFix, per square centimeter	G	9366
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K	1415
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	G	1416
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K	1417
J8561	Everolimus, oral, 0.25 mg	K	1418
Q4122	Dermacell, per square centimeter	K	1419

Other changes to CY 2012 HCPCS and *CPT* codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and *CPT* codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011, and replaced with permanent HCPCS codes in CY 2012. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT codes.

Table 5 displays those drugs, biologicals, and radiopharmaceuticals that have undergone changes in either their HCPCS/CPT codes, their long descriptors, or both. Each product's CY 2011 HCPCS/CPT code and CY 2011 long descriptor are noted in the two left hand columns, with the CY 2012 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

Table 5 – Other CY 2012 HCPCS and *CPT* code changes for certain drugs, biologicals, and radiopharmaceuticals

CY 2011 HCPCS/ *CPT* code	CY 2011 long descriptor	CY 2012 HCPCS/ *CPT* code	CY 2012 long descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg

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CY 2011 HCPCS/ *CPT* code	CY 2011 long descriptor	CY 2012 HCPCS/ *CPT* code	CY 2012 long descriptor
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273***	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561**	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/ Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco

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CY 2011 HCPCS/ *CPT* code	CY 2011 long descriptor	CY 2012 HCPCS/ *CPT* code	CY 2012 long descriptor
Q1079	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

**HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.*

*** The short descriptor for HCPCS code J1561 has been revised from "Gamunex/Gamunex C" to "Gamunex, Gamunex-C, Gammaked" effective January 1, 2012.*

**** HCPCS code C9273 was replaced with HCPCS code Q2043 effective July 1, 2011.*

Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2012

For CY 2012, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, a single payment of ASP + 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payment for drugs and biologicals with pass-through status for the first quarter of CY 2012 is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was postponed beginning January 1, 2009.

Should the Part B Drug CAP program be reinstituted sometime during CY 2012, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2012 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2012, payment rates for many drugs and biologicals have changed from the values published in the CY 2012 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2011.

In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2012 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this instruction implementing the January 2012 update of the OPPS. However, the updated payment rates effective January 1, 2012 can be found in the January 2012 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp*.

Updated payment rates for certain HCPCS codes effective October 1, 2011, through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 6 and have been installed in the January 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. Your Medicare contractor will adjust any claims related to the changes shown in Table 6, provided you make the contractor aware of such claims.

Table 6 – Updated payment rates for certain HCPCS codes effective October 1, 2011, through December 31, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9600	K	0856	Porfimer sodium injection	$19,143.46	$3,828.69
Q4121	K	1345	Theraskin	$20.77	$4.15

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Correct reporting of biologicals when used as implantable devices

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

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

Hospitals are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the *CPT* codes describing application of a skin substitute (*15271-15278*). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

Payment for therapeutic radiopharmaceuticals

Beginning in CY 2010, non-pass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2012, the status indicator for separately payable therapeutic radiopharmaceuticals is “K” to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for non-pass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 7 – Non-pass-through separately payable therapeutic radiopharmaceuticals for January 1, 2012

CY 2012 HCPCS code	CY 2012 long descriptor	Final CY 2012 APC	Final CY 2012 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K

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CY 2012 HCPCS code	CY 2012 long descriptor	Final CY 2012 APC	Final CY 2012 SI
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

Payment offset for pass-through diagnostic radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR 6416, pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. (You can find the associated *MLN Matters*® article at *http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf*).

Effective July 1, 2011, the diagnostic radiopharmaceutical reported with HCPCS code A9584 (Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." HCPCS code A9584 will continue on pass-through status for CY 2012 and therefore, when HCPCS code A9584 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9584 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The "policy-packaged" portions of the CY 2012 APC payments for nuclear medicine procedures may be found on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage* in the download file labeled 2012 OPPS Offset Amounts by APC.

CY 2012 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table:

Table 8 – APCs to which nuclear medicine procedures are assigned for CY 2012

CY 2012 APC	CY 2012 APC title
0308	Positron Emission Tomography (PET) Imaging
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.

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CY 2012 APC	CY 2012 APC title
0406	Level I Tumor/Infection Imaging.
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

Payment offset for pass-through contrast agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20.00 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR6751, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made. You can find the *MLN Matters*® article associated with this CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf*.

CY 2012 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 9. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used.

For CY 2012, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in the table on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2012, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. HCPCS code C9275 is assigned a status indicator of "G". Therefore, in CY 2012, CMS will reduce the payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast enhanced procedure reported on the same claim on the same date as HCPCS code C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table

The "policy-packaged" portions of the CY 2012 APC payments that are the offset amounts may be found on the CMS website at: *http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp* in the download file labeled "2012 OPPS Offset Amounts by APC."

Table 9 – APCs to which a pass-through contrast agent offset may be applicable for CY 2011

CY 2012 APC	CY 2012 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Level II Endovascular Revascularization of the Lower Extremity
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast

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CY 2012 APC	CY 2012 APC Title
0333	Computed Tomography without Contrast followed by Contrast
0334	Combined Abdomen and Pelvis CT with Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Clarification of coding for drug administration services

As noted in CR 7271, in 2011 CMS revised the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 230.2 (Coding and Payment for Drug Administration)), to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, CMS noted that beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. CMS has subsequently become aware of new *CPT* guidance regarding the reporting of initial drug administration services in the event of a disruption in service; however, Medicare contractors are to continue to follow the guidance given in this manual. (You can find the associated *MLN Matters*® article at *http://www.cms.gov/MLNMattersArticles/downloads/MM7271.pdf* and this manual reference at *http://www.cms.gov/manuals/downloads/clm104c04.pdf*).

Provenge® administration

Effective July 1, 2010, the autologous cellular immunotherapy treatment reported with HCPCS code C9273 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) was granted pass-through status under OPPS and assigned status indicator "G." Effective July 1, 2011, this product was assigned to HCPCS code Q2043 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) with status indicator "G." HCPCS code Q2043 will continue on pass-through status for CY 2012.

Please note that the HCPCS long descriptor for CY 2012 for HCPCS code Q2043 includes payment for the drug itself, as well "all other preparatory procedures," referring 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. Payment for Q2043 does not include OPPS payment for drug administration.

Billing for screening and behavioral counseling interventions in primary care to reduce alcohol misuse – national coverage determination (NCD)

Effective for claims with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening, and for those who screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: 1) who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and 2) who are competent and alert at the time that counseling is provided; and 3) whose

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counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting. In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

To implement this recent coverage determination, CMS created two new G-codes to report annual alcohol screening and brief, face-to-face behavioral counseling interventions. The long descriptors for both G-codes appear in Table 10.

Table 10 – Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 status indicator	CY 2012 APC
G0442	Annual alcohol misuse screening, 15 minutes	S	0432
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	S	0432

Further reporting guidelines on "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" can be found in Pub. 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Section 210.8 and Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 180, as well as in Transmittals 138, and 2358, CR 7633 that was published on November 23, 2011. The related *MLN Matters*® on this NCD is at *http://www.cms.gov/MLNMattersArticles/downloads/MM7633.pdf*.

Screening for depression in adults – NCD

Effective for claims with dates of service on and after October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the annual depression screening. The long descriptor for the G-code appears in Table 11.

Table 11 – Annual depression screening

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 status indicator	CY 2012 APC
G0444	Annual depression screening, 15 minutes	S	0432

Further reporting guidelines on depression screening can be found in Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 210.9 and Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 190, as well as in Transmittals 139 and 2359, CR 7637 that was published on November 23, 2011. The *MLN Matters*® article on this NCD is at *http://www.cms.gov/MLNMattersArticles/downloads/MM7637.pdf*.

Billing for sexually transmitted infections (STIs) screening and high intensity behavioral counseling (HIBC) to prevent STIs – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with Dates of Service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for high intensity behavioral counseling (HIBC) to prevent sexually transmitted infections (STIs) for all sexually active

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OPPS...*continued*

adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report HIBC to Prevent STIs. The long descriptor for the G-code appears in Table 12.

Table 12 –STIs screening and HIBC to prevent STIs

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 status indicator	CY 2012 APC
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	S	0432

HCPCS code G0445 has been assigned to APC 0432 and given a status indicator assignment of "S." Further reporting guidelines on HIBC to prevent STIs will be provided in a future CR.

CMS is deleting screening code G0450 (Screening for sexually transmitted infections, includes laboratory tests for Chlamydia, Gonorrhea, Syphilis, and Hepatitis B) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 8, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

Billing for intensive behavioral therapy for cardiovascular disease – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit), which consists of the following three components: 1) encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years; 2) screening for high blood pressure in adults age 18 years and older; and 3) intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease. Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. For the purposes of this NCD , a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the CVD risk reduction visit. The long descriptor for the G-code appears in Table 13.

Table 13 – Intensive behavioral therapy for cardiovascular disease

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 status indicator	CY 2012 APC
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes	S	0432

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Further reporting guidelines on intensive behavioral therapy for cardiovascular disease can be found in 100-03, *Medicare National Coverage Determinations Manual*, Pub. Chapter 1, Section 210.11 and Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 160, as well as in Transmittals 137 and 2357, CR 7636 that was published on November 23, 2011. The *MLN Matters*® article on this NCD is at *http://www.cms.gov/MLNMattersArticles/downloads/MM7636.pdf*.

Intensive behavioral therapy for obesity – NCD

Effective for claims with dates of service on and after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m2), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for: 1) One face to face visit every week for the first month; 2) One face to face visit every other week for months 2-6; and 3) One face to face visit every month for months 7-12.

To implement this recent coverage determination, CMS created a new G-code to report counseling for obesity. The long descriptor for the G-code appears in Table 14.

Table 14 – Intensive behavioral therapy for obesity

CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 status indicator	CY 2012 APC
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	S	0432

Further reporting guidelines on intensive behavioral therapy for obesity will be provided in a future CR.

CMS is deleting screening code G0449 (Annual face to face obesity screening, 15 minutes) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 29, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

Payment window for outpatient services treated as inpatient services

CMS is revising its billing instructions to clarify that in situations where there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were. See the *Medicare Claims Processing Manual*, Chapter 4, Section 10.12 and Chapter 1, Section 50.3.2 for the updated billing guidelines.

Partial hospitalization APCs

For CY 2012, CMS is updating the four PHP per diem payment rates based on the median costs calculated using the most recent claims data for each provider type: two for CMHCs (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a community mental health center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176. The tables below provide the updated per diem payment rates:

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Table 15 – CY 2011 median per diem costs for CMHC PHP services plus transition

APC	Group title	Median per diem costs plus transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	$97.64
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$113.83

Table 16 – CY 2011 median per diem costs for hospital-based PHP services

APC	Group title	Median per diem costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$160.74
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$191.16

Molecular pathology procedure test codes

The American Medical Association's (AMA) *CPT* editorial panel created 101 new molecular pathology procedure test codes for CY 2012. These new codes are in the following *CPT* code range: *81200-81299, 81300-81383,* and *81400-81408*. For payment purposes under the hospital OPPS these test codes will be assigned to status indicator "E" (Not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available) effective January 1, 2012. These new codes will be listed in the January 2012 OPPS Addendum B, which can be downloaded from *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp*.

Please note that each of the new molecular pathology procedure test code represents a test that is currently being utilized and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understand that existing *CPT* test codes are "stacked" to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare in the following manner – *83891* (one time) + *83898* (multiple times) + *83904* (multiple times) + *83909* (multiple times) + *83912* (one time) – in order to represent the performance of the entire test. If the new *CPT* test coding structure were active, Laboratory A would bill Medicare the new, single *CPT* test code that corresponds to the test represented by the "stacked" codes in the example above rather than billing each component of the test separately.

Effective January 1, 2012, under the hospital OPPS, hospitals are advised to report both the existing *CPT* "stacked" test codes that are required for payment and the new single *CPT* test code that would be used for payment purposes if the new *CPT* test codes were active. Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment [i.e., *83891* (one time) + *83898* (multiple times) + *83904* (multiple times) + *83909* (multiple times) + *83912* (one time)] along with the new, single *CPT* test code that corresponds to the test represented by the "stacked" test codes.

Use of modifiers for discontinued services (modifiers 52, 53, 73, and 74)

CMS is revising the guidance related to use of modifiers for discontinued services in the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.4.

Changes to OPPS Pricer logic

a) Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2012. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of Pub. L. 108-173.

b) New OPPS payment rates and copayment amounts will be effective January 1, 2012. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2012 inpatient deductible.

c) For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2012. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier

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payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d) However, there will be a change in the fixed-dollar threshold in CY 2012. The estimated cost of a service must be greater than the APC payment amount plus $1,900 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2011 was $2,025.

e) For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2012. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f) Effective January 1, 2012, 4 devices are eligible for pass-through payment in the OPPS Pricer logic. Categories C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable)) and C1830 (Powered bone marrow biopsy needle) have an offset amount of $0 because CMS is not able to identify portions of the APC payment amounts associated with the cost of the devices. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY2012. Pass-through offset amounts are adjusted annually. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g) Effective January 1, 2012, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h) Effective January 1, 2012, there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, the Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2012 APC payments for nuclear medicine procedures and may be found on the CMS website.

i) Effective January 1, 2012, there will be 1 contrast agent receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the “policy-packaged” portions of the CY 2012 APC payments for procedures using contrast agents and may be found on the CMS website.

j) Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k) Effective January 1, 2012, CMS is adopting the FY 2012 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of Pub. L. 108-173 to non-IPPS hospitals discussed below.

Coverage determinations

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

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Additional information

You can find the official instruction, CR 7672, was issued to your FI, A/B MAC, or RHHI via two transmittals. The first transmittal revises the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R152BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* at *http://www.cms.gov/Transmittals/downloads/R2376CP.pdf*.

You will find the revised *Medicare Benefit Policy Manual*, Chapter 6 (Hospital Services Covered Under Part B), Sections 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010) and 20.5.2 (Coverage of Outpatient Therapeutic Services Incident to a Physicians Service Furnished on or After January 1, 2010); and the revised *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 50.3.2 (Policy and Billing Instructions for Condition Code 44), and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Sections 10.2.2 (Cardiac Resynchronization Therapy), 10.12 (Payment Window for Outpatient Services Treated as Inpatient Services), 20.6.4 (Use of Modifiers for Discontinued Services), and 10.2.1 (Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes) as an attachment to that CR.

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

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Implementation Date: January 3, 2012

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Announcing – updates to 'Intern and Resident Information System (IRIS)' software

The provider community and teaching hospitals shall take notice of three updated files (medical school codes, residency type codes, and IRISV3 operating instructions as of December 2011) in the IRIS software programs (IRISV3 and IRISEDV3) for collecting and reporting information on resident training in hospital and non-hospital settings:

- The Centers for Medicare & Medicaid Services (CMS) added 62 new IRIS residency type codes to the IRIS residency code table; 47 of these codes are revised codes for 48 obsolete allopathic and osteopathic residency type codes. Providers may begin using the revised codes for cost reporting periods beginning before Sunday, July 1, 2012; however, these codes shall be used for cost-reporting periods beginning on or after Sunday, July 1, 2012.
- CMS also added 15 new IRIS medical school codes to the IRIS medical school code table.
- Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after Friday, September 30, 2011.

The IRIS programs are available for download at *http://www.CMS.gov/IRIS*.

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

Source: CMS PERL 201201-41

Allowing physician assistants to perform SNF level of care certifications and recertifications

Provider types affected

Skilled nursing facilities (SNFs) and swing-bed hospitals that bill Medicare contractors (fiscal intermediaries (FIs) or A/B Medicare administrative contractors (A/B MACs)) for providing Part A SNF services to Medicare beneficiaries are affected.

What providers need to know

This article is based on change request (CR) 7701, which implements Section 3108 of the Affordable Care Act. This section adds physician assistants to the list of practitioners who can perform SNF level of care certifications and recertifications. Performing this function is a requirement for Medicare coverage of SNF services under Part A. CR 7701 directs Medicare contractors to recognize that, effective with services furnished on or after January 1, 2011, physician assistants can perform the required initial certification and periodic recertifications of a beneficiary's need for a SNF level of care.

Note: Contractors will reopen and reprocess any claims brought to their attention for Part A SNF services that were mistakenly denied (prior to this update) based on having a physician assistant complete the required SNF level of care certification or recertification. However, contractors will not search claims history to identify these claims.

Additional information

The official instruction, CR 7701, was issued to your FI or A/B MAC regarding this change via two transmittals. The first modifies the *Medicare General Information, Eligibility, and Entitlement Manual* and it may be viewed at *http://www.cms.gov/transmittals/downloads/R76GI.pdf*. The second updates the *Medicare Benefit Policy Manual*, which is available at *http://www.cms.gov/Transmittals/downloads/R153BP.pdf*. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Implementation Date: February 13, 2012

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Temporary workaround for the assessment reference date reason code 31742 for SNF and swing bed claims

The Centers for Medicare & Medicaid Services (CMS) has developed a workaround for skilled nursing facility (SNF) and swing bed (SB) claims incorrectly returned to the provider for assessment reference date (ARD) reason code 31742 to allow these claims to process. Providers with claims returned due to the incorrect application of this reason code should send them back to Medicare for processing. Be sure to bill the correct ARDs with occurrence code 50 prior to sending these claims to Medicare for processing.

Source: CMS PERL 201201-16

Revised FY 2012 SNF PC Pricer available

The fiscal year (FY) 2012 skilled nursing facility (SNF) PC Pricer has been revised to correct an intermittent problem. The corrected version has been posted to the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/PCPricer/04_SNF.asp*, under the "Skilled Nursing Facilities (SNF PPS) PC Pricer." If you use the FY 2012 SNF PC Pricer, please go to the page above and download the revised version.

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

Source: CMS PERL 201201-20

Video slideshow presentation "Skilled Nursing Facility PPS MDS 3.0 and RUG-IV Policies and Clarifications" available on CMS YouTube channel

The Centers for Medicare & Medicaid Services (CMS) has posted a video slideshow presentation from the Thursday, November 3, 2011, national provider call on the *"Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Minimum Data Set (MDS) 3.0 and Resource Utilization Group-Version 4 (RUG-IV) Policies and Clarifications"* to the *CMS YouTube channel*.

During this national provider call, CMS subject matter experts provided an overview of the policies, along with clarifications on the SNF PPS fiscal year (FY) 2012 policies related to the MDS 3.0. The agenda included:

- Allocation of group therapy
- Changes to the MDS assessment schedule
- End of therapy (EOT) other Medicare required assessment (OMRA) clarifications
- End of therapy with resumption (EOT-R)
- Change of therapy (COT) OMRA
- Question and answer session

For more information on SNF PPS and other available educational resources, please visit the *SNF PPS FY2012 RUG-IV Education & Training Web page*.

Source: CMS PERL 201201-33

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ESRD PPS and consolidated billing for limited Part B services

Note: This article was revised on December 21, 2011, to clarify the cost report language for low volume facility adjustments. All other information remains the same. This information was previously published in the February 2011 *Medicare A Bulletin*, pages 49-52.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7064 which announces the implementation of an end-stage renal disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

Caution – what you need to know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Go – what you need to do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the *Background* and *Additional information* sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331*) requires the Centers for Medicare & Medicaid services (CMS) to implement an end-stage renal disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

Wage levels among the areas in which ESRD facilities are located;

- Patient-level adjustments for case-mix;
- An outlier adjustment (if applicable);
- Facility-level adjustments;
- A training add-on (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;

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ESRD...*continued*

2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training add-on

Facilities that are certified to furnish training services will receive a **training add-on payment amount of $33.44**, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments specific to pediatric patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

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

ESRD PPS 4-year phase-in (transition) period

The ESRD PPS provides ESRD facilities with a four-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS four-year transition period blended rate determination

Calendar year	Blended rate
2011	75 percent of the old payment methodology, and 25 percent of new PPS payment
2012	50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For calendar year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The **ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to

continued on next page

ESRD...*continued*

determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD Pricer will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three new adjustments applicable to the adult rate

1. **Comorbid adjustments**: The new ESRD PPS provides for three categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than four consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The three chronic comorbid categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma) and
   - Myelodysplastic syndrome.

   The 3 acute comorbid categories eligible for a payment adjustment are:
   - Bacterial pneumonia;
   - Gastrointestinal bleeding; and
   - Pericarditis.
2. **Onset of dialysis adjustment**: An adjustment will be made for patients that have Medicare ESRD coverage during their first four months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS Form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. **Low-volume facility adjustment**: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

Change in processing home dialysis claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Consolidated billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Other billing reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue

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ESRD...*continued*

code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.

- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign group code CO.
- All 72x claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2134CP.pdf*. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits;
- Attachment 5, which contains a list of DME ESRD supply HCPCS codes that are NOT payable to DME suppliers;
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

Also see MM7388 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7388.pdf*) for the criteria for a low volume facility and instructions on how to receive the ESRD low volume adjustment for low volume facilities.

You may also want to review the following articles:

- *MLN Matters*® article MM7476 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7476.pdf*), which alerts providers to changes to Attachments 4, 5 and 8 of CR 7064; and
- MM7497 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7497.pdf*), which informs independent laboratories (ILs) that effective January 1, 2012, CMS has eliminated the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. It states that organ disease panels will be paid under the clinical laboratory fee schedule and will not be subject to the 50/50 rule when billed by ILs.

If you have any questions, please contact your carriers, DME MACs, FIs, and/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: MM7064 Revised
Related Change Request (CR) #: 7064
Related CR Release Date: January 14, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2134CP
Implementation Date: January 3, 2011

Educational Events

Upcoming provider outreach and educational events – February 2012

Medicare Part A "Ask the contractor teleconference" (ACT) webcast

When: Tuesday, February 7
Time: 2:00 – 3:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Virtual Medifest 2012: Where Knowledge and Medicare Connect

When: February 28-March 1
Time: 10:00 a.m. – 4:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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

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

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking 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

January is National Glaucoma Awareness Month

With January designated as National Glaucoma Awareness Month, the Centers for Medicare & Medicaid Services (CMS) asks you to join it in promoting increased awareness of glaucoma and the glaucoma screening service covered by Medicare. Today, more than 2.2 million Americans age 40 and older have open angle glaucoma, the most common form of glaucoma, and at least half don't even know they have it. Through early detection and treatment, you can help prevent blindness.

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

Medicare's coverage of glaucoma screening includes a dilated eye examination with an intraocular pressure (IOP) measurement and a direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the vision of your patients who may be at high-risk for glaucoma by educating them about their risk factors and reminding them of the importance of getting an annual glaucoma screening exam covered by Medicare.

For more information

- *The CMS Glaucoma Screening Brochure*
- *The CMS Guide to Medicare Preventive Services (see Chapter 7)*
- *The MLN Preventive Services Educational Products Web page*
- *The National Eye Institute*

Thank you for joining CMS in promoting increased awareness of glaucoma and the glaucoma screening benefit covered by Medicare.

Source: CMS PERL 201201-34

New and revised preventive resources available from the *MLN*®

"Medicare Preventive Services Series: Part 2," – WBT revised

This Web-based training course (WBT) is designed to provide education on Medicare preventive services. It includes information on Medicare's coverage for the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysm (AAA), screening electrocardiogram (EKG), annual wellness visit (AWV), cardiovascular screening blood tests, diabetes-related services, human immunodeficiency virus (HIV) screening, and smoking and tobacco-use cessation counseling services.

To access the WBT, visit the *MLN® products* page, scroll to the "Related Links Inside CMS," and select the "Web-Based Training (WBT) Courses."

"Preventive Services Educational Resources for Health Care Professionals" – *MLN Matters*® article released

The new *"Preventive Services Educational Resources for Health Care Professionals"* *MLN Matters*® special edition article (#SE1142) is designed to provide education on available educational resources related to Medicare-covered preventive services. It includes a list of *MLN*® products that can help Medicare fee-for-service (FFS) providers understand coverage, coding, reimbursement, and billing requirements related to these services.

Source: CMS PERL 201201-35

Medicare Quarterly Provider Compliance Newsletter released

The new *"Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 2]" (ICN 907703)* has been released in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program and highlights the top issues of the particular quarter. Please visit *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf* to download, print, and search an archive of previously-issued newsletters.

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

Source: CMS PERL 201201-42

Federally Qualified Health Center fact sheet revised

The revised *"Federally Qualified Health Center"* (FQHC) fact sheet (ICN 006397) includes the following information: background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC prospective payment system; FQHC payments; and Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact FQHCs.

Source: CMS PERL 201201-35

Updates from the *Medicare Learning Network®*

New *Medicare Coverage of Radiology and Other Diagnostic Services* fact sheet released

A new *"Medicare Coverage of Radiology and Other Diagnostic Services"* fact sheet (ICN 907164) has been released in downloadable format. This fact sheet is designed to provide education on Medicare coverage and billing information for radiology and other diagnostic services, and it includes specific information concerning billing and coding requirements and an overview of coverage guidelines.

New fast fact on *MLN®* Provider Compliance Web page

A new fast fact is now available on the *MLN® Provider Compliance* Web page. This page provides the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month.

Items and Services That Are Not Covered Under the Medicare Program booklet and *Medicare Claim Submission Guidelines* fact sheet now available in hardcopy

The *"Items and Services That Are Not Covered Under the Medicare Program"* booklet (ICN 906765), available now in hardcopy, 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.

The *"Medicare Claim Submission Guidelines"* fact sheet (ICN 906764), available now in hardcopy as well, includes information about applying for a National Provider Identifier and enrolling in the Medicare program, filing Medicare claims, and private contracts with Medicare beneficiaries.

Medicare Claim Review Programs booklet revised

The revised *"Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC"* booklet (ICN 006973) is designed to provide education on the different Centers for Medicare & Medicaid Services (CMS) claim review programs and assist providers in reducing payment errors, including, in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including medical review, recovery audit contractor, and the comprehensive error rate testing program.

continued on next page

Updates...*continued*

Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) fact sheet revised

This revised *"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)"* fact sheet (ICN 904084) is designed to provide education on SBIRT, an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

MLN® guided pathways (basic, A, and B) provider-specific resource booklets revised

The revised *MLN*® guided pathways curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-based PECOS equivalents). The resource booklets are:

- *MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers*
- *MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Providers (Part A)*
- *MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Professionals and Suppliers (Part B)*

MLN Guided Pathways Provider-Specific resource booklet revised

The revised *"MLN Guided Pathways to Medicare Resources"* provider-specific resource booklet provides various specialties of health care professionals, (physicians, chiropractors, optometrists, podiatrists), nurses (advanced practice nurses, clinical nurse specialist, nurse practitioner, midwife) physician assistants, social workers, psychologists, therapists (occupational, physical, speech-language pathology), dietitians, nutritionists, suppliers (ambulance, ambulatory surgical center, durable medical equipment, prosthetics, orthotics, and supplies, federally qualified health center, rural health clinic, labs, mammography, radiation therapy, portable X-ray), and providers (community mental health center, comprehensive outpatient rehabilitation facility, end-stage renal disease, home health agency, hospice, outpatient physical therapy, pathology and skilled nursing facility) with resources specific to their specialty including *Internet-Only Manuals* (IOMs), *Medicare Learning Network*® publications, Centers for Medicare & Medicaid Services (CMS) Web pages, and more. This version includes the addition of pathways for anesthesiology assistants/certified registered nurse anesthetists, anesthesiologists, ophthalmologists, and optometrists along with a fully developed pathway for mass immunization roster biller.

All of the *MLN*® guided pathways booklets above are available at *http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp*.

Advanced Payment Accountable Care Organization Model fact sheet available

The new *"Advanced Payment Accountable Care Organization Model"* fact sheet (ICN 907403) is designed to provide education on the advance payment model for accountable care organizations (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.

Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program fact sheet available

The new *"Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program"* fact sheet (ICN 907404) is designed to provide education on the provisions of the final rule that implements the Medicare shared savings program with accountable care organizations (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.

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

The new *"Improving Quality of Care for Medicare Patients: Accountable Care Organizations"* fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

continued on next page

Updates...*continued*

Provider exhibit program

Reminder – mark your calendars. The *Medicare Learning Network*® will be exhibiting at the following health care provider conferences in the coming weeks:

- American College of Preventive Medicine 2012

  Wednesday, February 22, 2012, through Saturday, February 25, 2012

  Buena Vista Palace, Booth #11; Orlando, Fla.
- American Medical Group Association (AMGA) 2012 Annual Conference

  Wednesday, March 7, 2012, through Saturday, March 10, 2012

  Manchester Grand Hyatt; San Diego, Calif.
- American Medical Student Association

  Thursday, March 8, 2012, through Sunday, March 11, 2012

  Hyatt Regency Houston, Booth #12; Houston, Texas
- American College of Cardiology (ACC.12) 61st Annual Scientific Session & Expo

  Saturday, March 24, 2012, through Monday, March 26, 2012

  Chicago, Ill.
- National Hospice and Palliative Care Organization

  Thursday, March 29, 2012, through Saturday, March 31, 2012

  National Harbor, Md.

Please make a note of these dates and locations and add them to your calendar. If you are interested in having a Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*® exhibit at your event, contact us at *MLNexhibits@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 201201-35

November 17 ICD-10 call – video slideshow presentation and podcasts available

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation and podcasts from the November 17 national provider call on "ICD-10 Implementation Strategies and Planning."

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today.

YouTube video slideshow presentation

Did you miss the November 17 ICD-10 National Provider Call? The call presentation is now available on the CMS YouTube channel as a video slideshow that includes the call audio with captions.

To access the YouTube video slideshow presentation, select the link in the "Related Links Outside CMS" section of the Web page at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081*.

Podcasts

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 November 17 ICD-10 call:

- Podcast 1 of 4: Introduction, General ICD-10 Requirements, and CMS Implementation Planning
- Podcast 2 of 4: General Implementation Planning and Strategies

continued on next page

ICD-10...*continued*

- Podcast 3 of 4: National Committee on Vital and Health Statistics (NCVHS) Meeting Update and Medicare fee-for-service (FFS) Claims Processing, Billing, and Reporting Guidelines
- Podcast 4 of 4: Question and Answer Session

The podcasts are now available on the CMS website at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081*.

The four podcasts with corresponding written transcripts, as well as the complete audio file and complete written transcript can be accessed by scrolling to the "Downloads" section at the bottom 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 201201-07

Video slideshow presentations from ICD-10 national provider calls available on CMS YouTube channel

Is your organization preparing for a smooth transition to ICD-10 on Tuesday, October 1, 2013? ICD-10 national provider calls, hosted by the Centers for Medicare & Medicaid Services (CMS) provider communications group, can help you prepare for the U.S. health care industry's change from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding.

Video slideshow presentations from the following national provider calls are available on the *CMS YouTube channel*. These video slideshows include the call slide presentation and audio with captions; each call includes presentations by CMS subject matter experts, followed by a question and answer session.

- ICD-10 Implementation Strategies and Planning – Thursday, November 17, 2011

  The ICD-9-CM and ICD-10 Cooperating Parties – CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the Centers for Disease Control and Prevention (CDC) – discuss ICD-10 implementation strategies and planning, and the CMS provider billing group discuss the Medicare fee-for-service (FFS) claims processing guidance issued in August 2011.
- ICD-10 Implementation Strategies for Physicians – Wednesday, August 3, 2011

  CMS subject matter experts discuss how physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding and provide updates on national ICD-10 implementation issues affecting all providers.
- CMS ICD-10 Conversion Activities – Wednesday, May 18, 2011

  CMS subject matter experts discuss the ICD-10 conversion process currently taking place within CMS, including a case study from the coverage and analysis group on their transition to ICD-10 for the lab national coverage determinations (NCDs).

Podcasts, complete audio files, and complete written transcripts for these ICD-10 national provider calls are also available on the CMS ICD-10 Web page at *http://www.CMS.gov/ICD10/Tel10/list.asp*.

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out 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 201201-32

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