Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

February 2012

In this issue

Proposed new steps to protect taxpayer dollars

Affordable Care Act gives new authority to recover overpayments more quickly

On Tuesday, February 14, the Centers for Medicare & Medicaid Services (CMS) proposed that providers and suppliers must report and return self-identified overpayments either within 60 days of the incorrect payment being identified or on the date when a corresponding cost report is due, whichever is later.

The new announcement is one in a series of steps Medicare is taking to protect taxpayer dollars, including efforts to prevent overpayments from occurring. These efforts include letting private auditors working on behalf of Medicare catch wasteful spending before it happens, by expanding the use of recovery audit contractors; testing changes to outdated hospital billing systems to help prevent over-billing; and changing processes for approving payments for medical equipment with high error rates.

A Medicare overpayment means any funds that a person receives or retains under Medicare to which the person is not entitled. Examples of overpayments in Medicare include:

- Duplicate submission of the same service or claim
- Payment to the incorrect payee
- Payment for excluded or medically-unnecessary services
- Payment for non-covered services

Before the Affordable Care Act, providers did not face an explicit deadline for returning taxpayers' money. Thanks to the Affordable Care Act, there will be a specific timeframe by which overpayments must be reported returned. Any failure to report and return the overpayment within the applicable time frame could be a violation of the False Claims Act. Providers also could be subject to civil monetary penalties or excluded from participating in federal health care programs for failure to report and return an overpayment.

To read the proposed rule that would require providers and suppliers receiving funds under the Medicare program to report and return overpayments within specific timeframes, visit *http://www.FederalRegister.gov/a/2012-03642*.

The full text of this excerpted CMS press release (issued Tuesday, February 14) can be found at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4266*.

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

Source: CMS PERL 201202-38

Contents

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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.

Release of reports on improved access to preventive services under the Affordable Care Act

Affordable Care Act *extended free preventive services to 54 million Americans with private health insurance in 2011; free preventive care also provided to 32.5 million in Medicare*.

The Department of Health & Human Services (HHS) secretary, Kathleen Sebelius, announced on Wednesday, February 15 that the Affordable Care Act provided approximately 54 million Americans with at least one new free preventive service in 2011 through their private health insurance plans, and that an estimated 32.5 million people with Medicare received at least one free preventive benefit, including the new annual wellness visit. Together, this means an estimated 86 million Americans were helped by health reform's prevention coverage improvements. The new data was released in two new reports from HHS.

The Affordable Care Act requires many insurance plans to provide coverage without cost-sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults. The law also makes proven preventive services free for most people on Medicare.

The report on private health insurance coverage also examined the expansion of free preventive services in minority populations. The results showed that an estimated 6.1 million Latinos, 5.5 million blacks, 2.7 million Asian Americans, and 300,000 Native Americans with private insurance received expanded preventive benefits coverage in 2011 as a result of the new health care law.

The report discussing Medicare preventive services found that more than 25.7 million Americans in traditional Medicare received free preventive services in 2011. The report also looked at Medicare Advantage plans and found that 9.3 million Americans – 97 percent of those in individual Medicare Advantage plans – were enrolled in a plan that offered free preventive services. Assuming that people in Medicare Advantage plans utilized preventive services at the same rate as those with traditional Medicare, an estimated 32.5 million people benefited from Medicare's coverage of prevention with no cost-sharing.

The full report on expanded preventive benefits in private health insurance is available at *http://aspe.HHS.gov/health/reports/2012/PreventiveServices/ib.shtml*. The report on expanded preventive benefits in Medicare and other ways that the Affordable Care Act strengthens Medicare is available at *http://www.CMS.gov/newsroom*.

The full text of this excerpted HHS press release (issued Wednesday, February 15) can be found at *http://www.HHS.gov/news/press/2012pres/02/20120215a.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 201202-49

Affordable Care Act announcements

Care Innovation Summit builds on Affordable Care Act; highlights private and public innovations to improve health care quality and lower costs

Obama Administration officials and a breadth of representatives from across the health care system met in Washington Thursday, January 26, 2012, for a day-long meeting to explore how they can collaborate and improve the quality of health care while at the same time lowering costs.

The Obama Administration also released a new report highlighting the success of the Center for Medicare & Medicaid Innovation. Created by the Affordable Care Act, the Innovation Center has already worked to test and support innovative new health care models that can reduce costs and strengthen the quality of health care. The CMS Innovation Center year-in-review report is available at *http://www.Innovation.CMS.gov/documents/pdf/CMMIreport_508.pdf*.

The summit showcased nearly half a dozen announcements of major new initiatives by leading health care organizations, including new "challenges" to reverse the trend of diabetes, advance the field of Alzheimer's prevention and treatment, and bolster the battle against HIV/AIDS. For more information on the Care Innovation Summit, visit *http://www.Innovation.CMS.gov/summit*.

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(Announcements continued)

The full text of this excerpted Department of Health and Human Services (HHS) press release (issued Thursday, January 26) can be found at *http://www.HHS.gov/news/press/2012pres/01/20120126a.html*.

Affordable Care Act will save states and taxpayers $17.7 billion on prescription drugs; proposed rule cuts costs and increases transparency in Medicaid prescription drug pricing

Provisions in the health care reform law, the Affordable Care Act, will save taxpayers and states an estimated $17.7 billion over five years on prescription drugs bought through Medicaid, according to estimates in a proposed rule issued Friday, January 27.

The announcement, implementing the Medicaid prescription drug provisions of the Affordable Care Act, will increase transparency in drug pricing, and ensure taxpayers and states are not overpaying for prescription drugs.

The Medicaid pharmacy regulation notice of proposed rulemaking can be found in the *Federal Register* at *http://www.gpo.gov/fdsys/pkg/FR-2012-02-02/pdf/2012-2014.pdf*. The comment period on the proposed rule will be open until Monday, April 2. The Centers for Medicare & Medicaid Services (CMS) plans to issue a final rule in 2013.

The full text of this excerpted press release can be found on the CMS website at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4251*.

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

Source: CMS PERL 201202-06

Major improvements to Medicare online enrollment system

During the past year, the Centers for Medicare & Medicaid Services (CMS) has listened to your feedback about the Medicare online enrollment system: Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). As a result, CMS has made upgrades in order to reduce data entry time and increase access to information.

Providers and staff using Internet-based PECOS will now see the following improvements:

- **Electronic signature** – you now have the ability to digitally sign and certify the application.
- **Access to more information** – now you can see if a request for revalidation has been sent by your Medicare administrative contractor (MAC).
- **Multiple views of your information** – switch between topic view and fast track view:
  - The fast track view allows you to quickly review all enrollment information on a single screen.
- **Overall usability** – CMS is making the system easier to use:
  - You can access previously-used address information when completing an application.
  - You can quickly update and resubmit an application returned for correction via Internet-based PECOS as part of any application submission.
  - You will have fewer screens and steps to navigate when you are changing information or revalidating your application(s).

Learn more about Internet-based PECOS at *https://PECOS.CMS.hhs.gov*, and be on the look-out for more enhancements in the coming months.

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

Source: CMS PERL 201202-47

All Medicare provider and supplier payments to be made by electronic funds transfer

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 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 are required to submit the CMS-588 EFT form with the 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 201202-17

2012 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than March 15 on the FCSO Medicare website at *http://medicare.fcso.com/MEDPARD/*.

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

Source: Pub 100-04, Transmittal 2319, CR 7573

Updating beneficiary information with the coordination of benefits contractor

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

Provider action needed

Stop – impact to you

A new Medicare secondary payer (MSP) initiative will affect how you may update beneficiary information to the coordination of benefits contractor (COBC).

Caution – What you need to know

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the COBC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's common working file (CWF).

Go – what you need to do

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information.

Background

There has been considerable discussion about the accuracy of beneficiary Medicare secondary payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the COBC by phone.

Therefore (as noted below), CMS and the COBC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

In compliance with Section 111 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both group health plans (GHP) and non group health plans (NGHP)) submit coverage information to the COBC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a responsible reporting entity

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(Beneficiary continued)

(RRE), and the COBC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records.

CMS initiatives

This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the COBC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the COBC. To reduce such conflicts in the future, CMS has developed and implemented a data management "Reporting Hierarchy" process, which the COBC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found at *http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf*.

The COBC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

COBC initiatives

- **Provider attempting update with the beneficiary in the office:**

  The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are available: 1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.

- **Provider attempting update when the beneficiary is not in the office:**

  No update will be made from a telephone call. The provider has three options to have the record updated:

  1) Have the beneficiary contact COBC;
  2) Contact the beneficiary's insurer to resolve the issue; or
  3) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider with new information:**

  The COBC will take new information for a beneficiary, but if the new information requires changes to an existing record, two options are available:

  1) The beneficiary will need to call to close out the record; or
  2) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider update for deceased beneficiary:**

  A single update can be made by one provider for a deceased beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional information

An explanation of the GHP RRE Hierarchy rules can be found at *http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf*.

General information about mandatory insurer reporting is available at *http://www.cms.gov/mandatoryinsrep*.

The COBC's contact information is:

Telephone:

1-800-999-1118 (8 a.m. to 8 p.m. ET)

Fax:

1-734-957-9598 (address the fax to Medicare Coordination of Benefits)

Mailing address:

Medicare –Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232

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Health care fraud prevention and enforcement efforts result in record-breaking recoveries totaling nearly $4.1 billion

On Tuesday, February 14, Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius released a new report showing that the government's health care fraud prevention and enforcement efforts recovered nearly $4.1 billion in taxpayer dollars in fiscal year (FY) 2011. This is the highest annual amount ever recovered from individuals and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

These findings, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste, and abuse in the Medicare and Medicaid programs, and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act.

The recently-enacted Affordable Care Act provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional $350 million for HCFAC activities. The administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data-sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

The departments also continued their successes in civil healthcare fraud enforcement during FY2011. Approximately $2.4 billion was recovered through civil healthcare fraud cases brought under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. This marked the second year in a row that more than $2 billion has been recovered in FCA healthcare matters and, since January 2009, the department has used the FCA to recover more than $6.6 billion in federal healthcare dollars.

The fraud prevention and enforcement report announced Tuesday, February 14 coincided with the announcement of a proposed rule from CMS aimed at recollecting overpayments in the Medicare program. Before the Affordable Care Act, providers and suppliers did not face an explicit deadline for returning taxpayers' money. Thanks to the Affordable Care Act, there will be a specific timeframe by which self-identified overpayments must be reported and returned.

The HCFAC annual report can be found at *http://oig.HHS.gov/publications/hcfac.asp*. More information on the fraud prevention accomplishments under the Affordable Care Act can be found at *http://www.Healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html*.

The full text of this excerpted HHS press release (issued Tuesday, February 14) can be found at *http://www.HHS.gov/news/press/2012pres/02/20120214a.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 201202-52

Prior authorization of power mobility devices demonstration and recovery audit prepayment review demonstration

On Tuesday, November 15, 2011, the Centers for Medicare & Medicare (CMS) announced three demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sustainability of the Medicare trust funds and protect beneficiaries who depend upon the Medicare program.

CMS is pleased to announce that the prior authorization of power mobility devices (PMDs) demonstration and the recovery audit prepayment review demonstration – which were delayed from their initial Sunday, January 1 start-date – are expected to move forward on or after Friday, June 1, 2012. For additional information on these demonstrations, please visit *http://go.CMS.gov/cert-demos*.

These demonstrations will begin after receipt of a Paperwork Reduction Act (PRA) Office of Management and Budget control number. CMS posted a PRA notification for these demonstrations on Friday, February 3 at *http://www.CMS.gov/PaperworkReductionActof1995/PRAL/list.asp*.

CMS significantly revised the prior authorization of PMDs demonstration in response to provider and supplier concerns. For more information on the adopted changes please visit *http://go.CMS.gov/PAdemo*.

The Part A to Part B rebilling demonstration began Sunday, January 1, 2012.

To view the relevant *Federal Register* notice, visit *https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-02821.pdf.*

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

Source: CMS PERL 201202-10

The role of zone program integrity contractors (ZPICs)

Provider types affected

This article is intended for all physicians, providers, and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs), durable medical equipment (DME) MACs, and home health and hospice (HH+H) MACs for services and supplies provided to Medicare beneficiaries.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services' (CMS') ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, Program Safeguard Contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare fee-for-service contracting reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare administrative contractors (MACs).

As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled zone program integrity contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, durable medical equipment prosthetics, orthotics, and supplies, home health and hospice and Medicare-Medicaid data matching. Medicare Part C and D program

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integrity efforts are handled separately by one national contractor known as the Medicare drug integrity contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity(CPI) in CMS.

The following table lists all of the ZPICs and their zones.

ZPIC	Zone	States in zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, and Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, and West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, and Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, and Virgin Islands

Medicare fraud

Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud committed against the program may be prosecuted under various provisions of the United States code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

Contacts for reporting potential fraud

Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

ZPIC functions

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare trust fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare program include:

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's fraud prevention system;
- Performing medical review, as appropriate;
- Performing data analysis in coordination with CPI's fraud prevention system;
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:

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(ZPICs continued)

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf*.

Non-ZPIC functions

The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

- Claims processing, including paying providers/suppliers;
- Provider outreach and education;
- Recouping monies lost to the trust fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
- Medical review not for benefit integrity purposes;
- Complaint screening;
- Claims appeals of ZPIC decisions;
- Claim payment determination;
- Claims pricing; and
- Auditing provider cost reports.

Additional information

More information about Medicare contracting reform is available at *http://www.cms.gov/MedicareContractingReform*.

The *Medicare Learning Network*® (*MLN*) brochure titled "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers," which is designed to provide education on the Medicare Part A and B administrative appeals process, is available at *http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf*.

The *MLN* fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is available at *http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

For the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities, please visit the *MLN* Provider Compliance web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp*.

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Analysis of the DMEPOS competitive bidding program shows no changes in health outcomes

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program in nine different areas of the country. Since the program's implementation, CMS has used real-time claims analysis to track groups of Medicare beneficiaries potentially affected by the program. This analysis has consistently shown that the competitive bidding program preserves beneficiary health outcomes.

CMS has now released a broad-view analysis that compares the impact of the program on the general Medicare population as well as Medicare beneficiaries likely to use competitively-bid equipment based on their health conditions. For these groups, it compares rates of health outcomes (such as hospitalizations, length of hospital stays, and number of emergency department visits) in the competitive bidding areas to rates in regions without competitive bidding. The new analysis enables an easier comparison between subpopulations and between areas with competitive bidding and without competitive bidding. This results in a clearer depiction of the effect of the DMEPOS competitive bidding program on Medicare beneficiaries' health outcomes. Consistent with prior analyses, CMS has found that beneficiary health outcomes are stable in competitive bidding areas. To view the results, please visit *http://www.CMS.gov/DMEPOSCompetitiveBid*.

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

Source: CMS PERL 201202-43

Now available: New education materials for round 2 and national mail-order bidders

New educational materials for the round 2 and national mail-order competitions 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*. The Centers for Medicare & Medicaid Services urges all bidders to take advantage of these new materials as well as the many other helpful tools and resources on the CBIC website.

First, the *DBidS Reference Guide* has been issued. This guide provides step-by-step instructions for using the online bidding system, known as the DMEPOS Bidding System (DBidS).

Second, the final in a series of webcasts is now available. This webcast, titled *How to Submit a Bid*, explains how to submit a bid using the online bidding system, DBidS. All 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 a transcript for each webcast is 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*.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9:00 a.m. to 9:00 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 201201-51

Bidding is now open for the round 2 and national mail-order competitions of the DMEPOS competitive bidding program

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

All bids must be submitted in DMEPOS Bidding System (DBidS), the online bidding system, by 8:59:59 p.m. ET on March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the competitive bidding implementation contractor (CBIC) on or before March 30, 2012. The contract period for the round 2 and national mail-order competitions is July 1, 2013-June 30, 2016.

All bidders must submit certain required hardcopy documents as specified in the *Request for Bids (RFB) Instructions*. CMS urges all bidders to take advantage of the covered document review process. Under this process, CMS will notify suppliers that submit their hardcopy financial documents by the covered document review date (CDRD) of any missing financial documents. **The CDRD for the round 2 and national mail-order competitions is February 29, 2012 – financial documents must be RECEIVED on or before February 29, 2012, to qualify for the covered document review process.** This process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit the missing financial document(s) within 10 business days of the notification.

Competitive bidding areas and product categories for the round 2 and national mail order competitions, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bids. CMS will send important bidding updates via email, so all suppliers interested in bidding are urged to sign up for email updates on the CBIC website (at *www.DMECompetitiveBid.com*). If you have any questions about the bidding process, please contact the CBIC customer service center at 1-877-577-5331.

The target registration dates for authorized officials (AOs) and backup authorized officials (BAOs) to register for a user ID and password in CMS' Individuals Authorized Access to the CMS Computer Services (IACS) system have passed. End users (EUs), as well as any AOs and BAOs who have not yet registered, should now be registering. Only suppliers that have registered in IACS and received a user ID and password will be able to access the online bidding system and submit bids. If the AO for your company has not already registered, we cannot guarantee that he or she will be able to complete the registration process before registration closes. If your AO does not register, you cannot bid and will not be eligible for a contract. In addition, suppliers whose AOs have not registered are at 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 CDRD.

Registration will close on February 9, 2012, at 9:00 p.m. ET – no AOs, BAOs, or EUs can register after registration closes. Suppliers that do not register cannot bid and are not eligible for contracts.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "IACS Reference Guide" posted on the CBIC website. To register, visit the *CBIC website* and click on "REGISTRATION IS OPEN" above the registration clock on the homepage. 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.

To bid, visit the *CBIC website* and click on "BIDDING IS OPEN" above the clocks on the home page.

Please note that the RFB instructions initially posted on the CBIC website contained target bid submission deadlines. CMS is in the process of updating these instructions to reflect the actual bid submission deadlines, which are shown in this announcement.

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

Source: CMS PERL 201201-52

Extension of licensure deadline for the round 2 and national mail-order competitions of the DMEPOS competitive bidding program

The Centers for Medicare & Medicaid Services (CMS) is extending the licensure deadline for the round 2 and national mail-order competitions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The original licensure deadline required suppliers to have all required state licenses on file with the national supplier clearinghouse (NSC) and indicated in the Provider Enrollment, Chain, and Ownership System (PECOS) before submitting a bid.

New deadline: Bidding suppliers must now ensure that copies of all applicable state licenses are **received** by the NSC on or before Tuesday, May 1, 2012.

Bids will be disqualified if a bidder does not meet all state licensure requirements for the applicable product categories and for every state in a competitive bidding area (CBA). Every supplier location is responsible for having all applicable license(s) for each state in which it provides services. For a multi-state CBA, the bidder must collectively have all applicable license(s) for every state in the CBA. Each location is not required to have licenses for every state in the CBA as long as each state has a bidding location licensed for the product category.

Please note that the extension of the licensure deadline does **not** change any other deadlines. All bids must be submitted in DBidS, the online bidding system, by 8:59:59 p.m. (Eastern Time) on Friday, March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be received by the competitive bidding implementation contractor (CBIC) on or before Friday, March 30, 2012.

A licensure directory for each state, the District of Columbia, and the territories may be found on the NSC website at *www.PalmettoGBA.com/NSC*. Licensure requirements vary from state to state. The NSC licensure directory provides a good starting point to assist in identifying the licenses you need. State licensure requirements change periodically and may have exceptions, so the NSC's licensure directory serves only as a guide. It remains the bidding supplier's responsibility to ensure compliance with the most current state and federal laws and regulations.

For more information on licensure requirements, you may refer to the *"Licensure for Bidding Suppliers" fact sheet* and the *"Request for Bids (RFB) Instructions"*. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. (Eastern Time) during the registration and bidding periods.

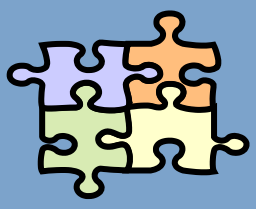
Please note that the RFB instructions initially posted on the CBIC website contained the original licensure deadline. These instructions have now been updated to reflect the new licensure deadline shown in this announcement.

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

Source: CMS PERL 201202-07

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*



Incentive Programs

Determining eligibility for the Medicare HPSA physician bonus payment

Physicians who may be eligible for the Medicare health professional shortage area (HPSA) bonus payment should be aware of the following information and educational resources regarding determining eligibility, in order to minimize errors during the post-payment review process.

Information on the HPSA bonus, including the list of zip codes eligible for automatic payment, can be found at on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.CMS.gov/HPSApsaPhysicianBonuses/01_overview.asp*.

Two *MLN Matters*® articles are available which go into further detail:

- "2012 Annual Update for the HPSA Bonus Payments" (MM7517) is available at *http://www.CMS.gov/MLNMattersArticles/downloads/MM7517.pdf*, and
- "HPSA Bonus Payment Policy Reminders" (SE1202) is available at *http://www.CMS.gov/MLNMattersArticles/downloads/SE1202.pdf*.
- Websites to help determine existing designations and eligibility for the Medicare HPSA physician bonus include:
  - *http://HPSAfind.HRSA.gov/HPSAsearch.aspx* – to identify designations within a state,
  - *http://www.FFIEC.gov/geocode/default.aspx* – to identify census tracts by entering an address), and
  - *http://DataWarehouse.HRSA.gov/geoadvisor/ShortageDesignationAdvisor.aspx* – to see if an area is listed as being in an eligible area.

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

Source: CMS PERL 201202-08

Update to the PCIP for critical access hospitals paid under optional method

On Tuesday, November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a Listserv message with billing instructions for critical access hospitals (CAHs) paid under the optional method regarding the primary care incentive payment (PCIP) program. The message instructed CAH providers to continue submitting their national provider identifiers (NPIs) using the "other provider" field located in loop 2310C on the current electronic claim format.

After further research, CMS has determined that, in addition to reporting the NPI in loop 2310C, CAH providers will need to report the same NPI as well as the information that is required in loop 2310B defined as "operating physician." This will ensure CAH claims submitted using the accredited standards committee (ASC X12) version 5010A2 will continue to receive their PCIP bonus without any interruption.

Change request 7686 has been created and will be implemented by contractors to update the Medicare systems to assign the PCIP bonus payments based on the NPI from loop 2310D, "rendering physician." However, until the successful implementation of CR 7686 – expected to take place in July – the reporting of the NPI for the PCIP bonus payments should continue as described above.

Source: CMS PERL 201201-47

System update – rendering provider NPI reporting for the PCIP for critical access hospitals

Provider types affected

Critical access hospitals (CAHs) submitting claims under the optional method to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7686, which instructs Medicare contractors to implement a system update to include the rendering provider field to allow correct physician national provider identifier (NPI) reporting for the primary care incentive program (PCIP) for critical access hospitals (CAHs) reimbursed under the optional method. Be sure your staffs are aware of the changes described in the *Background* section.

Background

Effective April 1, 2011, CR 7115 "Primary Care Incentive Payment Program (PCIP), Section 5501(a) of the Affordable Care Act, Payment to a Critical Access Hospital (CAH) paid under the Optional Method," instructed CAH providers to submit their NPIs using the "Other Provider" field located at loop 2310C on the current electronic claim, the 837I version 4010A1 format. CR 7115 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7115.pdf*.

CR 7686 updates the instructions in CR 7115 by providing for a "Rendering Provider" field. Upon implementation of CR 7686, you should use the 837I version 5010A2 "Rendering Provider" field (loop 2310D) instead of the "Other Operating Physician" field (loop 2310C). The "Rendering Provider" field on the 837I must be populated by the eligible primary care practitioner's NPI in order for the primary care services to qualify for the incentive bonus.

Providers using the fiscal intermediary shared system (FISS) should use the new "Rendering Physician" field in FISS to report the NPI information.

Note: You should continue to use loop 2310C, as well as the information that is required in loop 2310B defined as "operating physician", for purposes of PCIP reporting until implementation of CR 7686. Effective July 1, 2012, you should begin using loop 2310D.

Eligibility for PCIP payment

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care specialty designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the Medicare physician fee schedule (excluding hospital inpatient care and emergency department visits) for such practitioner during the time period that has been specified by the Secretary of Health and Human Services.

CMS provides Medicare contractors with a list of the NPIs of the eligible primary care practitioners around the beginning of the incentive payment year. If a claim for a primary care service is submitted by a CAH paid under the optional method for an eligible primary care physician's or non-physician practitioner's professional services, the "rendering provider" field on the claim must be populated by the eligible primary care practitioner's NPI in order for the primary care service to qualify for the incentive payment. Primary care services potentially eligible for the incentive payment and furnished on different days must be submitted on separate CAH claims so a determination about the eligibility of the service based on the rendering practitioner can be made. If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care practitioner based on the NPI in the "rendering provider" field. In addition to the CAH NPI, the "rendering provider" NPI shall be shown on the special incentive remittance for CAHs.

Additional information

The official instruction, CR 7686, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2403CP.pdf*.

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

MLN Matters® Number: MM7686 Revised
Related Change Request (CR) #: 7686
Related CR Release Date: January 26, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2403CP
Implementation Date: July 2, 2012

New educational resources for the eRx incentive program

The Centers for Medicare & Medicaid Services (CMS) has created a number of useful resources for eligible professionals participating in the Medicare electronic prescribing (eRx) incentive program, including:

- *2012 eRx Incentive Program: Future Payment Adjustments* – this article provides guidance on avoiding future eRx incentive program payment adjustments for individual eligible professionals and selected group practices participating in the 2012 eRx group practice reporting option (GPRO).
- *2012 Physician Quality Reporting System and eRx Incentive Program Group Practice Reporting Option: Participation for the Incentive Payment Made Simple* – this fact sheet provides guidance for group practices wishing to participate in the 2012 physician quality reporting system and the 2012 eRx incentive program as a CMS selected group practice.
- *2012 eRx Incentive Program: Participation for the Incentive Payment Made Simple* – this fact sheet provides step-by-step advice for participating in the 2012 eRx incentive program.
- *2012 eRx Incentive Program Updates for 2012* – this fact sheet contains information about changes to the eRx incentive program for 2012 and future payment adjustments as authorized by MIPPA.

To access these and other educational products on the Medicare eRx incentive program, visit the *"Educational Resources"* section of the *electronic prescribing incentive program* Web page.

Source: CMS PERL 201202-39

New Web page on CQMs added to the EHR website

The Centers for Medicare & Medicaid Services (CMS) has created a *new page* to the electronic health record (EHR) *website* dedicated to the clinical quality measures (CQMs) and their role in the Medicare and Medicaid EHR incentive programs. The page intends to help providers better understand the purpose of CQMs and how to report on the measures.

The new CQM page of the website includes information on the following topics:

- General program definitions, like "Reporting Period"
- Eligible professional (EP) CQM reporting requirements
- Eligible hospital and critical access hospital (CAH) CQM reporting requirements
- Information on the CQM pilot program
- Resources and additional information on CQMs

You can also find helpful CQM resources on the new page, including the *Guide to CQMs* and a *webinar video* that provides an overview of the measures. Also be sure to review the *CQM EP reporting table* and the *CQM eligible hospital and CAH reporting table*. Each document lists the CQMs for the Medicare and Medicaid EHR incentive programs for 2011-2012.

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

Source: CMS PERL 201202-41

Important electronic health record incentive program messages

One-year milestone for the Medicare and Medicaid EHR incentive programs marked January 3

Tuesday, January 3, was the one-year anniversary of the start of registration for the Medicare and Medicaid electronic health record (EHR) incentive programs. Over the past year, there has been a tremendous amount of interest in the incentive programs as providers across the country have implemented EHRs.

Year-one highlights

- 43 states have started their Medicaid EHR incentive programs
- More than 176,000 people have registered for the Medicare and/or Medicaid EHR incentive programs
- More $2.5 billion has been paid in incentive payments to eligible professionals (EPs) and eligible hospitals and critical access hospitals (CAHs) across the country

The Centers for Medicare & Medicaid Services (CMS) has created useful resources for participants in the Medicare and Medicaid EHR incentive programs, including:

1. *An Introduction to the Medicare EHR Incentive Program for Eligible Professionals* – this interactive guide walks EPs through every aspect of the Medicare program, and provides helpful resources and tips along the way.
2. Updated user guides – CMS has updated the registration and attestation user guides, which direct EPs and eligible hospitals through the CMS registration and attestation system. There are five guides that can be downloaded from the *Educational Materials* page of the EHR website.
3. Provider testimonial videos – these videos, which can be found on the *CMS YouTube channel*, highlight providers' experiences participating in the EHR incentive programs.

A look ahead

As we move into 2012 and the second participation year of the Medicare and Medicaid EHR incentive programs, CMS is hopeful that providers will begin or continue their participation in the programs, and take advantage of these incentives for meaningful use of EHRs.

If you are considering registering for the programs, but have not done so yet, take a look at the CMS EHR website and use the *eligibility tool* to find out if you can participate.

Remember that 2012 is the last year in which EPs can receive a full incentive payment in the Medicare EHR incentive program; beginning in 2013, EPs will receive a smaller overall total payment.

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

CMS has updated the EHR information center with enhanced functionality

CMS is proud to announce that after a review of collected feedback, enhancements and changes have recently been made to the EHR information center interactive voice response (IVR) system.

Among these caller-friendly revisions is a new feature to assist with hot topics, including registration and attestation, as well as updated password reset menus. These improvements will enable eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to obtain information about the EHR incentive program more easily and efficiently.

Directions for calling the EHR information center

To contact the IVR, dial 888-734-6433 or 888-734-6563 (TTY number).

Take advantage of the new options from the main menu:

- Press 1 for hot topics
  - For information on when registration begins, press 1.
  - For information on attestation, press 2.
  - For information on being a dually-eligible hospital, press 3.
  - For information on registration tips, press 4.
  - For information on payment time frames, press 5.

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(EHR continued)

- For information on important upcoming dates, press 6.
- For information on the clinical quality measures (CQM) eReporting pilot, press 7.
- For information on Health Professional Shortage Area (HPSA) payments, press 8.

- Press 2 for information on NPPES (national plan and provider enumeration system) and PECOS (provider enrollment, chain, and ownership system) password resets
  - For EPs needing NPPES/PECOS password resets, press 1.
  - For eligible hospitals needing PECOS password resets, press 2.
- Press 0 to speak with an information specialist.
  - For registration questions, press 1.
  - For all other questions, press 2.
- Press # to repeat the menu.

EHR information center hours of operation:

7:30 a.m. - 6:30 p.m. (CT), Monday through Friday, except federal holidays. (General information is available on the IVR anytime, except during planned system maintenance.)

Program information can also be found on the *FAQs section* of the EHR incentive programs website, where users can search for any questions they have about the Medicare or Medicaid EHR incentive programs.

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

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

Source: CMS PERL 201202-05

New information on the appeals process for Medicare and Medicaid EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has added new information to the *Attestation section* of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs website about the appeals process.

On Thursday, December 1, CMS began accepting appeals for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). To help EPs, eligible hospitals, and CAHs, the CMS Office of Clinical Standards and Quality (OCSQ) is providing guidance on how to file an appeal. Note that the filing deadline for an eligibility appeal for an eligible hospital ended Monday, January 30, 2012.

OCSQ's Division of Health Information Technology released the first informal review decision for the EHR incentive program on Monday, January 19. Beginning in February, this informal review decision and other appeal decisions will be posted on the *OCSQ appeals website*. Starting in March, providers may find their decisions by visiting the *appeals portal*.

For general questions and for information on how to file an appeal, EPs, eligible hospitals, CAHs, and Medicare advantage organizations may contact OCSQ's designated appeal support contractor, Provider Resources Inc. at:

Toll-free number: 855-796-1515 (Between 9:00 a.m. and 5:00 p.m. ET, Monday through Friday)

Email: *OCSQappeals@provider-resources.com*

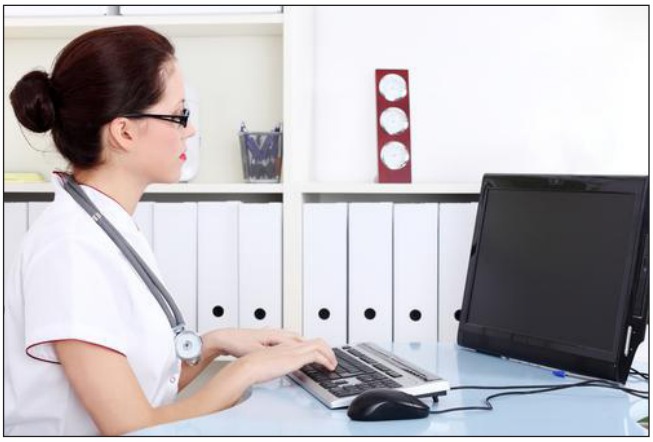
Want more information about the EHR incentive programs? Visit the *EHR Incentive Programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201201-49

Electronic health record (EHR) updates

CMS has updated the EHR information center with new self-service options

Following months of review and collective input, the electronic health record (EHR) information center interactive voice response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.



For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. The Centers for Medicare & Medicaid Services (CMS) is proud to announce that providers can now obtain information through an extensive IVR self-service option. Included in this option is a reinforced privacy protection module that requires your individual national provider identifier (NPI), the last five digits of your tax identification number (TIN), and your EHR registration ID. Once accepted, this newly enhanced self-service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing 888-734-6433, pressing 3 for self-service, and entering the authentication elements. These options will be available on the IVR effective Thursday, February 16.

EHR information center hours of operation:

7:30 a.m. - 6:30 p.m. CT, Monday through Friday, except federal holidays. (Note that general information and self-service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the *FAQs section* of the EHR incentive programs website, where users can search for any questions they have about the Medicare or Medicaid EHR incentive programs.

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

Updated and new FAQs added to the CMS EHR website

CMS wants to help keep you updated with information on the Medicare and Medicaid electronic health record (EHR) incentive programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR incentive programs be made? *Read the answer.*
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR incentive programs, as well as the requirements for receiving an EHR incentive payment? *Read the answer*.
- For the Medicare and Medicaid EHR incentive programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR hospital calculations? *Read the answer.*
- In order to qualify for payment under the Medicaid EHR incentive program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their state Medicaid agency an official letter containing information about the clinic's electronic health record from IHS (which is an operating division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? *Read the answer.*
- For the Medicaid EHR incentive program, how do we determine Medicaid patient volume for

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procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. *Read the answer.*

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

Stay informed via the CMS EHR incentive programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR incentive programs. The *CMS EHR incentive program Listserv* provides timely information on program requirements and changes in the EHR incentive programs.

By subscribing to this Listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new *frequently asked questions* that are published on the CMS EHR incentive programs website. *Join* the Listserv and visit the *Listserv section* of the EHR incentive programs website to take a review some of the recent messages CMS has sent. CMS encourages you to let others know about the CMS EHR incentive program Listserv, and to share its messages.

Want more information about the EHR incentive programs? Make sure to visit *the EHR incentive programs website* for complete information about the CMS Medicare and Medicaid EHR incentive programs.

Source: CMS PERL 201202-23

Find fees faster: Try FCSO's fee schedule lookup

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

Proposed national coverage determination for transcatheter aortic valve replacement

On Thursday, February 2, the Centers for Medicare & Medicaid Services (CMS) proposed that Medicare patients across the country have access to a new procedure, known as "transcatheter aortic valve replacement" (TAVR).

The result of an unprecedented level of collaboration between CMS, the Food and Drug Administration, the Agency for Healthcare Research and Quality, the American College of Cardiology, the Society of Thoracic Surgeons and Edwards Lifesciences, this proposed coverage decision memorandum for TAVR continues CMS's commitment to cross-agency collaboration and ensuring patients have access to the latest and best medical technology.

CMS is requesting public comments on this proposed determination pursuant to Section 1862(l) of the Social Security Act. CMS is specifically interested in public comments on the use of coverage with evidence development (CED) in this decision. After considering the public comments, CMS will make a final determination and issue a final decision memorandum.

The proposed decision will be open for 30 days of public comment before CMS issues a final decision later this year. To read the full proposal, visit *http://www.CMS.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=257*.

The full text of this excerpted blog post can be found on the CMS blog at *http://blog.CMS.gov/2012/02/02*.

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

Source: CMS PERL 201202-11

Intensive behavioral therapy for obesity

Provider types affected

This *MLN Matters*® article is intended for primary care physicians and other primary care practitioners billing Medicare contractors (carriers, fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries in a primary care setting. .

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7641, which informs Medicare contractors about implementing coverage of intensive behavioral therapy (IBT) for obesity.

Caution – what you need to know

Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as body mass index (BMI) equal to or greater than 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:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months.

Medicare coinsurance and Part B deductible are waived for this service.

Go – what you need to do

See the *Background* and *Additional information* Sections of this article for further details regarding this change. Be sure your staffs are aware of this new coverage determination and that Healthcare Common Procedure Coding System (HCPCS) code G0447 (Face-to-Face Behavioral Counseling for Obesity, 15 minutes) will be used to bill for these services.

This code was effective November 29, 2011, and will appear in the January 2012 quarterly update of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (IOCE).

Background

Based upon authority in the Social Security Act to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, and the services are reasonable and necessary for the prevention or early detection of illness or disability, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on IBT

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for obesity. Screening for obesity in adults is a "B" recommendation by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Medicare Part A and Part B.

In 2003, the USPSTF found good evidence that BMI "is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity." The USPSTF also found fair to good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥30 kg/m2) "produces modest, sustained weight loss."

Effective for claims with dates of service on or 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:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months as discussed below.

High intensity counseling combined with behavioral interventions in obese adults "produces modest, sustained weight loss."

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.), over the course of the first 6 months of intensive therapy. **This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice.** For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs.) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

IBT for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m2);
2. Dietary (nutritional) assessment; and,
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Intensive behavioral intervention for obesity should be consistent with the 5-A framework:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Billing requirements

Diagnostic codes

Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize HCPCS code G0447 (Face-to-Face Behavioral Counseling for Obesity, 15 minutes). G0447 must be billed along with 1 of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45). The type of service (TOS) for G0447 is 1. (ICD-10 codes will be Z68.30-Z68.39, Z68.41- Z68.45)

Effective for claims with dates of service on or after November 29, 2011, Medicare contractors will deny claims for HCPCS G0447 that are not submitted with the appropriate diagnostic code (V85.30-V85.39, V85.41-V85.45).

Claims submitted with HCPCS G0447 that are not submitted with these diagnosis codes will be denied with the following messages:

- Claim adjustment reason code (CARC) 167 – "This (these) diagnosis(es) is (are) not covered. **Note:**

(continued on next page)

(Obesity continued)

Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

- Remittance advice remark code (RARC) N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Per *MLN Matters*® article MM7228, when modifier GZ is used, contractors will use CARC 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.). This is true with all denials noted below that have the group code CO. MM7228 may be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*.

Specialty codes

Effective for services on or after November 29, 2011, Medicare will pay claims for G0447, only when services are submitted by the following provider specialty types found on the provider's Medicare enrollment record:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

If your specialty type is not one of the above, your claim will be denied using the following codes:

- CARC of 185 – "The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.),"
- RARC N95 – "This provider type/provider specialty may not bill this service."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: In addition, Medicare may cover behavioral counseling for obesity services when billed by one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under our regulation at 42 CFR Section 410.26(b) (conditions for services and supplies incident to a physician's professional service) or 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician service).

Place of service (POS) codes

Effective for services on or after November 29, 2011, Medicare will pay for obesity counseling claims containing HCPCS G0447 only when services are provided with the following POS codes:

- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic.

Line items on claims for G0447 will be denied if not performed in these POSs using the following codes:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid POS. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N428 – "Not covered when performed in this place of service."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file)and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Frequency limitation

Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22 limit will be denied using the following codes: (Note:

(continued on next page)

(Obesity continued)

When applying this frequency limitation, a claim for the professional service and a claim for a facility fee will be allowed.)

- CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Your contractor will not search their files for claims that may have been paid in error. However, contractors may adjust claims that are brought to their attention.

Institutional claims notes

Claims submitted with either a type of bill (TOB) 13x or TOB 85x (where the revenue code is not 096x, 097x, or 098x) will be identified as facility fee service claims.

Claims submitted with TOBs 71x, 77x, or 85x (where the revenue code is 096x, 097x, or 098x) will be identified as professional service claims.

Medicare will pay for G0447 on institutional claims in hospital outpatient departments TOB 13x based on OPPS and in critical access hospitals TOB 85x based on reasonable cost.

The CAH Method II payment is for G0447 with revenue codes 096x, 097x, or 098x is based on 115 percent of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.

Medicare will line-item deny any claim submitted with G0447 when the TOB is not 13x, 71x, 77x, or 85x with the following:

- CARC 5 – "The procedure code/bill type is inconsistent with the Place of Service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC M77 – "Missing/incomplete/invalid place of service."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file) and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Medicare will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting G0447.

Rural health clinics and federally qualified health centers claims notes

Rural health clinics, using TOB 71x, and federally qualified health centers, using TOB 77x, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not appliced to this service. Such claims will be paid based on the all-inclusive payment rate.

For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item DOS, the service line with HCPCS G0447 will be denied with the following messages:

- Claim adjustment reason code (CARC) 97 – "The benefit for this service is included in the payment/ allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present" and
- Group code CO (contractual obligation)

Note: Obesity counseling is not separately payable with another encounter/visit on the same day. This does not apply for initial preventive physical examination (IPPE) claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services.

Additional information

The official instruction, CR 7641, issued to your FI, carrier, and A/B MAC regarding this change, was issued in 2 transmittals at *http://www.cms.gov/transmittals/downloads/R2409CP.pdf* and *http://www.cms.gov/transmittals/downloads/R142NCD.pdf*.

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

MLN Matters® Number: MM7641 Revised
Related Change Request (CR) #: 7641
Related CR Release Date: February 3, 2012
Effective Date: November 29, 2011
Related CR Transmittal #:R2409CP, R142NCD
Implementation Date: March 6, 2012 for non-shared system edits, July 2, 2012 for shared system edits, CWF provider screen, HICR, and MCSDT changes

Screening for sexually transmitted infections and high intensity behavioral counseling

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for Medicare beneficiaries.

Provider action needed

Effective for dates of service on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover screening for sexually transmitted infections (STIs) – specifically chlamydia, gonorrhea, syphilis, and hepatitis B – with the appropriate Food and Drug Administration (FDA) approved/cleared laboratory tests when ordered by the primary care provider. The tests must be used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare provider for these services.

In addition, Medicare will cover high intensity behavioral counseling (HIBC) to prevent STIs. Ensure that your billing staffs are aware of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must be:

1) Reasonable and necessary for the prevention or early detection of illness or disability;
2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for screening for STIs and HIBC to prevent STIs and determined that the criteria listed above were met, enabling CMS to cover these preventive services. Therefore, effective November 8, 2011, CMS will cover screening for the indicated STIs and HIBC to prevent STIs. The covered screening lab tests must be ordered by the primary care provider. The HIBC must be provided by primary care providers in primary care settings such as by the beneficiary's family practice physician, internal medicine physician, or nurse practitioner (NP) in the doctor's office.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0445 (high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes), has been created for use when reporting HIBC to prevent STIs, effective November 8, 2011. This code is included in the January 2012 Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE) updates.

This code may be paid on the same date of service as an annual wellness visit (AWV), evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior – as required for coverage.

The appropriate screening diagnosis code (ICD-9-CM V74.5 (screening bacterial – sexually transmitted) or V73.89 (screening, disease or disorder, viral, specified type NEC)), when used with the screening lab tests identified by change request (CR) 7610, will indicate that the test is a screening test covered by Medicare.

Diagnosis code V69.8 (other problems related to life style) is used to indicate that the beneficiary is at high/increased risk for STIs. Providers should also use V69.8 for sexually active adolescents when billing G0445 counseling services.

Diagnosis codes V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy) are also to be used when appropriate.

For services provided on an annual basis, this is defined as a 12-month period.

Further details

CMS will cover screening for chlamydia (*86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810,*

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(Infections continued)

87800 (used for combined chlamydia and gonorrhea testing), gonorrhea (*87590, 87591, 87850, 87800* (used for combined chlamydia and gonorrhea testing), syphilis (86592, 86593, 86780), and hepatitis B (hepatitis B surface antigen) *87340, 87341*)) with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the CLIA regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. As per the requirements, the presence of V74.5 or V73.89 and V69.8, denoting STI screening and high-risk behavior, respectively, and/or V22.0, V22.1, or V23.9, denoting pregnancy as appropriate, must also be present on the claim for STI services along with one of the procedure codes above.

Screening for chlamydia and gonorrhea:

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test;
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test; and
- Women at increased risk for STIs annually.

Screening for syphilis:

- Pregnant women when the diagnosis of pregnancy is known and then repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening test; and
- Men and women at increased risk for STIs annually.

Screening for hepatitis B:

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known and then re-screening at the time of delivery for those with new or continuing risk factors.

Coverage for HIBC

CMS will also cover up to two, individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs (G0445) for all sexually active adolescents and for adults at increased risk for STIs (V69.8), if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements:

- Education;
- Skills training; and,
- Guidance on how to change sexual behavior.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners;
- Using barrier protection inconsistently;
- Having sex under the influence of alcohol or drugs;
- Having sex in exchange for money or drugs;
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea);
- Having an STI within the past year;
- IV drug use (hepatitis B only); and,
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age.

Community social factors such as high prevalence of STIs in the community populations should also be considered in determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending HIBC.

High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient's sexual history which is part of any complete medical history, typically part of an AWV or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

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

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(Infections continued)

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, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.**

For the purposes of this NCD, a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (Sections 1833(u)(6), 1833(x)(2)(A)(i)(I) and 1833(x)(2)(A)(i)(II)), as follows:

- 1833(u) (6) physician defined.—For purposes of this paragraph, the term "physician" means a physician described in Section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.
- 1833(x)(2)(A)(i) (I) is a physician (as described in Section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in Section 1861(aa)(5)).

Billing reminders

- Institutional providers should note that coverage requires services be performed in a primary care setting. Consequently, if STI services are billed on types of bill (TOB) other than 13x, 14x and 85x (when the revenue code on the 85x is not 096x, 097x, or 098x), OR, if G0445 is submitted on a TOB other than 13x, 71x, 77x, or 85x, payment for the services will be denied using the following:
  - Claim adjustment reason code (CARC) 170 – "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - Remittance advice remark code (RARC) N428 – "This service was denied because Medicare only covers this service in certain settings."
- When applying frequency limitations to HIBC services, contractors will allow both a claim for the professional service and a claim for the facility fee. Institutional claims may be identified as facility fee claims for screening services if they contain G0445, and TOB 13x or TOB 85x (when the revenue code is not 096x, 097x, or 098x). All other claims should be identified as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71x or 77x, or 85x when the revenue code is 096x, 097x, or 098x.
- Contractors will allow institutional claims, TOBs 71x and 77x, to submit additional revenue lines on claims with G0445. Also, HCPCS G0445 will not pay separately with another encounter/visit on the same day for TOBs 71x and 77x with the exception of: initial preventive physical claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services. If HCPCS G0445 is present on revenue lines along with an encounter/visit with the same line-item date of service, contractors will assign group code CO and reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Services Payment Information REF), if present."
- G0445 on institutional claims in hospital outpatient departments (TOB 13x) are paid based on OPPS, in critical access hospitals (TOB 85x, not equal to 096x, 097x, or 098x) based on reasonable cost. HCPCS G0445 with revenue codes 096x, 097x, or 098x, when billed on TOB 85x method II is paid based on 115 percent of the lesser of the MPFS amount or submitted charge.
- Medicare will enforce the frequency requirement for STI services, as mentioned above. Medicare will deny line items that exceed the coverage frequency requirements using the following:
  - CARC 119 – "Benefit maximum for this period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
- Medicare will deny line items on claims submitted for screening for STIs if the claim lacks the appropriate ICD-9-CM code as mentioned earlier. Such services will be denied payment using:
  - CARC 50 – "These are non-covered services because this is not deemed a "medical necessity" by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N386 – "This decision was based on a National Coverage Determination (NCD), An NCD provides a coverage determination as to whether a specific item or service is covered.

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(Infections continued)

A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

- The presence of ICD-9 code V74.5 or V73.89 identifies STI laboratory tests as screening lab tests payable under CR7610 rather than as diagnostic tests.
- Screening for STIs must be ordered by a primary care provider, and HIBC services, G0445, must be performed by a primary care provider in a primary care setting, with one of the following specialty codes:
  - 01 – General practice
  - 08 – Family practice
  - 11 – Internal medicine
  - 16 – Obstetrics/gynecology
  - 37 – Pediatric medicine
  - 38 – Geriatric medicine
  - 42 – Certified nurse midwife
  - 50 – Nurse practitioner
  - 89 – Certified clinical nurse specialist
  - 97 – Physician assistant
- STI screenings ordered by other than the above types of providers will be denied payment when submitted on professional claims using:
  - CARC 184 – "The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Medicare will deny line items for G0445 if performed by other than the above types of providers when submitted on professional claims using:
  - CARC 185 – "The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N95 – "This provider type/provider specialty may not bill this service."

Claims for G0445 must be for services performed in the following places of service (POS):

- 11 – Physician office;
- 22 – Outpatient hospital;
- 49 – Independent clinic; or
- 71 – State or local public health clinic.

- Medicare will deny line items for G0445 if the POS code is other than 11, 22, 49, or 71, using the following:
  - CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N428 – "Not covered when performed in this Place of Service."
- Upon full implementation in Medicare systems on July 2, 2012, providers may submit eligibility inquiries in order to identify the next eligible date that beneficiaries may receive these services.
- Until systems are implemented, contractors will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0445, or TOBs 13x, 14x, and 85x, when the revenue code is not 096x, 097x, or 098x, for STI services.
- Effective for dates of service on or after November 8, 2011, contractors will not apply deductible or coinsurance to claim lines containing HCPCS G0445, HIBC services.
- Contractors will load HCPCS G0445 to their HCPCS file with an effective date of November 8, 2011.

Additional information

The official instruction, CR 7610, was issued to your FI, carrier and A/B MAC regarding this change via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2402CP.pdf*. The second transmittal conveys the NCD and it is at *http://www.cms.gov/Transmittals/downloads/R141NCD.pdf*.

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

MLN Matters® Number: MM7610
Related Change Request (CR) #: 7610
Related CR Release Date: January 26, 2012
Effective Date: November 8, 2011
Related CR Transmittal #: R2402CP and R141NCD
Implementation Date: July 2, 2012 for full implementation

Enrollment requirements for fixed wing and helicopter air ambulance operators

Note: This article was revised on January 30, 2012, to provide clarification, based on the CMS 855B enrollment application, of the licensure and certification requirement. This information was previously published in the November 2011 *Medicare A Connection*, Page 38.

Provider types affected

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

Provider action needed

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

Air ambulance suppliers must maintain either directly or through appropriate arrangements, compliance with all applicable federal and state licenses, and certifications and report the following FAA certifications: Specific pilot certification, instrument and medical certifications, and air worthiness certification.

Background

Medicare contractors must ensure that the air ambulance suppliers remain in compliance with all licensure, and other pertinent Federal and State requirements. The Medicare contractor evaluation process will include an evaluation of all documentation submitted with the CMS 855 B provider enrollment application, and as appropriate, verification with the FAA website.

Attachment 1 to the CMS 855 B Medicare enrollment application (Clinics/Group Practices and Certain other Suppliers (07/11) outlines the information that should be submitted with the initial or revalidation air ambulance application. (The 855B application is available at *http://www.cms.gov/CMSforms/downloads/cms855b.pdf*.) In pertinent part Attachment 1 specifies the following additional information is to be submitted with the application:

- A written statement, signed by the president, chief executive officer or chief operating officer of the airport from where the aircraft is hangared that gives the name and address of the facility; and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) on the application.

If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany the enrollment application. In addition, Medicare contractors shall accept the following as acceptable proof:

- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 certificate must accompany the enrollment application.
- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

Additional Information

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

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

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

Preparing for the version 5010 upgrade – questions to ask your vendor

The compliance deadline to upgrade to version 5010 from version 4010/4010A was January 1. The Center for Medicare & Medicaid Services (CMS) announced an enforcement discretion period for 90 days until Saturday, March 31, during which it would not initiate enforcement action with respect to any HIPAA-covered entity that is non-compliant with the ASC X12 version 5010 (version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. However, you should continue to upgrade your systems as promptly as possible in order to meet this deadline.

In order to ensure a smooth upgrade prior to April, you will need to complete both phase I internal and phase II external testing of version 5010 transactions. As part of your external testing, you will need to conduct tests with outside trading partners, which include vendors, clearinghouses, billing services, and payers. Your vendor is a critical partner in achieving version 5010 compliance.

You should take the following steps to evaluate your vendor and vendor products to ensure a timely version 5010 upgrade:

- Establish a tracking system and timeline for milestones
- Review existing and new contractual obligations with vendors
- Coordinate vendor capabilities with your practice needs and expectations
- Evaluate ease of use of vendor products

You might want to also ask your vendor some of the following questions about the version 5010 upgrade to help assess your readiness for this upgrade:

- Have they upgraded their systems to meet version 5010 standards?
- If they have not yet upgraded, when will they do so?
- What will be the cost for each upgrade?
- What versions of their software will be upgraded, and will these upgrades require any additional hardware upgrades?
- How often will updates occur and what is the delivery method?
- How are issues logged and how will they be addressed?
- Is there training available for new system changes and/or functionalities?

Please visit the CMS ICD-10 website for additional information and resources about the *version 5010* upgrade.

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 201202-16

Important update regarding HIPAA version 5010/D.0 implementation

The Centers for Medicare & Medicaid Services (CMS) has posted a new document titled *Important Update Regarding HIPAA Version 5010/D.0 Implementation* to CMS' "Versions 5010 & D.0 & 3.0" Web page: *http://www.CMS.gov/versions5010andd0/01_overview.asp*. The document includes descriptions used for interpreting the 277CA responses as well as links to the common edits and enhancement module (CEM) error description documents.

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

Source: CMS PERL 201202-46

Medicare FFS version 5010 requirement changes for non-specific procedure codes

Medicare fee-for-service (FFS) has amended the not otherwise classified (NOC) code set listing effective Monday, January 16, 2012. Thus, it has been determined that anesthesia codes that include the phrase "not otherwise specified" in their code descriptors (procedure codes *00100* through *01996*) do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements. Anesthesia procedure code *01999*, "Unlisted anesthesia procedure(s)" meets the requirements of a non-specified code and continues to require additional information to be supplied in the SV101-7 data element.

Additionally, various pathology and laboratory codes identified in procedure code section 8800 and a variety of other NOC codes have been removed. These codes do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements.

The majority of procedure codes impacted and removed from the NOC code list are anesthesia codes, laboratory/pathology codes, and physicians quality reporting system codes.

Medicare FFS's complete listing of the NOC codes can be found at *http://www.CMS.gov/ElectronicBillingEDITrans/40_FFSEditing.asp*. Medicare will be updating the code set, at minimum, on a quarterly basis (January, April, July, and October) as the NOC list is refined and the parent code sets are updated. Please check back to the *website* frequently for the most updated list.

For more information on version 5010 and D.0, please visit *http://www.CMS.gov/Versions5010andD0*.

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

Source: CMS PERL 201201-46

Use of unique numbering recommended for key data elements in inbound 837 claims

With the implementation of Accredited Standards Committee (ASC) X12 version 5010 transactions for acknowledgements (TA1, 999, and 277CA), Medicare fee-for-service is recommending the use of unique numbering for several enveloping control/reference numbers built into the version 5010 claims transitions. Using unique numbering for the IAS13, ST02, and BHT03 data elements on the inbound 837 institutional and professional claims will allow Medicare trading partners to easily match submitted claims with the acknowledgement transactions.

Examples of those pairing include:

- 837 ISA13 is mapped to the TA1 response transaction and located in the TA101 data element
  - The implementation guide for the TA1 (ASC X12 TA1 TR3) states for TA101: "This is the value in ISA13 from the interchange to which this TA1 is responding."
- 837 ST02 is mapped to the 999 response in the 2000.AK202 data element
  - The implementation guide for the 999 (ASC X12 999 TR3) states for AK202: "Use the value in ST02 from the transaction set to which this 999 transaction set is responding."
- 837 BHT03 is mapped to the 277CA response in the 2200B.TRN02 data element
  - The implementation guide for the 277CA (ASC X12 277CA TR3) states for TRN02: "This element contains the value submitted in the BHT03 data element from the 837."

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

Source: CMS PERL 201202-03

Resolution of the 5010 electronic claims submission 496 edit

With the implementation of Accredited Standards Committee (ASC) X12 version 5010, the Medicare administrative contractors (MACs) have received a large increase in calls from billers regarding the 496 edit, more commonly referred to as "the linkage problem." In some cases, the problem may be the result of a provider not being properly linked to a clearinghouse/vendor submitter in Medicare's system; however, the problem may also be the result of billing errors. The tips that follow will assist you in determining the reason for receipt of a 496 edit and help you understand the resolution of the edit.

Since the 4010 versus 5010 electronic claim formats are not the same, you cannot assume a successful provider and clearinghouse/vendor submitter linkage in 4010 means you should be successfully linked in 5010. Some linkages were initially made nearly a decade ago. The Centers for Medicare & Medicaid Services (CMS) has found that several large clearinghouses that have been repeatedly bought, sold, and combined are now using new submitter numbers.

Prior to the implementation of the common edits and enhancement module (CEM) software, Medicare contractors maintained their own electronic data interchange (EDI) edits. Now that the 5010 format has a definitive CEM edit to ensure that all linkages are valid, invalid submitter IDs are being stopped for bad linkage.

In addition to the provider and clearinghouse/vendor linkage issue, the 496 edit can also occur because of the following national provider identifier (NPI) billing issues:

- Using a rendering provider's NPI instead of the billing provider NPI (rendering provider is not associated with the clearinghouse/vendor submitter)
- Billing Part B services for a provider associated with a group under his/her individual NPI when it should be billed under the group NPI

Resolution of the 496 edit requires evaluation of the health care claims acknowledgement message (277CA) and all edits incurred in addition to it. While generally a 496 edit may indicate a simple linkage issue, additional edits might focus on the submission of an inappropriate or incorrect NPI as a result of improper billing.

The 277CA, if delivered back to the provider from the clearinghouse/vendor, will have the following message components in the status segment (STC) related to a 496 edit:

- First part: Claim status category code = "A8" – acknowledgement / rejected for relational field error
- Second part: Claim status code = "496" – submitter not approved for electronic claim submissions on behalf of this entity
- Third part: Entity identifier code = "85" – billing provider

This message, "A8:496:85," utilizes the Washington Publishing Company (WPC)-maintained national code values and relays that the claim was rejected for a relationship error between the submitter and the billing providers NPI. You will receive this same set of codes for a linkage problem and an improper billing problem (use of rendering versus billing provider NPI, for example, as described above).

Clearinghouse/vendor evaluation of all edits received should be completed before asking for linkage problem resolution from your MAC.

Contact your MAC EDI support line after researching the nature of your 496 edits for assistance with the provider and clearinghouse/vendor submitter linkage and the collection of the CMS-required provider authorization to bill for each customer. The MAC EDI support lines are available at *http://www.CMS.gov/ElectronicBillingEDITrans/03_EDISupport.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 201202-59

Claim status category and claim status codes update

Provider types affected

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

What providers need to know

This article, based on change request (CR) 7670, explains that the claim status and claim status category codes for use by Medicare contractors with the health care claim status request and response ASC X12N 276/277 and the health care claim acknowledgement ASC X12N 277 were updated during the February 2012 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 2, 2012. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations. .

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information

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

The official instruction, CR 7670, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at *http://www.cms.gov/transmittals/downloads/R2371CP.pdf*.

MLN Matters® Number: MM7670 Revised
Related Change Request (CR) #: 7670
Related CR Release Date: December 22, 2011
Effective Date: April 1, 2012
Related CR Transmittal #: R2371CP
Implementation Date: April 2, 2012

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

ASC X12 decides against proposing version 6020 for consideration as next version of standard under HIPAA

The Accredited Standards Committee X12 (ASC X12) recently announced that it will not propose version 6020 for consideration as the next version of the standard under the Health Insurance Portability and Accountability Act (HIPAA). In its press release, ASC X12 stated that after listening to and reviewing testimony to the National Committee on Vital Health Statistics (NCVHS), holding discussions with health care industry stakeholders and the Centers for Medicare & Medicaid Services' (CMS) representatives, and acknowledging the many health IT initiatives underway, it decided not to recommend its version 6020 TR3s to the designated standards maintenance organizations (DSMO). ASC X12's decision removes the option that this version would be considered for adoption under HIPAA.

In announcing its decision, ASC X12 noted that the health care industry is better served by focusing on upgrading to version 5010 standards this year. Lessons learned from this implementation will generate better information that can be applied to changes to the next version of the standard. Furthermore, industry participation in that process will be more robust. CMS supports ASC X12's caution that even though the 6020 version will not be recommended for adoption, stakeholder input is still imperative. The 6020 version will still serve as the basis for the next version, but industry will have much-needed time to determine changes that are needed.

CMS will continue to support the work of ASC X12, the DSMO, other standards development organizations, operating rule entities, and industry stakeholders to improve the process for developing, adopting and maintaining standards and implementation specifications. Visit the *ASC X12 website* for more information on this decision.

Keep up to date on version 5010 and ICD-10. 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 201202-37

PWK is coming

PWK will allow documentation to be submitted for an initial claim

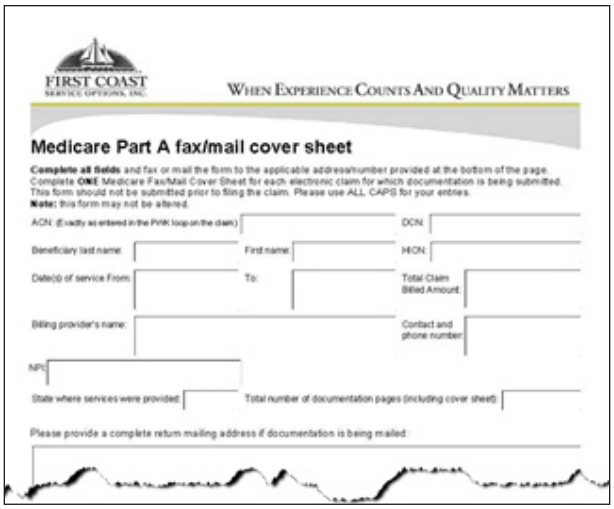
Effective April 2, 2012, First Coast Service Options Inc. (FCSO) will implement the PWK (paperwork) segment of the X12N version 5010. This will allow for voluntary submission of supporting documentation for a version 5010 electronic claim via mail or fax (PWK 02 segment, BM [by mail] or FX [by fax] qualifier, respectively).

PWK is a segment within the 2300/2400 Loop of the 837 Professional and Institutional electronic transactions that provides the link between electronic claims and additional documentation. PWK will allow providers to submit electronic claims that require additional documentation and, through the dedicated PWK process, have the documentation imaged to be available during the claims adjudication. Eliminating the need for costly development and allowing providers and Medicare contractors to utilize efficient, cost-effective electronic data interchange (EDI) technology will create a significant cost savings.

FCSO will make available a fax/mail coversheet that providers or trading partners shall use to submit the unsolicited additional documentation. The FCSO fax/mail coversheet will be an interactive form posted to our website. Providers or trading partners will complete required data elements and then be able to print a hardcopy of the form to mail or fax with their documentation. **Modifications to the fax/mail coversheet will not be permitted.** Separate forms will be provided for Part A and B. FCSO will also provide secure faxination numbers for those providers or trading partners who elect to fax the additional documentation.

PWK fax/mail coversheets

FCSO is requiring the following section of the form to be completed with valid information to ensure the paperwork documentation is appended to the pending claim in our system: ACN (Attachment Control Number (submitted in the PWK06 segment)), DCN (document control number [Part A]), ICN (internal control number [Part B] located in the 277CA, loop 2200D, REF02 segment -1K qualifier), the beneficiary's health insurance claim number (HICN)/ Medicare number, Billing provider's name and NPI (national provider identifier).


FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

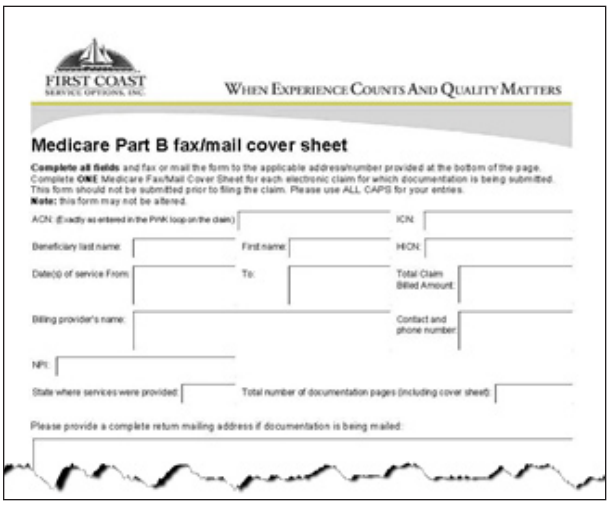
Medicare Part A fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE** Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries.
Note: this form may not be altered.

ACN: (Exactly as entered in the PWK loop on the claim) | DCN:
Beneficiary last name: | First name: | HICN:
Date(s) of service From: | To: | Total Claim Billed Amount:
Billing provider's name: | Contact and phone number:
NPI:
State where services were provided: | Total number of documentation pages (including cover sheet):
Please provide a complete return mailing address if documentation is being mailed:

FCSO will return PWK coversheets with missing or inaccurate data. The coversheet will be returned based on how it was received (fax or mail).

Note: FCSO will not return any paperwork documentation that accompanies a rejected PWK coversheet; nor will the documentation be used for adjudication of the claim.


FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Medicare Part B fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE** Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries.
Note: this form may not be altered.

ACN: (Exactly as entered in the PWK loop on the claim) | ICN:
Beneficiary last name: | First name: | HICN:
Date(s) of service From: | To: | Total Claim Billed Amount:
Billing provider's name: | Contact and phone number:
NPI:
State where services were provided: | Total number of documentation pages (including cover sheet):
Please provide a complete return mailing address if documentation is being mailed:

PWK documentation may not be submitted prior to submission of a claim. Submitters must send all relevant PWK data at the same time for the same claim. Thus, if the claim was submitted with multiple PWK iterations, all PWK data for the claim must be submitted together under one coversheet.

If the PWK segment is completed and additional documentation is needed for adjudication, FCSO will allow **seven calendar "waiting" days** (from the claim date of receipt) **for the paperwork documentation to be faxed** or **ten calendar waiting days to be mailed**.

If the PWK data is not received within the waiting timeframe and additional documentation is needed, a development request will be sent. If documentation is received after the timeframe has elapsed, the coversheet will be returned and the documentation will not be used for adjudication of the claim. Thus, the paperwork will need to then accompany our request for additional documentation to prevent possible claim denials.

(continued on next page)

(PWK continued)

Claims submitted with a PWK segment, that would not otherwise suspend for review and/or require additional development, will process routinely and will not be held for the seven or ten day waiting period.

Faxination numbers

FCSO will provide designated faxination lines to expedite receipt of the PWK coversheets/attachments, depending on the provider's line of business and location (Part A or Part B; Florida, Puerto Rico, or the U.S. Virgin Islands.

Each fax/mail coversheet will include the appropriate FCSO return mailing address and faxination number, based on the provider's selection.

5010 Companion Guide

Additional information on the PWK segment is available in the X12 Version 5010 837I and 837P Companion Guides.

- Part A: *837 Institutional Claim Transaction Specific Information*
- Part B: *837 Professional Claim Transaction Specific Information*

Source: CR 7330, CR 7041, CR 7306

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

Revised editing for hepatitis B administration code G0010

Provider types affected

All providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and A/B Medicare administrative contractors (MACs) for services paid under the outpatient prospective payment system (OPPS) are affected.

Provider action needed

This article is based on change request (CR) 7692 which informs Medicare contractors that effective for claims processed with dates of service on or after January 1, 2011, OPPS providers should report code G0010 for the administration of hepatitis B vaccine rather than *90471* or *90472* to ensure the correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine. If any claims containing this code were processed incorrectly prior to the implementation of CR 7692, you should bring them to the attention of your contractor on or after July 2, 2012, for adjustment. Please make sure your billing and coding staffs are aware of these changes.

Background

In CR 7342, Transmittal 2174, dated March 18, 2011, the Centers for Medicare & Medicaid Services (CMS) retroactively assigned HCPCS code G0010 to APC 0436, level I, drug administration,and changed the status indicator for HCPCS code G0010 from status indicator "B" to status indicator "S" effective January 1, 2011.

At the time of the release of CR 7342, the *Medicare Claims Processing Manual* was not updated to reflect this revised billing guidance. In CR 7692, CMS is updating the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.1, to reflect the current billing instructions

Additional Information

CR 7692, the official instruction issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2390CP.pdf*. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7692
Related Change Request (CR) #: N/A
Related CR Release Date: January 25, 2012
Effective Date: January 1, 2011
Related CR Transmittal #: R2390CP
Implementation Date: July 2, 2012

ICD-10 inclusion of type of bill 33x

Provider types affected

This *MLN Matters*® Article is intended for home health agencies (HHAs) who submit claims to Medicare fiscal intermediaries (FIs), Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

You must include International Classification of Diseases, 10th Edition (ICD-10) codes on 33x type of bills (TOB) that you submit with dates of service /discharge on or after October 1, 2013, and ICD-9 codes on those that you submit with dates of service/discharge before that date. Do not submit such bills with both types of codes included.

Caution – what you need to know

Change request (CR) 7704, from which this article is taken, provides guidance on reporting claims submissions and date span requirements for 33x TOBs containing ICD-10 codes with dates of service on and after October 1, 2013.

(continued on next page)

(ICD-10 continued)

Go – what you need to do

You should make sure that your billing staffs are aware of these 33x TOB coding requirements.

Background

On October 1, 2013, all Medicare claims submissions of diagnosis and hospital inpatient procedure coding will require a change from the ICD-9 to the 10th Edition (ICD-10). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, necessitating systems changes throughout the entire health care industry.

The Centers for Medicare & Medicaid Services (CMS) released CR 7492, on August 19, 2011, to provide guidance on reporting, claims submissions and date span requirements for ICD-10 diagnosis codes, effective October 1, 2013. You can find the *MLN Matters*® Article associated with this CR ("Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)") at *http://www.cms.gov/MLNMattersArticles/downloads/MM7492.pdf*.

CR 7492, however, did not include TOB 33x as a bill type for the requirements provided. CR 7704, from which this article is taken, adds TOB 33x to all requirements identified in CR 7492.

You should note that your FI, A/B MAC or RHHI will return to provider (RTP) 33X bill types they receive that include ICD-9 codes, and which have dates of service or dates of discharge/through dates on or after October 1, 2013. When they do RTP these claims, they will use the following message:

> "For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code".

Further, they will RTP any 33x TOB with through dates prior to October 1, 2013, which are billed with ICD-10 diagnosis codes, using the following message:

> "For dates of service prior to October 1, 2013, claims may not contain ICD-10 codes. Please re-submit claim with the appropriate ICD-9 code".

Finally, they will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim; using the following message:

> "Claims may not be submitted with both ICD-9 and ICD-10 diagnosis codes. Please correct. For dates of service prior to October 1, 2013, resubmit with the appropriate ICD-9 diagnosis code. For dates of service after October 1, 2013, resubmit with the appropriate ICD-10 diagnosis code".

Note: Medicare will allow HHAs to use the payment group code derived from ICD-9 codes on claims, which span October 1, 2013, but will require those claims to be submitted using ICD-10 codes.

Additional information

You can find more information about the inclusion of TOB 33x in the ICD-10 requirements by going to CR 7704, located at *http://www.cms.gov/transmittals/downloads/R1039OTN.pdf*.

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*.

MLN Matters® Number: MM7704
Related Change Request (CR) #: 7704
Related CR Release Date: February 3, 2012
Effective Date: October 1, 2013
Related CR Transmittal #: R1039OTN
Implementation Date: July 2, 2012

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Update to abortion condition codes associated with reason code 32809

Provider types affected

Hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for abortion services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

You must bill for abortion services provided to Medicare beneficiaries using updated condition codes, effective October 1, 2002.

Caution – what you need to know

Change request (CR) 7687, from which this article is taken, updates the abortion condition codes that are associated with reason code 32809.

Go – what you need to do

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

Background

Effective October 1, 1998, Medicare does not cover abortions except when the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, a physical injury or illness, including a life endangering physical condition caused by the pregnancy itself that would (as certified by a physician) place the woman in danger of death unless an abortion is performed.

Beginning July 1, 1999, providers billed for abortion services using modifier G7 defined as "the pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening." This modifier is used on claims with dates of services October 1, 1998, to the present.

CR 7687 announces that (effective October 1, 2002) reason code 32809 is updated with the correct condition codes as follows:

Condition code	Description
AA	Abortion performed due to rape
AB	Abortion performed due to incest
AD	Abortion performed due to life endangering physical condition

Please note that previous condition codes A7 and A8, effective October 1, 2002, are discontinued and reserved for national assignment.

Billing instructions

Hospitals will bill Medicare using bill type 11x. Medicare will pay only when the above condition codes are present in form locators (FLs) 18-28 along with an appropriate ICD-9-CM principal diagnosis code that will group to DRG 770 (abortion w D&C, aspiration curettage or hysterotomy), or with an appropriate ICD-9-CM principal diagnosis code and one of the four appropriate ICD-9-CM/ ICD-10-CM operating room procedure codes listed below that will group to DRG 779 (abortion w/o D&C).

ICD-9-CM	ICD-10-CM
69.01	• 10A07ZZ Abortion of products of conception, via natural or artificial opening • 10A08ZZ Abortion of products of conception, via natural or artificial opening endoscopic
69.02	• 10D17ZZ Extraction of products of conception, retained, via natural or artificial opening • 10D18ZZ Extraction of products of conception, retained, via natural or artificial opening endoscopic

(continued on next page)

(Abortion continued)

ICD-9-CM	ICD-10-CM
69.51	• 10A07ZZ Abortion of products of conception, via natural or artificial opening • 10A08ZZ Abortion of products of conception, via natural or artificial opening endoscopic
74.91	• 10A00ZZ Abortion of products of conception, open approach • 10A03ZZ Abortion of products of conception, percutaneous approach • 10A04ZZ Abortion of products of conception, percutaneous endoscopic approach

Note that you must use ICD-9-CM codes 69.01 and 69.02 or the related 1CD-10-CM codes to describe exactly the procedure or service performed, and that your FI/MAC will manually review claims with the above ICD-9-CM/ICD-10-CM procedure codes to verify that all of the above conditions are met.

Additional Information

You can find more information about the updated Medicare manual instructions by going to CR 7687, located at *http://www.cms.gov/Transmittals/downloads/R2397CP.pdf*. You will find the revised *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), Section 100.1 (Billing for Abortion Services) as an attachment to that CR. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7687 Revised
Related Change Request (CR) #: CR 7687
Related CR Release Date: January 26, 2012
Effective Date: October 1, 2002
Related CR Transmittal #: R2397CP
Implementation Date: July 2, 2012

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HHS announces intent to delay ICD-10 compliance date

As part of President Obama's commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius announced on February 16 that the Department of Health and Human Services (HHS) will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013; a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

"ICD-10 codes are important to many positive improvements in our health care system," said HHS Secretary Kathleen Sebelius. "We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system."

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

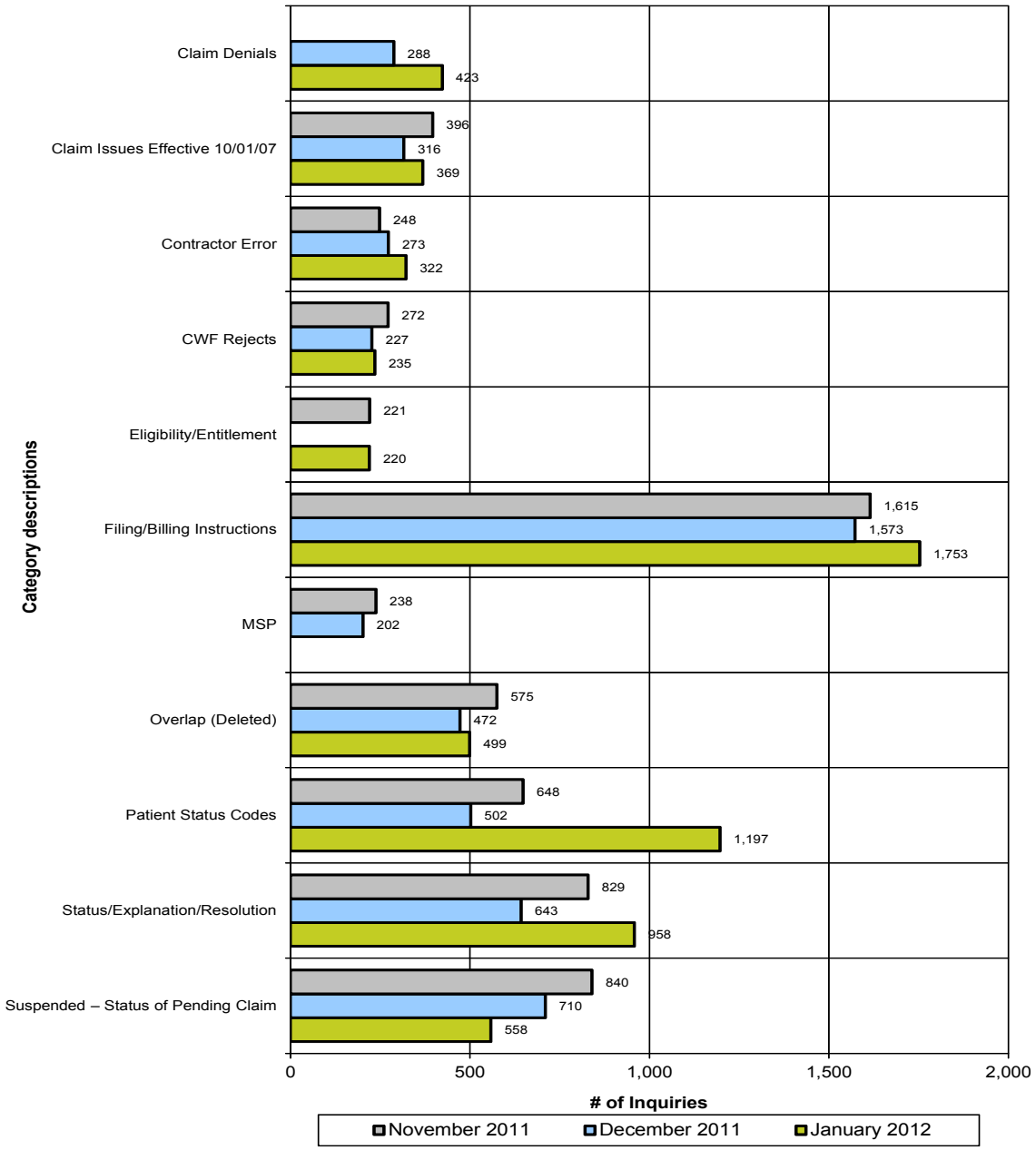
Source: CMS PERL 201202-45

Top inquiries, rejects, and return to provider claims – November 2011-January 2012

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 November 2011-January 2012.

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 November 2011-January 2012



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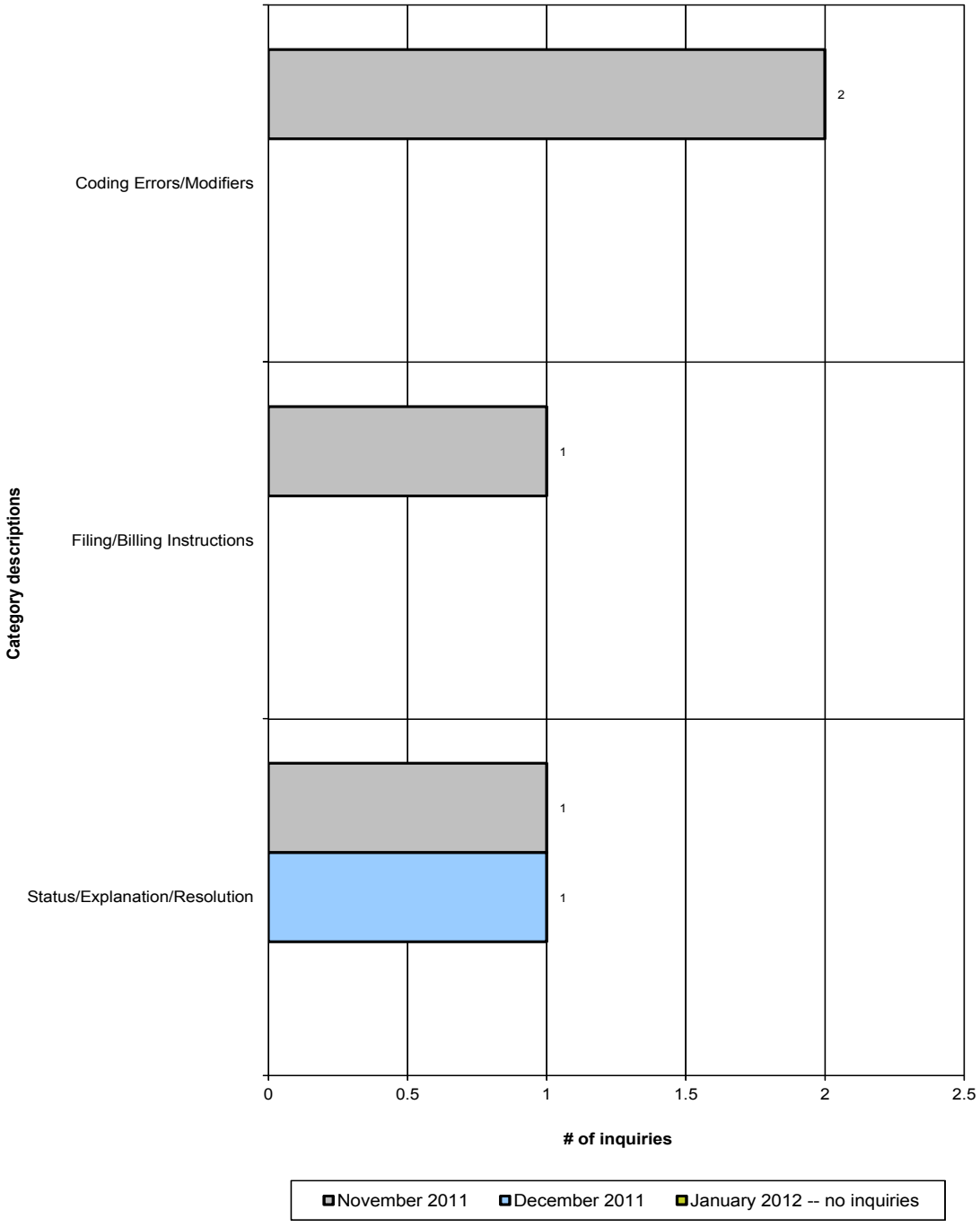
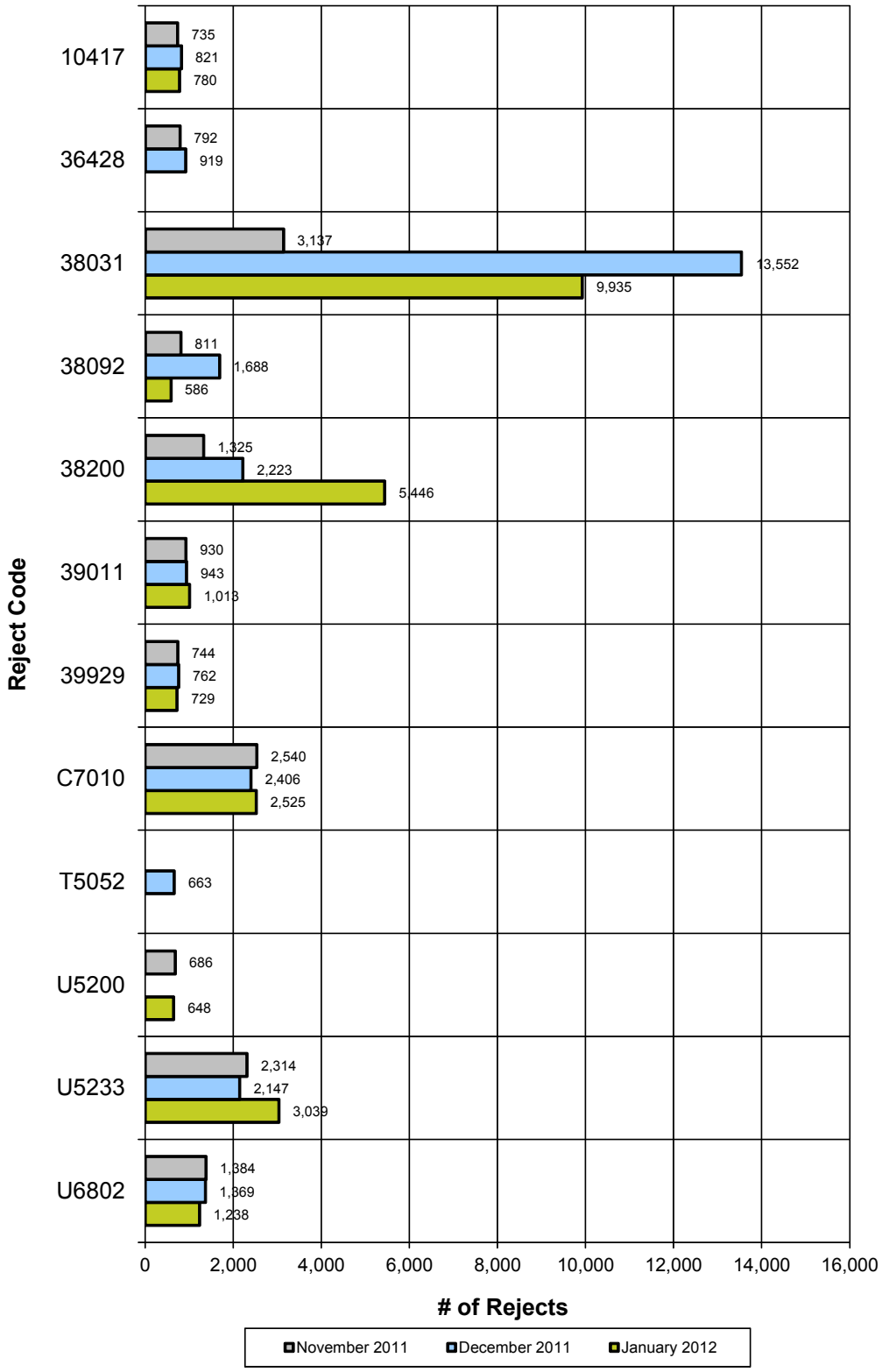
(Inquiries continued)

U.S. Virgin Islands Part A top inquiries for November 2011-January 2012



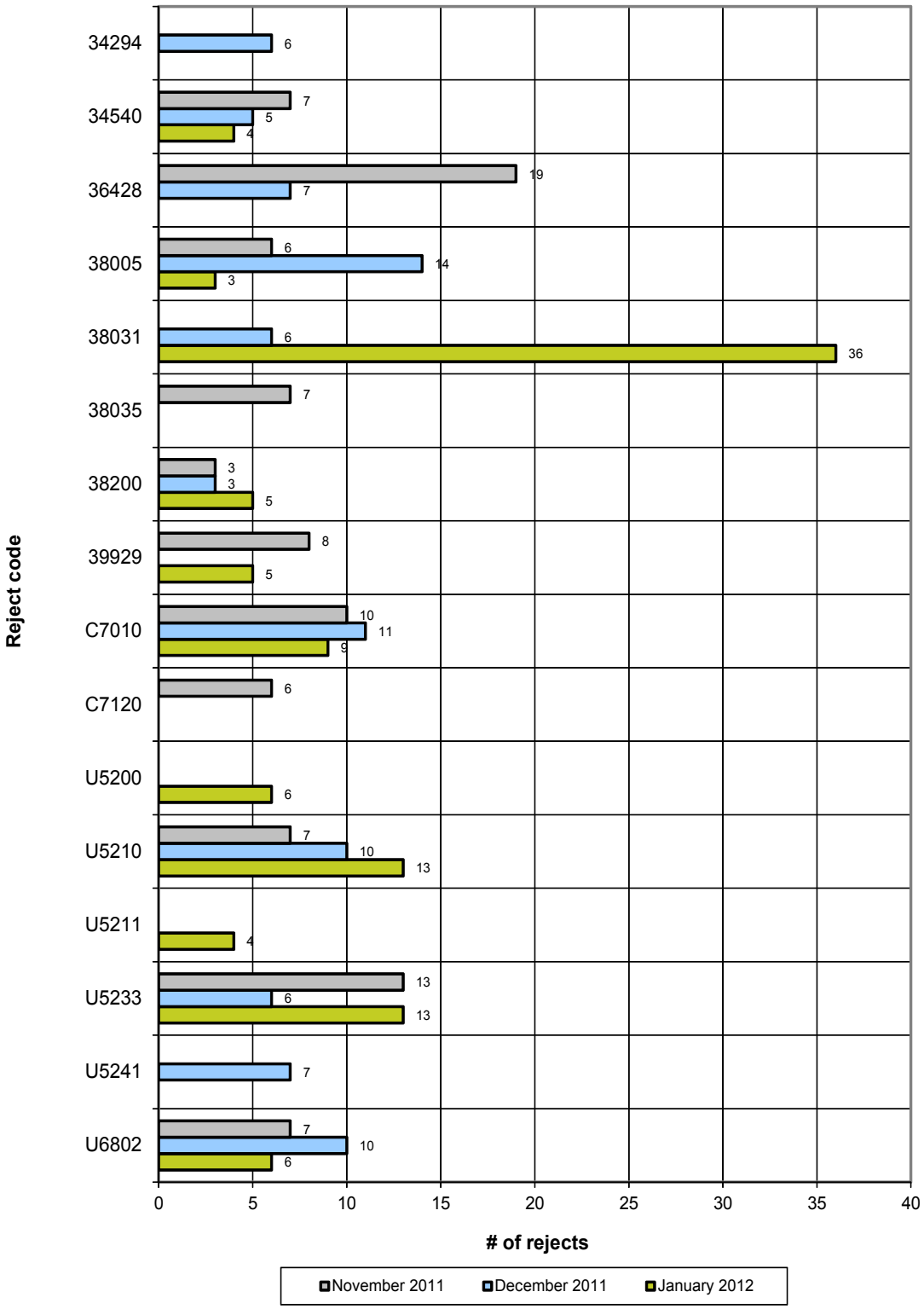
Florida Part A top rejects for November 2011-January 2012



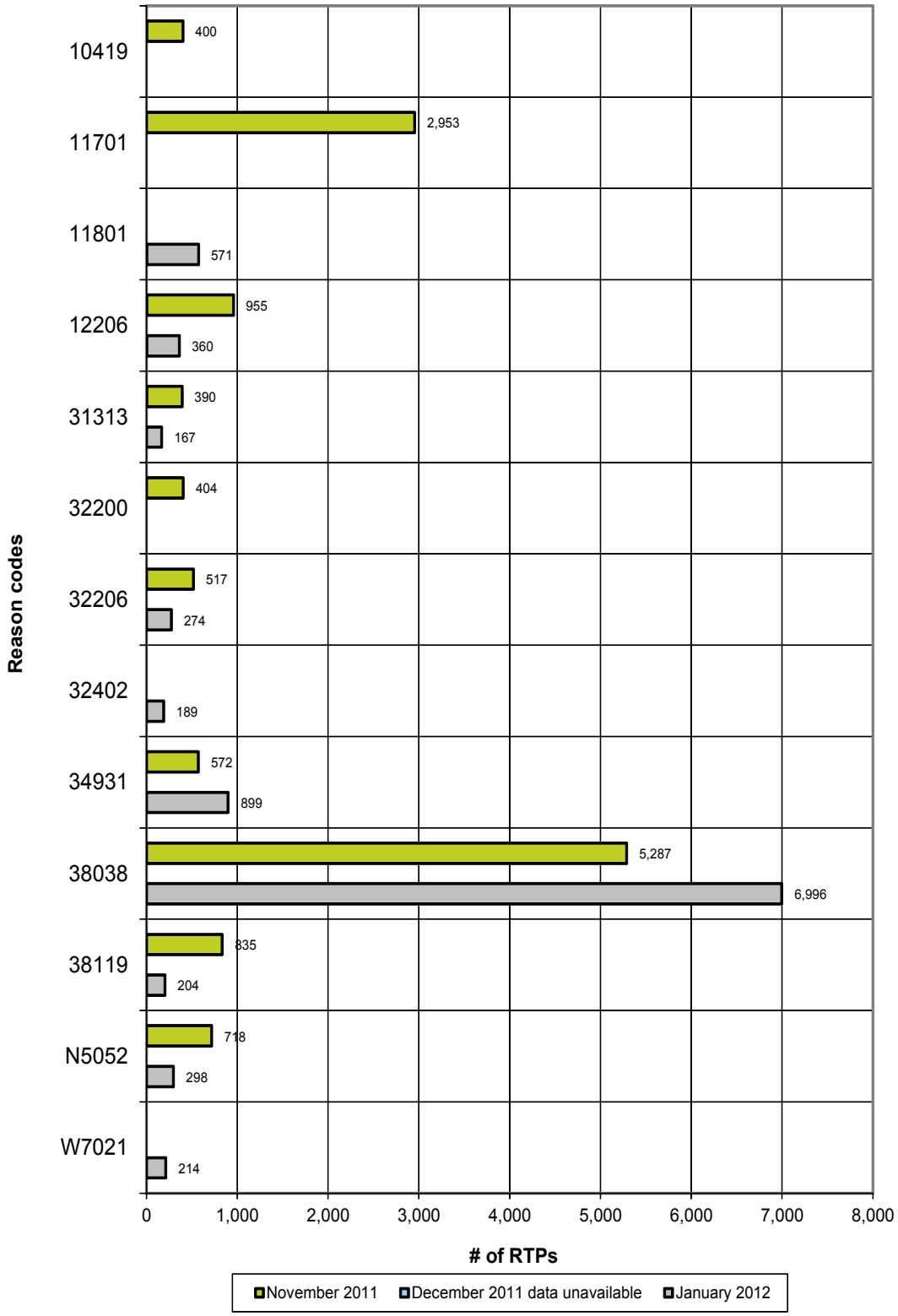
(continued on next page)

(Rejects continued)

U.S. Virgin Islands Part A top rejects for November 2011-January 2012



Florida Part A top return to providers (RTPs) for November 2011-January 2012



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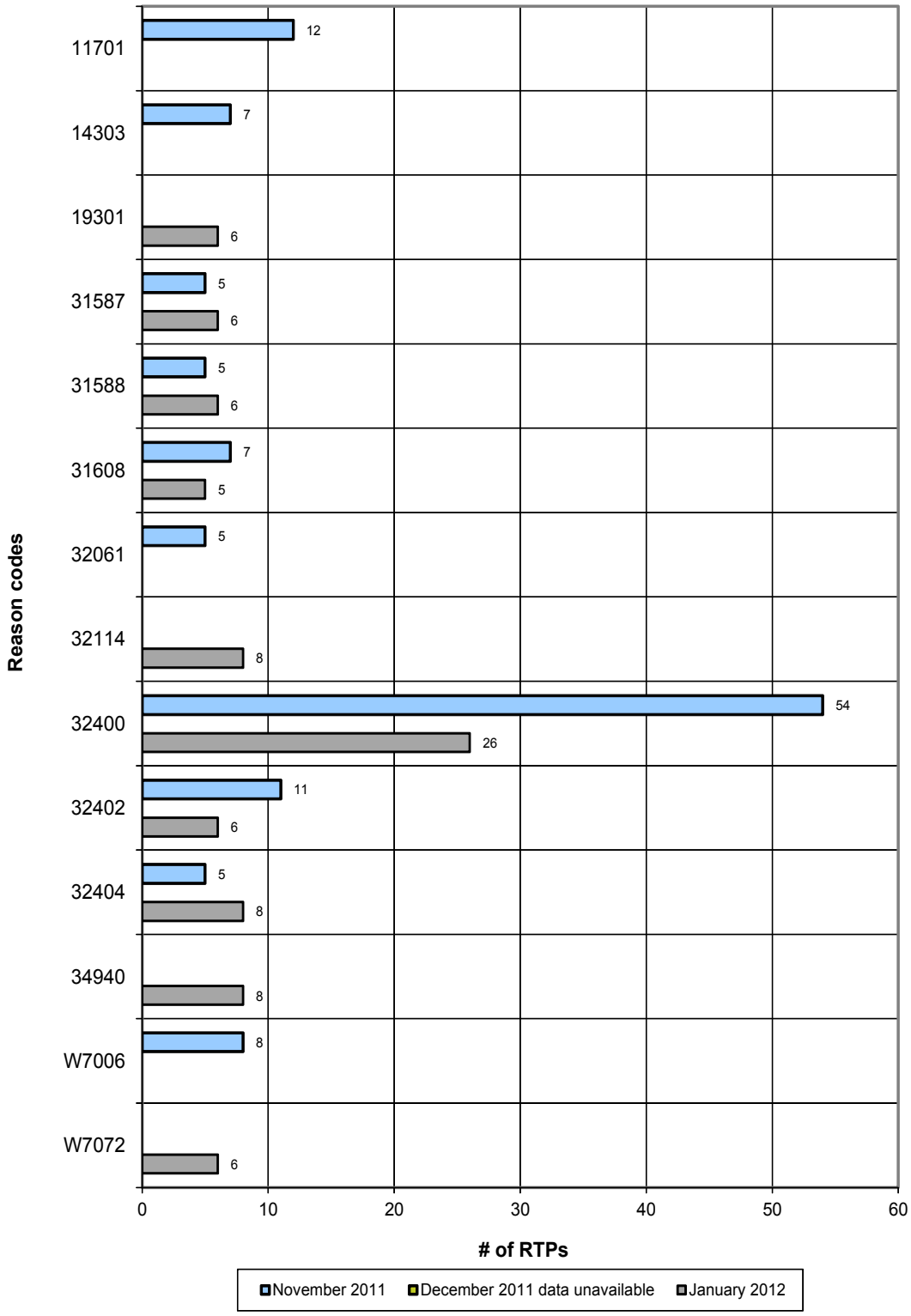
(RTPs continued)

U.S. Virgin Islands Part A top return to providers (RTPs) for November 2011-January 2012



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

Provider types affected

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

Provider action needed

Stop – impact to you

Medicare will use the April 2012 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2012, with dates of service April 1, 2012, through June 30, 2012.

Caution – what you need to know

Change request (CR) 7734, from which this article is taken, instructs your Medicare contractors to download and implement the April 2012 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2012, October 2011, July 2011, and April 2011 files.

Go – what you need to do

You should make sure that your billing staffs are aware of the release of these April 2012 ASP Medicare Part B drug files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c); (see *http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf*) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and "Not Otherwise Classified" (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (including inpatient hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/manuals/downloads/clm104c04.pdf*.)

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

Files	Effective for dates of service
April 2012 ASP and ASP NOC	April 1 – June 30, 2012
January 2012 ASP and ASP NOC	January 1 – March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011 – December 31, 2011
July 2011 ASP and ASP NOC	July 1 – September 30, 2011
April 2011 ASP and ASP NOC files	April 1 – June 30, 2011

Additional information

You can find the official instruction, change request (CR) 7734, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R2396CP.pdf*. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7734
Related Change Request (CR) #: CR 7734
Related CR Release Date: January 26, 2012
Effective Date: April 1, 2012
Related CR Transmittal #: R2396CP
Implementation Date: April 2, 2012

Rural health clinic and federally qualified health centers payment rate increases

Note: This article was revised on January 31, 2012, to reflect a revised change request (CR) 7533 issued on January 30. The CR was revised to provide the corrected 2012 payment rate increases for rural health clinics (RHCs) and federally qualified health centers (FQHCs). The Medicare Economic Index rate that was previously published did not contain the productivity adjustment that is always used for determining the RHC and FQHC upper payment limit. This article reflects the corrected rates. This information was previously published in the November 2011 *Medicare A Connection*, Page 6.

Provider types affected

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

What you need to know

This article is based on CR 7533 which provides instructions for the calendar year (CY) 2012 payment rate increases for RHC and FQHC services.

Background

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

- The RHC upper payment limit per visit is increased from $78.07 to $78.54 effective January 1, 2012, through December 31, 2012 (i.e., CY 2012). The 2012 rate reflects a 0.6 percent increase over the 2011 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI).
- The FQHC upper payment limit per visit for urban FQHCs is increased from $126.22 to $126.98 effective January 1, 2012, through December 31, 2012 (i.e., CY 2012), and the maximum Medicare payment limit per visit for rural FQHCs is increased from $109.24 to $109.90 effective January 1, 2012, through December 31, 2012 (i.e. CY 2012). The 2012 FQHC rates reflect a 0.6 percent increase over the 2011 rates in accordance with the rate of increase in the MEI.

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

Additional information

The official instruction, CR 7533 issued to your A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2406CP.pdf*.

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

MLN Matters® Number: MM7533 Revised
Related Change Request (CR) #: 7533
Related CR Release Date: January 30, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2406CP
Implementation Date: January 3, 2012

CY 2012 home health PPS PC Pricer updates

The calendar year (CY) 2012 home health prospective payment system (HH PPS) PC Pricer is now available for download. The HHA PC Pricer is on the Web page, *http://www.cms.gov/PCPricer/05_HH.asp*, under the Downloads section. If you use the CY 2012 HHA PPS PC Pricer, please go to the page above and download the latest 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 201201-54

Inpatient psychiatric facility prospective payment system FY 2012 Pricer file update

The fiscal year (FY) 2012 inpatient psychiatric facility prospective payment system (IPF PPS) PC Pricer has been updated with newer provider data, and is now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/PCPricer/09_inppsy.asp*. This Pricer is for claims dated from October 1, 2011, to September 30, 2012, and the update is dated February 10, 2012.

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

Source: CMS PERL 201202-30

Summary of policies in the CY 2012 MPFS final rule and the telehealth originating site facility fee payment amount

Note: This article was revised on February 2, 2012, to reflect a revised change request (CR) 7671 issued on January 18, 2012. The CR was revised to amend language in the summary of the multiple procedure payment reduction and revisions to the practice expense geographic adjustment policies described below in the *Background* section of this article. In addition, the article now reflects a new transmittal number, CR release date, and a revised Web address for accessing the CR. All other information remains the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 77-80.

Provider types affected

Physicians and non-physician practitioners who submit claims to fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs) are affected by this article.

What you need to know

This article is based on change request (CR) 7671, which summarizes the policies in the CY 2012 Medicare physician fee schedule final rule and announces the telehealth originating site facility fee payment amount for CY 2012. Please be sure that your staffs are aware of these changes.

Background

The purpose of this article is to inform you about the CR 7671, which summarizes the policies in the CY 2012 Medicare physician fee schedule (MPFS) and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year.

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2012.
- The final rule (published in the *Federal Register* on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate proposed notices earlier this year:
  - The *Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule* (published in the *Federal Register* on June 6, 2011), and
  - The *Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012* (published in the *Federal Register* on July 19, 2011).
- The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the *Federal Register* on November 29, 2010).
- Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

Updated policies

Summary of policies in the CY 2012 Medicare physician fee schedule (MPFS)

Misvalued codes under the physician fee schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several

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(MPFS continued)

years to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services that have been identified as misvalued, reducing payments for these services by approximately $100 million. CMS also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years.

Multiple procedure payment reduction policy

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The MPPR currently applies only to the technical component (TC). The procedure with the highest PC and TC payment would be paid in full. Beginning CY 2012, the PC payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations.

Revisions to the practice expense geographic adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 types of physician services. The Affordable Care Act revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent components of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average while CMS studied the changes that are being undertaken in the 2012 physician fee schedule final rule.

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with section 3102 (b) of the Affordable Care Act and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to the offices of physicians industry to calculate the PE employee wage index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the “all other services” and “other professional expenses” Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of statutory provisions, including a floor of 1.0 for the work GPCI and the limited recognition of cost differences for employee wage and office rent in the PE GPCI, will result in some payment reductions in the areas that benefitted from them in 2010 and 2011. Congress may choose to extend one or both of these provisions for CY 2012 subsequent to the release of this CR. In the event that Congress decides to extend either of these provisions for CY 2012, CMS will update the GPCIs for all impacted areas appropriately.

CMS is additionally basing the GPCI cost share weights on the revised and rebased 2006 MEI finalized by OACT in the CY 2011 final rule with comment period. CMS opted not to adopt the 2006-based MEI for GPCI cost share weights in the 2011 final rule in response to public comments. CMS subsequently addressed many of these commenters concerns in the CY 2012 final rule through the changes that are described above.

The Institute of Medicine (IOM) also has been evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment. Their first report released in full in September includes an evaluation of the accuracy of geographic adjustment factors for the hospital wage index and the GPCIs and the methodology and data used to calculate them. CMS already is implementing many of the IOMs recommendations through the revisions to the GPCIs adopted in the CY 2012 final rule with comment period. Some IOM recommended revisions to the GPCIs will require a change in law.

Implementation of the 3-day payment window policy in wholly owned or wholly operated entities

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of

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(MPFS continued)

2010 (PACMBPRA) was enacted. Section 102 of this Act, entitled "Clarification of 3-Day Payment Window," clarified when certain non-diagnostic 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 "3-day payment window," and a 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 non-diagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

When a physician's office or clinic that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3 day payment 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 a physician's office or practice has received confirmation of a beneficiary's inpatient admission from the admitting hospital, it should, for services furnished during the 3 day payment window, append CMS payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days) to all claim lines for diagnostic services and for those non-diagnostic services that have been identified as related to the inpatient stay. The new modifier will be available for use on January 1, 2012, and CMS encourages wholly owned or wholly operated physician offices and entities to begin to use the modifier when services are subject to the 3 day payment window policy. CMS will delay implementation of the policy until July 1, 2012, so that physician's offices and entities may coordinate their internal claims and payment practices. Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

Annual wellness visit providing a personalized prevention plan

The Affordable Care Act provided for Medicare coverage for an annual wellness visits (AWV) providing personalized prevention plan services. The statute required that a health risk assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published "A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries." This framework includes sections on:

- History of health risk assessments,
- Defining the HRA framework and rationale for its use
- Use of HRAs and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

As discussed in the preamble to the CY 2012 physician fee schedule final rule, CMS believes it is important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

CMS is providing payment for the AWV through the same level II HCPCS codes as were used in CY 2011 and is adjusting the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.

Molecular pathology procedure codes

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure codes released by the American Medical Association (AMA). However, each of these new molecular pathology procedure codes represents a test that is currently being furnished and which may be billed to Medicare. When these types of tests are billed to Medicare, the existing *CPT* codes are "stacked", or billed in combination with each other, to represent one given test. Under the new *CPT* coding structure for these molecular pathology services, a physician or laboratory would bill Medicare the new, single *CPT* procedure code that corresponds to the test represented by the "stacked" codes rather than billing each component of the test separately. CMS notes that not all of the current "stacked" molecular pathology *CPT* codes represent physicians' services paid on the physician fee schedule (PFS); many are only payable on the clinical laboratory fee schedule (CLFS).

For payment purposes under the PFS and CLFS, these 101 new molecular pathology procedure codes will be assigned a MPFS procedure status indicator of

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(MPFS continued)

"B" (Bundled Code). Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (for example, a telephone call from a hospital nurse regarding care of a patient)). While these services would traditionally be assigned a procedure status indicator of "I" (Not Valid for Medicare purposes Medicare uses another code for the reporting of, and the payment for these services.), assigning these *CPT* codes a procedure status of B will allow CMS to gather claims information important to evaluating eventual pricing of these new molecular pathology *CPT* codes.

To that end, as of January 1, 2012, Medicare requests that Medicare claims for molecular pathology procedures reflect both the existing "stacked" *CPT* codes that are required for payment and the new single *CPT* code that would be used for payment purposes if the new *CPT* codes were active. While the allowed charge amount will be $0.00 for the new molecular pathology procedure codes that carry the procedure status indicator of B, Medicare requests that Medicare claims also reflect a charge for the non-payable service. Please note that these CPT codes are listed in the CY 2012 PFS final rule as having a procedure status indicator of I---the CY 2012 final rule text and accompanying files will be corrected to reflect the procedure status indicator of B for these 101 molecular pathology *CPT* codes.

Telehealth services

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as kidney disease education (KDE) counseling services and medical nutrition therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the list of Medicare telehealth services under the "category 2" methodology ("category 1" are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

Telehealth originating site facility fee payment amount

Section 1834(m) of the Social Security Act established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased, as of the first day of the year, by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for CY 2012 is 0.6 percent.

For CY 2012, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $24.24. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Additional information

For more information and access to the CY 2012 final rule, go to the "Physician Fee Schedule" available at *http://www.cms.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage*. The official instruction, CR 7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2379CP.pdf*.

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

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Related Change Request (CR) #: 7671
Related CR Release Date: January 18, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2379CP
Implementation Date: January 3, 2012

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Immediate recoupment for fee-for-service claims overpayments

Provider types affected

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

Provider action needed

CR 7688 is policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the *Key points* section of this article for specifics.

Background

Currently, Medicare contractors begin recoupment of an overpayment on day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key points

The "immediate recoupment" process implemented in CR 7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment

1. Providers who choose immediate recoupment must do so in writing to the contractors. Also, note the following:
2. The request may be for:
   a. a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
   b. a permanent request for the specific demanded overpayment and all future overpayments.
3. The request may be submitted via regular mail, facsimile, or email and the request must include the Provider's name, contact phone number, Medicare number and/or national provider identifier (NPI), provider or chief financial officer's signature, demand letter number and what option the provider is requesting.
4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.
5. Providers can terminate the immediate recoupment process at any time. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after qualified independent contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision. These rules are explained in Chapter 3, Section 200 of the *Medicare Financial Management Manual* that is available at *http://www.cms.gov/manuals/downloads/fin106c03.pdf*.

You may further review all of the specifics of this change along with the applicable manual section changes by reading the official instruction for CR 7688 issued to your Medicare contractor. The web address for CR 7688 is listed in the *Additional information* section of this article.

Note: If there is a remaining principal balance after the initial immediate recoupment, contractors shall continue recoupment and other collective activities. In addition, if you currently have an immediate recoupment arrangement, you must submit a new request to continue the immediate recoupment process.

Additional information

The official instruction, CR 7688, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R205FM.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: MM7688 Revised
Related Change Request (CR) #: 7688
Related CR Release Date: February 9, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R205FM
Implementation Date: July 2, 2012

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CMS gives consumers access to more details about infection rates at America's hospitals – data will save lives, cut costs

Central line-associated bloodstream infections (CLABSIs) are among the most serious of all health care-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the U.S. health care system. On Tuesday, February 7, the Centers for Medicare & Medicaid Services (CMS) announced that Hospital Compare will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in U.S. hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular Web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about Hospital Compare is online at *http://www.HospitalCompare.HHS.gov*.

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing Hospital Compare, visit the *CMS YouTube channel*.

The full text of this excerpted CMS press release (issued Tuesday, February 7) can be found at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4260*.

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

Source: CMS PERL 201202-21

New short-term PEPPER to be released in February

A new release of the short-term acute care program for evaluating payment patterns electronic report (ST PEPPER), with statistics through the fourth quarter of fiscal year (FY) 2011, will soon be available for short-term acute care hospitals (STACHs) nationwide. This release of PEPPER includes a new target area, "Spinal Fusions."

The PEPPER provides hospital-specific data statistics for Medicare discharges in 30 areas that may be at risk for improper Medicare payments. Hospitals can use PEPPER to support internal auditing and monitoring activities. The PEPPER is a free report comparing a hospital's Medicare billing practices with other hospitals in the state, Medicare administrative contractor (MAC) or fiscal intermediary (FI) jurisdiction, and nation. The Centers for Medicare & Medicaid Services (CMS) has contracted with TMF Health Quality Institute to develop and distribute the reports.

The PEPPER will be distributed electronically to STACHs through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role by Friday, February 24. Users can access the *"ST PEPPER User's Guide"* for more information.

Note: For this PEPPER release, target area "PTCA with Stent" statistics are suppressed due to problems identified in the national Medicare claims data warehouse.

CMS encourages hospitals to *provide feedback on PEPPER* so that the reports can be continually improved.

Source: CMS PERL 201202-60

Update to the FY 2012 list of codes exempt from reporting present on admission

Provider types

Affected hospitals who submit claims to A/B Medicare administrative contractors (MACs) and fiscal intermediaries (FIs) for services to Medicare beneficiary inpatient services are affected.

Provider action needed

This article is based on change request (CR) 7680, which informs you about the update to the Fiscal Year (FY) 2012 International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) codes exempt from reporting present on admission (POA).

Hospitals (billing 5010 or direct data entry) should report a POA indicator of "W" for the codes listed in the background section below instead of a 'blank' as a workaround to allow claims to process until July 1, 2012. Make certain that your billing staffs are aware of these requirements.

Background

Present on admission

The Deficit Reduction Act of 2005 requires the Secretary of Health and Human Services to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present.

The Centers for Medicare & Medicaid Services (CMS) also requires hospitals to report present on admission indicators for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007. Some diagnosis codes are exempt from POA reporting.

The following ICD-9-CM codes have either been added or deleted from the list of diagnosis codes exempt from reporting a POA indicator effective October 1, 2011. Hospitals that received reason code 34931 should report a POA indicator of "W" (should they choose) as a workaround until the POA exempt list is updated in Medicare systems on July 2, 2012. A complete list of codes is available in the CR 7680 instruction accessible at the Web address shown in the following *Additional information* section.

ICD-9-CM diagnosis codes exempt from reporting POA, added to the list, effective October 1, 2011:

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

ICD-10 codes

CMS has provided the converted ICD-10-CM codes, listed below, for the additional codes only.

- Q25.5
- Q25.6
- Q25.7
- Z47.89
- Z78.9
- Z79.899
- Z83.5
- Z86.39
- Z86.71
- Z87.898
- O09.291
- O09.292
- O09.293
- O09.299
- O09.891

(continued on next page)

(POA continued)

- O09.892
- O09.893
- O09.899

ICD-9-CM diagnosis codes exempt from reporting POA, terminated from the list, effective October 1, 2011:

- 747.3
- V12.2
- V13.8
- V19.1

Additional information

The official instruction associated with this CR 7680, issued to your Medicare A/B MAC and FI regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1019OTN.pdf*. If you have questions, please contact your Medicare A/B MAC or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7680
Related Change Request (CR) #: 7680
Related CR Release Date: January 25, 2012
Effective Date: October 1, 2011
Related CR Transmittal #: R1019OTN
Implementation Date: July 2, 2012

Preservation of resident cap positions from closed hospitals

On Monday, January 30, the Centers for Medicare & Medicaid Services (CMS) released the results of its decisions regarding which teaching hospitals will receive increases to their direct graduate medical education (GME) and indirect medical education (IME) full-time equivalent (FTE) resident caps under Section 5506 of the Affordable Care Act. Section 5506 of the Affordable Care Act directed CMS to develop a process to permanently preserve the Medicare- funded residency slots from teaching hospitals that close.

The provision directed CMS to create a pool based on the number of Medicare cap slots associated with the closed teaching hospital's direct GME and IME caps. This pool of direct GME and IME slots is then to be redistributed, giving priority to those hospitals that are located in the same or contiguous CBSA (as the closed hospital) and that meet other criteria. Applications requesting slots from the first round of Section 5506 – that is, from the 14 teaching hospitals that closed between Sunday, March 23, 2008, and Tuesday, August 3, 2010 – were due to CMS by Friday, April 1, 2011.

To see the list of hospitals reviewed under this first round of Section 5506, visit *http://www.CMS.gov/AcuteInpatientPPS/06_dgme.asp* and look for the "Section 5506 Cap Increases Related to Applications Due April 1, 2011" file in the "Downloads" section of the page.

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

Source: CMS PERL 201201-53

Inpatient prospective payment system FY 2012 Pricer file update

The fiscal year (FY) 2012 inpatient prospective payment system (INP PPS) PC Pricer has been updated with new provider data, and is now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.CMS.gov/PCPricer/03_inpatient.asp*. This Pricer is for claims dated from October 1, 2011, to September 30, 2012, and the update is dated February 7, 2012.

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

Source: CMS PERL 201202-14

Update to Pub 100-04, *Medicare Claims Processing Manual,* Chapter 3: Inpatient Hospital Billing

Provider types affected

All providers submitting claims to Medicare contractors (fiscal intermediaries (FI) and A/B Medicare administrative contractors (MACs) for Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7706 which clarifies billing instructions in the *Medicare Claims Processing Manual* when life time reserve (LTR) days exhaust during the non-outlier portion of an inpatient prospective payment system (IPPS) stay. There are no policy changes with this instruction and this article serves as informational by providing two examples conveyed in CR 7706 in order to provide clarification.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying billing instructions in the *Medicare Claims Processing Manual*, Chapter 3, Inpatient Hospital Billing, Section 40, Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals when LTR days exhaust during the non-outlier portion of an IPPS stay. A new example has been added to this section to show how to utilize occurrence span code 70 when the beneficiary only has LTR days remaining and they are exhausted during the stay. The clarification is as follows:

If the beneficiary had one or more regular benefit days (full or coinsurance days) remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the non-outlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. IPPS uses occurrence span code 70 for the covered non-utilization period after regular benefit days are exhausted or when only LTR days are exhausted.

For example:

Example 1: No cost outlier, only LTR days available and exhaust prior to discharge

Dates of service:	01/05 – 01/16
Medically necessary days:	11
Benefit days available value code (VC) 83:	1 LTR
Covered days VC 80:	1
Noncovered days VC 81	10
Cost report days:	11
OC A3:	01/15 (includes covered non- utilization period)
Occurrence span code (OSC) 70:	01/06 – 01/15
Room & board revenue code:	11 total & covered units
Medicare approved revenue codes:	Charges in covered
Reimbursement:	Full DRG payment, no cost outlier
Beneficiary liability:	LTR copayment amount

Example 2: No cost outlier, coinsurance days available and exhaust prior to discharge

Dates of service:	01/05 – 01/16
Medically necessary days:	11
Benefit days available VC 82:	3 Coinsurance
Covered days VC 80:	3
Noncovered days VC 81	8
Cost report days:	11
OC 70:	01/08 – 01/15
Room & board revenue code:	11 total & covered units
Medicare approved revenue codes:	Charges in covered
Reimbursement:	Full DRG payment, no cost outlier
Beneficiary liability:	Coinsurance copayment amount

(continued on next page)

(Inpatient continued)

Additional information

The official instruction, CR 7706 issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2388CP.pdf*.

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

MLN Matters® Number: MM7706
Related Change Request (CR) #: 7706
Related CR Release Date: January 20, 2012
Effective DateApril 22, 2012
Related CR Transmittal #: R2388CP
Implementation Date: April 22, 2012

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Physician self-referral prohibition: Additional information on exception process for physician-owned hospitals

As a reminder, the outpatient prospective payment system (OPPS) final rule that was released Wednesday, November 30, 2011, stated that in order for a physician-owned hospital to receive an exception to the prohibition on facility expansion, it must satisfy eligibility criteria to qualify as an "applicable hospital" or "high Medicaid facility."

The Centers for Medicare & Medicaid Services has published additional guidance at *http://www.CMS.gov/PhysicianSelfReferral/85_Physician_Owned_Hospitals.asp* that will address the process for accessing data, as well as provide sample computations for determining whether a hospital satisfies the respective criteria. Questions regarding this issue can be emailed to *POHexceptions@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 201202-02

Swing Bed Services fact sheet revised

The *"Swing Bed Services"* fact sheet (ICN 006951) has been revised and is now available in downloadable format. It includes information on background, requirements that apply to hospitals and critical access hospitals, and swing bed services payments.

Source: CMS PERL 201201-55

Critical Access Hospital fact sheet revised

The revised *"Critical Access Hospital"* fact sheet (ICN 006400) is now available in downloadable format. This fact sheet includes background information, as well as information on critical access hospital (CAH) designation, CAH payments, reasonable cost payment principles that do not apply to CAHs, election of standard payment method or optional (elective) payment method, Medicare rural pass-through funding for certain anesthesia services, incentive payments, and grants to states under the Medicare rural hospital flexibility program.

Source: CMS PERL 201202-65

MPPR for physician services for certain diagnostic imaging procedures in critical access hospitals

Provider types affected

Critical access hospitals (CAHs) submitting claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) for certain diagnostic imaging procedures provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7684, which informs Medicare contractors about the changes necessary to implement multiple procedure payment reduction (MPPR) for physician services for certain diagnostic imaging procedures in critical access hospitals (CAHs) that have elected the optional method for outpatient billing. Be sure your staffs are aware of these changes.

Background

Section 3134 of the Affordable Care Act added Section 1848(c)(2)(K) of the Social Security Act, which specifies that the Secretary will identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a result of this examination, Medicare is making a change to the MPPR for physician services of certain diagnostic imaging procedures.

CR 7684 applies the MPPR to physician services of certain diagnostic imaging procedures billed by CAHs that have elected the optional method for outpatient billing. Payment is made to the CAH for physician services (revenue code (RC) 96x, 97x, or 98x) on bill type 85x based off the Medicare physician fee schedule (MPFS) supplemental file.

When the MPPR is applied, the remittance advice will show a claim adjustment reason code of 59 (processed based on the multiple or concurrenct procedure rules) and a group code of CO (contractual obligation). In addition, deductible and coinsurance are based on the reduced amount, but the 115 percent add-on after deductible and coinsurance still applies.

The MPPR on diagnostic imaging applies when multiple physician services are furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the service that yields the highest payment under the MPFS. Payment is made at 75 percent for the subsequent services furnished by the same physician to the same patient in the same session on the same day. The current list of codes subject to the MPPR on diagnostic imaging is in Attachment 1 of CR 7684, which may be accessed in the *Additional information* section.

Medicare uses the payment policy indicators on the MPFS to determine if a multiple procedure is authorized for a specific Healthcare Common Procedure Coding System (HCPCS) or *Current Procedural Terminology (CPT)* code. The MPFS is located at *http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp*. The FIs and MACs have access to the payment policy indicators via the physician fee schedule payment policy indicator file in the fiscal intermediary shared system.

Additional information

The official instruction, CR 7684, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2395CP.pdf*.

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

MLN Matters® Number: MM7684
Related Change Request (CR) #: 7684
Related CR Release Date: January 26, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2395CP
Implementation Date: July 2, 2012

SNF and swing bed reporting requirements for occurrence code 16 and assessment date reporting

Provider types affected

This article is for hospitals and SNFs submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for SNF or swing bed (SB) hospital services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7717 which discontinues the SNF and SB provider reporting requirement for reporting occurrence code 16 and updates instructions for assessment date reporting. CR 7717 updates current Medicare system edits to add the following assessment indicators (AIs) that only require one occurrence code 50 (assessment date reporting) for an assessment that produces two Health Insurance Prospective Payment System (HIPPS) codes required on the claim: 0A, 0B, 0C, 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 5A, 5B, and 5C.

Background

The Centers for Medicare & Medicaid Services (CMS) developed assessment indicators (AI) to identify on a claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the resource utilization group (RUG) that is included on the claim for payment of Medicare SNF services. In addition, AIs identify the effective date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time.

Change request (CR) 7717 updates current Medicare system edits and CMS manual sections to add the following assessment indicators (AIs) that only require one occurrence code 50 (assessment date reporting) for an assessment that produces two HIPPS codes required on the claim: 0A, 0B, 0C, 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 5A, 5B, and 5C.

In addition, CR 7717 instructs that, effective with the release of CR7717, CMS is discontinuing the requirement for SNF and SB providers to report Occurrence Code 16 to indicate the last day of therapy services. CR 7717 updates the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 30 (Billing SNF PPS Services) to remove this requirement, and the revised Section 30 is included as an attachment to CR 7717.

Additional Information

The official instruction, CR 7717, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2399CP.pdf*.

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

MLN Matters® Number: MM7717 Revised
Related Change Request (CR) #: CR 7717
Related CR Release Date: January 26, 2012
Effective Date: October 1, 2011
Related CR Transmittal #: R2399CP
Implementation Date: July 2, 2012

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FY 2012 inpatient SNF PPS PC Pricer update

The fiscal year (FY) 2012 inpatient skilled nursing facility prospective payment system (SNF PPS) PC Pricer has been updated with newer provider data, and is now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/PCPricer/04_SNF.asp*. This Pricer is for claims dated from October 1, 2011, to September 30, 2012, and the update is dated February 10, 2012.

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

Source: CMS PERL 201202-29

Inpatient rehabilitation facility no-pay billing for Medicare Advantage patients update

Provider types affected

This article is for IRFs that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for inpatient rehabilitation facility services provided to Medicare Advantage (MA) patients.

Provider action needed

Stop – impact to you

Change request (CR) 7674, from which this article is taken, provides hospitals with updated instructions on the submission of inpatient rehabilitation facility (IRF) "no-pay" bills to Medicare for Medicare Advantage (MA) patients.

Caution – what you need to know

For bills for IRF services provided to MA patients, effective July 1, 2012, you must submit informational only bills (TOB 111) with both condition code 04 and the case mix group (CMG) from the IRF patient assessment instrument (PAI). You may no longer use the default code of A9999.

Go – what you need to do

You should ensure that your billing staffs are aware of these updated instructions.

Background

On July 20, 2007, CMS issued CR 5647 to require hospitals (effective October 1, 2006) to submit "no pay" bills to their Medicare contractor for the (MA patients they treat, in order for the days to be eventually captured in the disproportionate share hospital (DSH) (or low income patient (LIP) for IRF) calculations. (You can find the associated *Medicare Learning Network®* (*MLN*) *Matters* article associated with CR 5647: "Capturing Days on Which Medicare Beneficiaries are Entitled to Medicare Advantage (MA) in the Medicare/ Supplemental Security Income (SSI) Fraction" at *http://www.cms.gov/MLNMattersArticles/downloads/MM5647.pdf*)

On March 14, 2008, CMS issued CR 5965 which instructed IRF hospitals to submit a default case mix group (CMG) code of A9999 for IRF "no-pay" claims (type of bill 111 with a condition code 04) for MA patients with discharges on or after October 1, 2006. At that time there was no requirement for IRF's to submit IRF patient assessment instruments (IRF PAI's) for MA patients. (You can find the associated *MLN Matters®* article associated with this CR: April 2008 inpatient rehabilitation facility (IRF) prospective payment system (PPS) pricer changes at *http://www.cms.gov/MLNMattersArticles/downloads/MM5965.pdf*.)

CR 7674, from which this article is taken, instructs IRF hospitals (effective July 1, 2012) to submit the case mix group (CMG) code from the IRF PAI for IRF "no-pay" claims (type of bill 111 with a condition code 04) for MA patients with discharges on or after October 1, 2011. Do not use the default CMG of A9999, effective July 1, 2012, as it will not be a valid code for claims received on or after that date.

Additional information

You can find more information about inpatient rehabilitation facility (IRF) no-pay billing for Medicare Advantage (MA) patients by going to CR 7674, located at *http://www.cms.gov/Transmittals/downloads/R2393CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), Sections 20.3 (Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients) and 3.140.2.4.3 (Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)) as an attachment to CR 7674.

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

MLN Matters® Number: MM7674
Related Change Request (CR) #: CR 7674
Related CR Release Date: January 25, 2012
Effective Date: October 1, 2011
Related CR Transmittal #: R2393CP
Implementation Date: July 2, 2012

Inpatient rehabilitation PPS FY 2012 Pricer file update

The fiscal year (FY) 2012 inpatient rehabilitation prospective payment system (IRF PPS) PC Pricer has been updated with newer provider data, and is now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/PCPricer/06_IRF.asp*. This Pricer is for claims dated from October 1 2011, to September 30, 2012, and the update is dated February 10, 2012.

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

Source: CMS PERL 201202-31

Find out first: Subscribe to FCSO eNews

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

Educational Events

Upcoming provider outreach and educational events – April 2012

Medicare Part A: Medicare changes and regulations

When: Tuesday, April 10
Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit our provider training website at *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 *fcsouniversity.com*.

Other Educational Resources

February is American Heart Month

Cardiovascular disease – including heart disease and stroke – is the leading cause of death in the United States. Every day, 2,200 people die from cardiovascular disease – that's 815,000 Americans each year, or 1 in every 3 deaths. The good news is that many risk factors for cardiovascular disease such as hypertension, high cholesterol, and smoking can be prevented and controlled. To help, Medicare provides payment for the following benefits:

- Initial preventive physical exam (also known as the "Welcome to Medicare" visit)
- Annual wellness visit, including personalized prevention plan service
- Cardiovascular screening (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Intensive behavioral therapy for cardiovascular disease
- Tobacco-use cessation counseling services

What can you do?

- Help seniors and others with Medicare better understand and identify their risk factors for heart disease and stroke
- Talk with your patients about what they can do to reduce, eliminate, or control their cardiovascular disease risk factors and encourage appropriate use of the Medicare preventive benefits that can help them reach these goals
- Learn more about and take advantage of information provided by campaigns like American Heart Month and *Million Hearts*, a national initiative to prevent 1 million heart attacks and strokes over five years

For more information

- *MLN Guide to Medicare Preventive Services for Healthcare Professionals*
- *MLN Expanded Benefits brochure*
- *MLN Annual Wellness Visit brochure*
- *MLN Tobacco-Use Cessation Counseling Services brochure*
- *National Coverage Determination (NCD) for Intensive Behavioral Therapy for Cardiovascular Disease*
- *MLN Preventive Services Educational Products Web page*
- *MLN Quick Reference Information: Medicare Preventive Services chart for providers*
- *CDC American Heart Month* and *CDC Heart Disease Guidelines and Recommendations* Web pages
- *HHS Million Hearts™ campaign*
- *CDC Report – Million Hearts: Strategies to Reduce the Prevalence of Leading Cardiovascular Disease Risk Factors*

Thank you for joining with CMS in promoting the increased awareness of cardiovascular disease, its risk factors, and related preventive benefits covered by Medicare.

Source: CMS PERL 201202-27

The Guide to Medicare Preventive Services: Errata Sheet to the Fourth Edition fact sheet released

"The Guide to Medicare Preventive Services: Errata Sheet to the Fourth Edition" fact sheet (ICN 907802) has been released and is available in downloadable format. This errata sheet reflects the changes to *The Guide to Medicare Preventive Services*, and includes updates such as information on newly-covered benefits, updated codes, and resources.

Source: CMS PERL 201201-55

New *MLN*® 'fast fact' highlights the importance of medical documentation

A new "fast fact" is now available on the *Medicare Learning Network*® (*MLN*®) *Provider Compliance* Web page. This Web page provides the latest *MLN*® products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. A new "fast fact" is added each month, so please bookmark the Provider Compliance Web page and check it often.

Source: CMS PERL 201202-42

Guidelines for Teaching Physicians, Interns, and Residents fact sheet revised

The "Guidelines for Teaching Physicians, Interns, and Residents" fact sheet (ICN 006347) has been revised and is now available in downloadable format. It includes information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines.

Source: CMS PERL 201201-55

Revised *Clinical Laboratory Fee Schedule* fact sheet

The *Clinical Laboratory Fee Schedule fact sheet* (ICN 006818) has been revised and is now available in downloadable format. This fact sheet includes background information as well as information coverage of clinical laboratory services and how payment rates are set.

Source: CMS PERL 201202-42

Tobacco-Use Cessation Counseling Services brochure revised

The *"Tobacco-Use Cessation Counseling Services"* brochure (ICN 006767) has been revised and is now available for download. This brochure is designed to provide education on tobacco-use cessation counseling services, and includes coverage information for both symptomatic and asymptomatic beneficiaries as well as information on tobacco-use cessation counseling.

Source: CMS PERL 201202-65

Medicare Learning Network® provider exhibit program schedule

Mark your calendars

The *Medicare Learning Network®* will be exhibiting at the following health care provider conferences in the coming weeks:

- *American Medical Group Association: 2012 Annual Conference*

  Wednesday, March 7 through Saturday, March 10

  Manchester Grand Hyatt; San Diego, Calif.

  Booth #802

- *American Medical Student Association*

  Thursday, March 8 through Sunday, March 11

  Hyatt Regency Houston; Houston, Texas

  Booth #12

- *National Association of Rural Health Clinics*

  Monday, March 19 through Tuesday, March 20

  Hyatt Regency; San Antonio, Texas

- *The American College of Cardiology's 61st Annual Scientific Session & Expo*

  Saturday, March 24 through Monday, March 26

  Chicago, Ill.

  Booth #19076

- *National Hospice & Palliative Care Organization*

  Thursday, March 29 through Saturday March 31

  National Harbor, Md.

  Booth #625

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

Source: CMS PERL 201202-42

MLN Matters® articles search tips

Looking for the latest new and revised *MLN Matters®* articles? The *Medicare Learning Network®* offers several ways to search and quickly find articles of interest to you:

- *MLN Matters®* **search engine** – an advanced search feature that allows you to search *MLN Matters®* articles from 2004 to the current year. For more information and introductions on how to use the search engine, visit the *MLN Matters* Search Tips Web page at *http://www.CMS.gov/MLNMattersArticles/02_Search.asp*.
- *MLN Matters®* **index** – a list of common keywords and phrases contained within *MLN Matters®* articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit *http://www.CMS.gov/MLNMattersArticles/01_Overview.asp* and scroll to the "Downloads" section of the page.
- *MLN Matters®* **dynamic lists** – an archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the *MLN Matters®* Article Web page at *http://www.CMS.gov/MLNMattersArticles*.
- *MLN Matters®* **electronic mailing list** – A free notification of new and revised *MLN Matters®* articles as they are released. For more information, including how to subscribe to the service, visit *http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf*. You can also view and search an archive of previous messages at *http://list.nih.gov/cgi-bin/wa.exe?A0=MLNMATTERS-L.*

Source: CMS PERL 201202-65

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