Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers March 2012

In this issue

CMS-855O form enables eligible professionals to order and refer services for Medicare beneficiaries

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and eligible professionals who may need to enroll/register in the Medicare Program for the sole purpose of ordering or referring Medicare-covered items and services to Medicare beneficiaries.

What you need to know

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare program in order to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) permits such physicians or other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. The submission and approval of a completed, CMS-855O form or its Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) equivalent will register/enroll the physician or other eligible professional in the Medicare program for the sole purpose of ordering and referring specific services for Medicare beneficiaries.

Background

Most physicians or other eligible professionals enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS permits certain physicians or other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish. The physicians or other eligible professionals who may wish to enroll in Medicare solely for the purpose of ordering and referring include, but are not limited to, those who are:

- Employed by the Department of Veterans Affairs (DVA);
- Employed by federally qualified health affairs centers (FQHCs), rural health clinics (RHCs);
- Employed by the Public Health Service (PHS) or critical access hospitals (CAHs);

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Find out first: Subscribe to FCSO eNews

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

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

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Medicare Publications
904-361-0723

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

CMS-855O *(continued)*

- Employed by the Department of Defense DOD) TRICARE;
- Licensed residents and physicians in a fellowship;
- Dentists, including oral surgeons;
- Employed by IHS or tribal organizations; and
- Pediatricians.

Physicians or other eligible professionals can apply for enrollment for the sole purpose of ordering and referring items and/or services to Medicare beneficiaries using either:

- The Internet-based PECOS, or
- The paper enrollment application process (CMS-855O). The CMS-855O is available at *http://www.cms.gov/cmsforms/downloads/CMS855O.pdf*.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

Note: You must obtain a National Provider Identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information about NPI enumeration, visit *http://www.cms.gov/NationalProvIdentStand*.

Additional information

For additional information about the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

The CMS-855O is available at *http://www.cms.gov/cmsforms/downloads/CMS855O.pdf*. An updated version of the CMS-855O will be available and implemented in April 2012. The *Medicare Learning Network*® fact sheet titled "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.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: SE1208
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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FISS and CWF system enhancement for storing line level rendering physicians/practitioners NPI information

Provider types affected

This *MLN Matters*® article is intended for critical access hospitals billing under method II, federally qualified health centers, and rural health clinics that submit claims to Medicare contractors (fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs)), for services provided to Medicare beneficiaries.

Provider action needed

Providers who submit a combined claim (claims that include both facility and professional components) will need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level. Please make sure your billing staff is aware of these changes.

Background

Medicare needs to identify primary physicians/practitioners of services not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, the Centers for Medicare & Medicaid Services (CMS) must be able to identify the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store that information in the databases that serve as the source for data analysis. Prior to the implementation of the 5010 version of the 837I, that information could only be collected at the claim level in the "other provider" field.

CMS can begin collecting this information at the line level following the implementation of the 5010 version of the 837I. To perform needed data analysis, it is critical that FISS be able to associate physician/practitioner identifying

(continued on next page)

NPI *(continued)*

information with each line item on institutional claims and be able to forward that information to the CWF.

Additional Information

The official instruction, CR 7578, issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1046OTN.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: MM7578
Related Change Request (CR) #: 7578
Related CR Release Date: February 17, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1046OTN
Implementation Date: FISS: July 2, 2012 and October 1, 2012, CWF: October 1, 2012

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PWK delayed

The Centers for Medicare & Medicaid Services (CMS) is delaying implementation of the paperwork (PWK) segment of the X12N version 5010. PWK was due to be implemented on April 1, 2012, via change requests 7041, 7306, and 7330. The delay is being initiated in order to address system concerns and impacts raised by Medicare administrative contractors (MACs). MACs will continue to work through their user acceptance testing of PWK while the concerns and impacts are addressed. CMS will communicate the revised implementation date once determined.

The PWK delay does not affect any current processes in place for the submission of additional documentation with your claims.

Source: TDL 12303

Provider inquiry screens regarding telehealth services eligibility dates

Provider types affected

This special edition *MLN Matters*® article is intended for physicians, non-physician practitioners (NPPs), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)) for telehealth services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article provides additional information related to telehealth services previously described in change request (CR) 7049. Some of those services have frequency limitations. When providers submit inquiries to Medicare, the Medicare systems respond with provider inquiry screens. These inquiry screens will provide the date on which the beneficiary is next eligible for these frequency-limited services. Specific examples of provider inquiry screens, including the next eligible date, are included in the *Background* section below. Make sure your billing staffs are aware of this additional information.

Background

Change request (CR) 7049 added 14 codes to the list of Medicare distant site telehealth services. Claims frequency editing is performed by Medicare's common working file (CWF) system on seven of those 14 codes listed in CR 7049 as described below.

The use of telehealth is limited in two ways:

1. Subsequent hospital care services, with the limitation of one telehealth visit every 3 days (*Common Procedural Terminology* (*CPT*) codes *99231, 99232,* and *99233*); and
2. Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (*CPT* codes *99307, 99308, 99309,* and *99310*).

CWF displays the telehealth frequency limitations data on all CWF responses to provider query screens, including the next eligible date. Examples of these new CWF screens for telehealth services are displayed below for your reference.

```
 ELGA                CWF  PART A  ELIGIBILITY SYSTEM                    ELGACRO
11/15/2011  14:10:50          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 11 OF 11
IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

(continued on next page)

Telehealth *(continued)*

```
ELGB                CWF  PART B  ELIGIBILITY SYSTEM                    ELGBCRO
11/15/2011  14:12:57          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 11 OF 11
IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 17003



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

```
ELGH                CWF PART A   ELIGIBILITY SYSTEM                    ELGHCRO
00/00/0000  00:00:00          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 12 OF 12
 IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



   TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                     |
   HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                     |
   NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                     |
   RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
   WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
   4TH    DAY                        | 31ST DAY
```

```
      HIQACOP               CWF  PART A  INQUIRY REPLY           PAGE 12 OF 12

 IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



   TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                     |
   HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                     |
   NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                     |
   RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
   WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
   4TH    DAY                        | 31ST DAY
```

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Telehealth *(continued)*

```
      HIQHCOP              CWF          INQUIRY REPLY          PAGE 13 OF 13

IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

```
MAPI75M                          FISS SWTT REGION MAFSSWTT
          SC                                ACCEPTED
 HIC                    NM          IT     DB            SX
PRVH SERVC TECH D PROF  D |PRVN SERVC TECH D PROF D | PRVN SERVC TECH D PROF D
TELH/99231
TELH/99232
TELH/99233
TELH/99307
TELH/99308
TELH/99309
TELH/99310
                PROCESS COMPLETED - -- PLEASE CONTINUE
          Press PF5-SCROLL BKWD PF3-EXIT PF7-PREV PAGE PF8-NEXT PAGE
```

Additional information

CR 7049 is available in two transmittals at *http://www.cms.gov/Transmittals/downloads/R2168CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R140BP.pdf*.

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

MLN Matters® Number: SE1209
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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

Note: This article was revised on March 9, 2012 to reflect the revised change request (CR) 7678 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7678 were revised. All other information is the same. This information was previously published in the January 2012 *Medicare A Connection*, Pages 20-21.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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

Key points

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

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

Additional Information

The official instruction, CR 7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1054OTN.pdf*.

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

MLN Matters® Number: MM7678 Revised
Related Change Request (CR) #: 7678
Related CR Release Date: March 7, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R1054OTN
Implementation Date: July 2, 2012

Provider and supplier enrollment requirements for fixed wing and helicopter air ambulance operators

Note: This article was revised on March 15, 2012, to reflect a revised change request (CR) 7363 issued on February 22. In the article, the bullets (in bold) were added to the *Background* section to conform with the revised CR 7363. Also, the implementation date, CR release date, transmittal number, and the Web address for accessing CR7363 were revised. All other information is the same. This information was previously published in the February 2012 *Medicare A Connection*, Page 29.

Provider types affected

This *MLN Matters*® article is intended for 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 on the enrollment 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 will accept the following as acceptable proof:

- If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider's name on the enrollment application.
- 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.

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Helicopter *(continued)*

- 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/R408PI.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: February 22, 2012
Effective Date: February 3, 2012
Related CR Transmittal #: R408PI
Implementation Date: March 9, 2012

Intensive behavioral therapy for obesity

Note: This article was revised on March 9, 2012 to reflect the revised change request (CR) 7641 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7641 were revised. All other information is unchanged. This information was previously published in the February 2012 *Medicare A Connection*, Pages 21-24.

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)

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Obesity *(continued)*

initiated a new national coverage analysis on IBT 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.

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:** 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

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Obesity *(continued)*

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

(continued on next page)

Obesity *(continued)*

- 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% 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/R2421CP.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: March 7, 2012
Effective Date: November 29, 2011
Related CR Transmittal #:R2421CP, 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

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

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

Effective and notice dates

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

Contents

Advance beneficiary notice

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

Revisions to LCDs

AA0425: Non-emergency ground ambulance services – revision to the LCD "Coding Guidelines" attachment

LCD ID number: L29916 (Florida)
LCD ID number: L29920 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for non-emergency ground ambulance services was effective for services provided on or after June 30, 2009, for Florida, Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Coding Guidelines" attachment has been revised based on the Centers for Medicare & Medicaid Services (CMS) Transmittal 2383, change request 7557 (*FISS Claims Processing Updates for Ambulance Services*), dated January 12, 2012, to add the following verbiage:

- Non-emergency trips (i.e., HCPCS codes A0426 and A0428 [when A0428 is billed without modifier QL]) require a National Provider Identifier (NPI) in the Attending Physician field.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for claims processed **on or after April 2, 2012**, for services provided **on or after April 1, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

AJ2796: Romiplostim (Nplate®) – revision to the LCD

LCD ID number: L30876 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for romiplostim (Nplate®) was effective for services provided on or after June 7, 2010, for Florida, Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, revisions have been made to the LCD related to label changes that have been made by the U.S. Food and Drug Administration (FDA) for Nplate®. Revisions include the following:

- The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to reflect chronic immune thrombocytopenia instead of chronic immune (idiopathic) thrombocytopenic purpura (ITP).
- The "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD have been revised to remove all statements related to the Nplate® NEXUS Program.

Effective date

This LCD revision is effective for claims processed **on or after February 16, 2012,** for services provided **on or after December 6, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

ANCSVCS: Noncovered services – revision to the LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised on January 31, 2012, Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2402, change request (CR) 7610, dated January 26, 2012. Based on this CR, the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Laboratory Procedures" section of LCD was revised to add the following language (Not medically reasonable and necessary except when billed with diagnosis V74.5 or V73.89) for *CPT* codes *87270* and *87320*.

Effective date

This LCD revision is effective for claims processed **on or after July 2, 2012,** for services provided **on or after November 8, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

A0279T: Circulating tumor cell testing – revision to the LCD

LCD ID number: L32096 – (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for circulating tumor cell testing was most recently revised on January 1, 2012. Since that time, the LCD has been revised to update language to clarify coverage under the sections of the LCD titled "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements." The LCD requires a signed statement by the patient and the physician to confirm a change in the chemotherapy regimen (treatment plan). Therefore, the "Utilization Guidelines" section of the LCD was updated with an example of an acceptable statement to include in the medical record.

Effective date

This LCD revision is effective for services provided **on or after March 20, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

A84484: Troponin – revision to the LCD

LCD ID number: L29000 (Florida)
LCD ID number: L29032 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for troponin was effective for services provided on or after February 16, 2009, for Florida and for services provided on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, the LCD has been revised to add ICD-9-CM diagnosis code 780.8 (Generalized hyperhidrosis) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 22, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

A85651: Sedimentation rate, erythrocyte – revision to the LCD

LCD ID number: L28983 (Florida)
LCD ID number: L29016 (Puerto Rico/U.S. Virgin Islands)
The local coverage determination (LCD) for sedimentation rate, erythrocyte was most recently revised on October 1, 2009. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to include diagnosis codes 285.29 (Anemia of other chronic disease) and 285.9 (Anemia, unspecified). In addition, verbiage was added to indicate that diagnosis codes E933.1, E933.8, E935.6, and E947.2 are secondary diagnoses and must not be billed as primary diagnoses.

Effective date

This LCD revision is effective for claims processed **on or after March 7, 2012**, for services provided **on or after January 12, 2004**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Retired LCDs

Multiple local coverage determinations (LCDs) being retired

LCD ID numbers: L28760, L29007, L28812, L28990, L28848, L28949 (Florida)
LCD ID numbers: L28761, L29039, L28819, L29022, L28881, L28970 (Puerto Rico/U.S. Virgin Islands)
Based on data analysis and a review of the local coverage determinations (LCDs), the following LCDs are being retired.

- AALEFACEPT: Alefacept
- AJ0636: Vitamin D Analogs in Chronic Renal Disease
- AJ0850: Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)
- AJ1080: Testosterone Cypionate and Testosterone Enanthate
- AJ9300: Gemtuzumab Ozogamicin (Mylotarg™)
- AJ9600: Porfimer (Photofrin®)

Effective date

The retirement of these LCDs is effective for services provided **on or after March 22, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Additional Information

Eylea® (aflibercept): Part A

Eylea® (aflibercept) is indicated for the treatment of patients with Neovascular (Wet) age-related macular degeneration. Eylea® was approved by the Food and Drug Administration (FDA) **November 18, 2011**.

Eylea® is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL. As approved by the FDA, the recommended dose for Eylea® is 2 mg (0.05 mL) administered by intravitreal injection every four weeks (monthly) for the first three months, followed by 2 mg (0.05 mL) via intravitreal injection once every eight weeks (two months). Payment for Eylea® is for the entire content of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial must be used and the sterile field, syringe, gloves, drapes, eyelid speculum, filter, and injection needles must be changed before Eylea® is administered to the other eye. After injection, any unused product must be discarded.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis of Neovascular (Wet) age-related macular degeneration, using the appropriate ICD-9-CM code of 362.52 and FDA guidance for use as well as the administration.

Your feedback matters

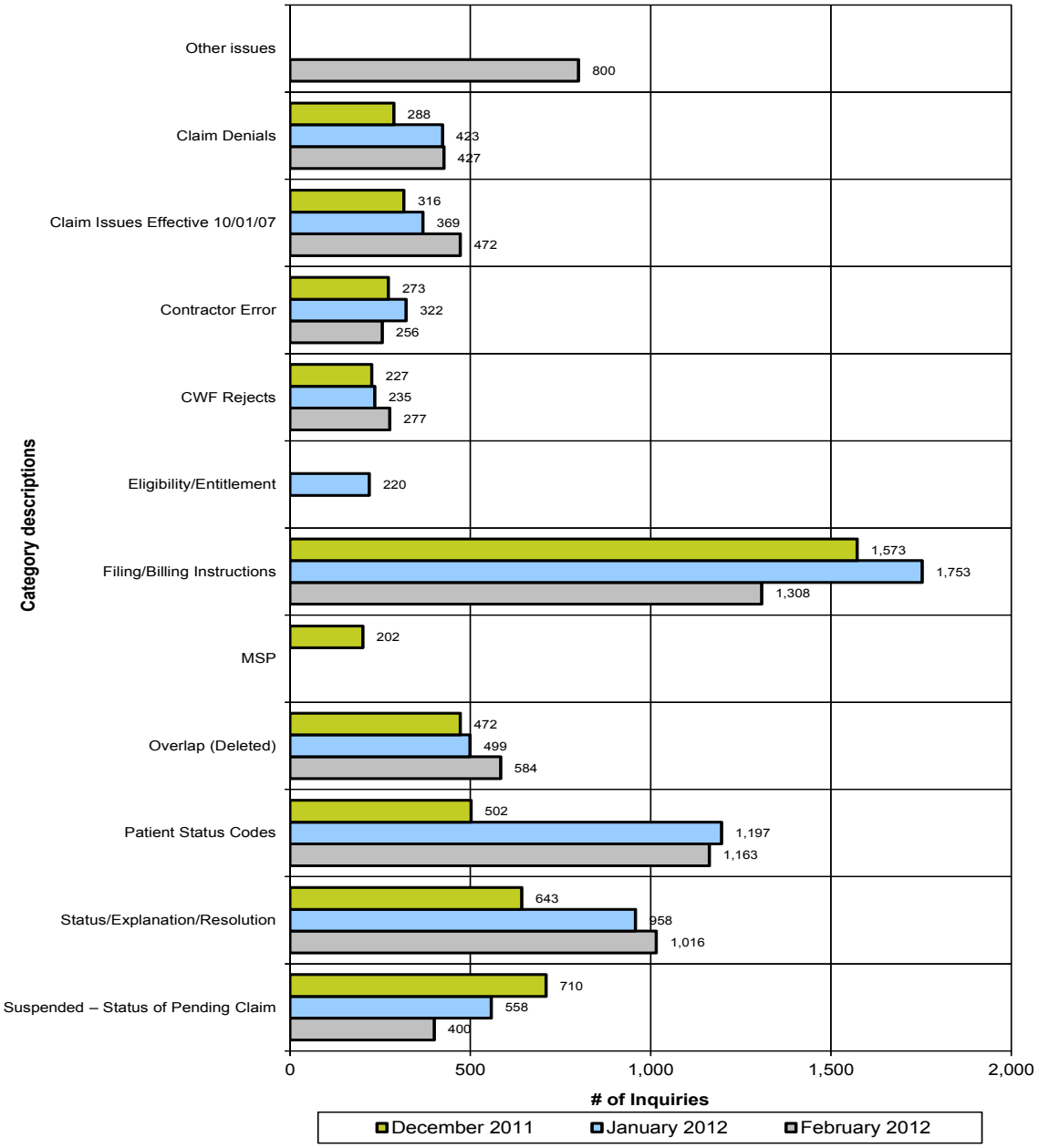
To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our Website highlights page at *http://medicare.fcso.com/Feedback/201743.asp* . You'll find the latest enhancements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

Top inquiries, rejects, and return to provider claims – December 2011-February 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 December 2011-February 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 December 2011-February 2012



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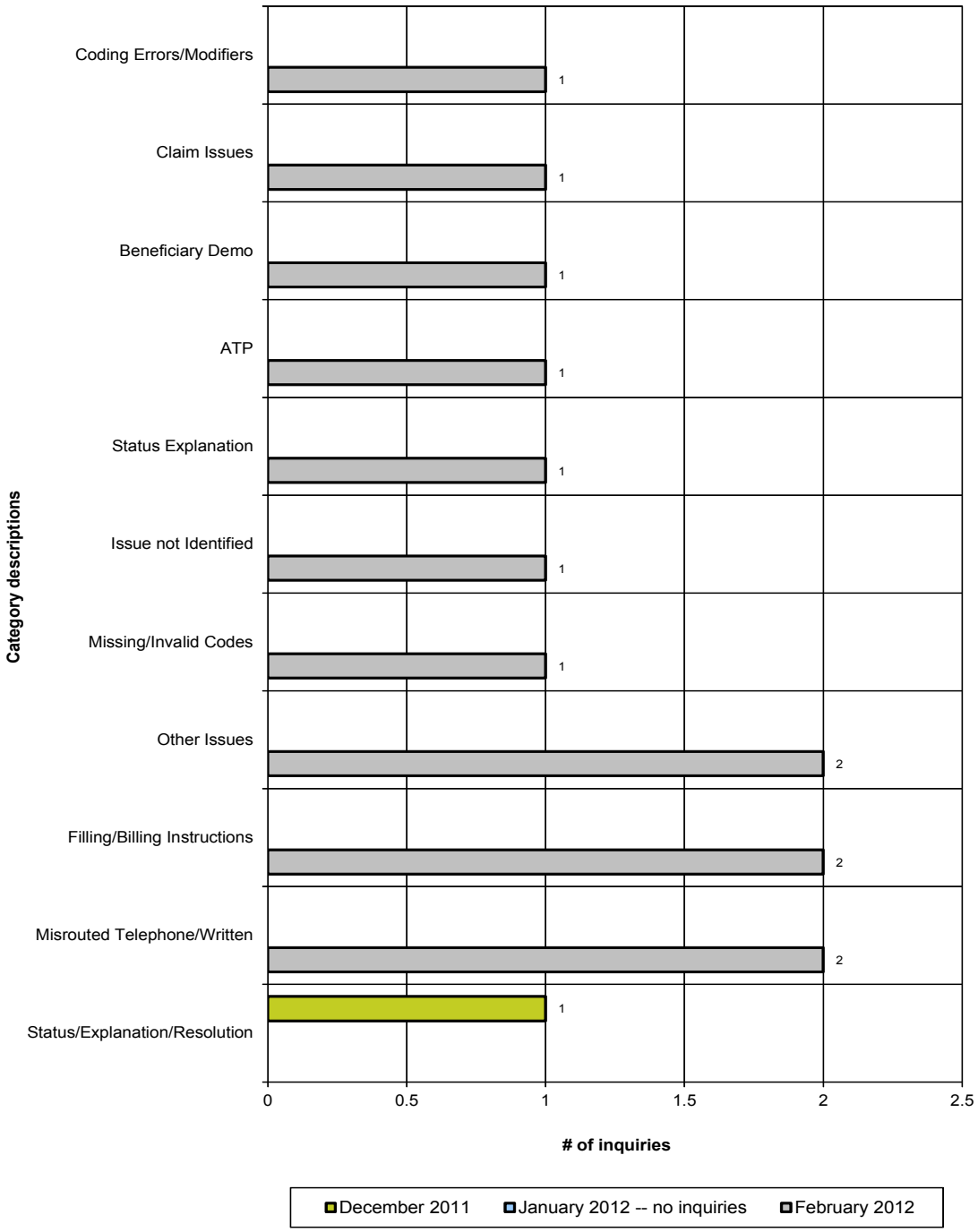
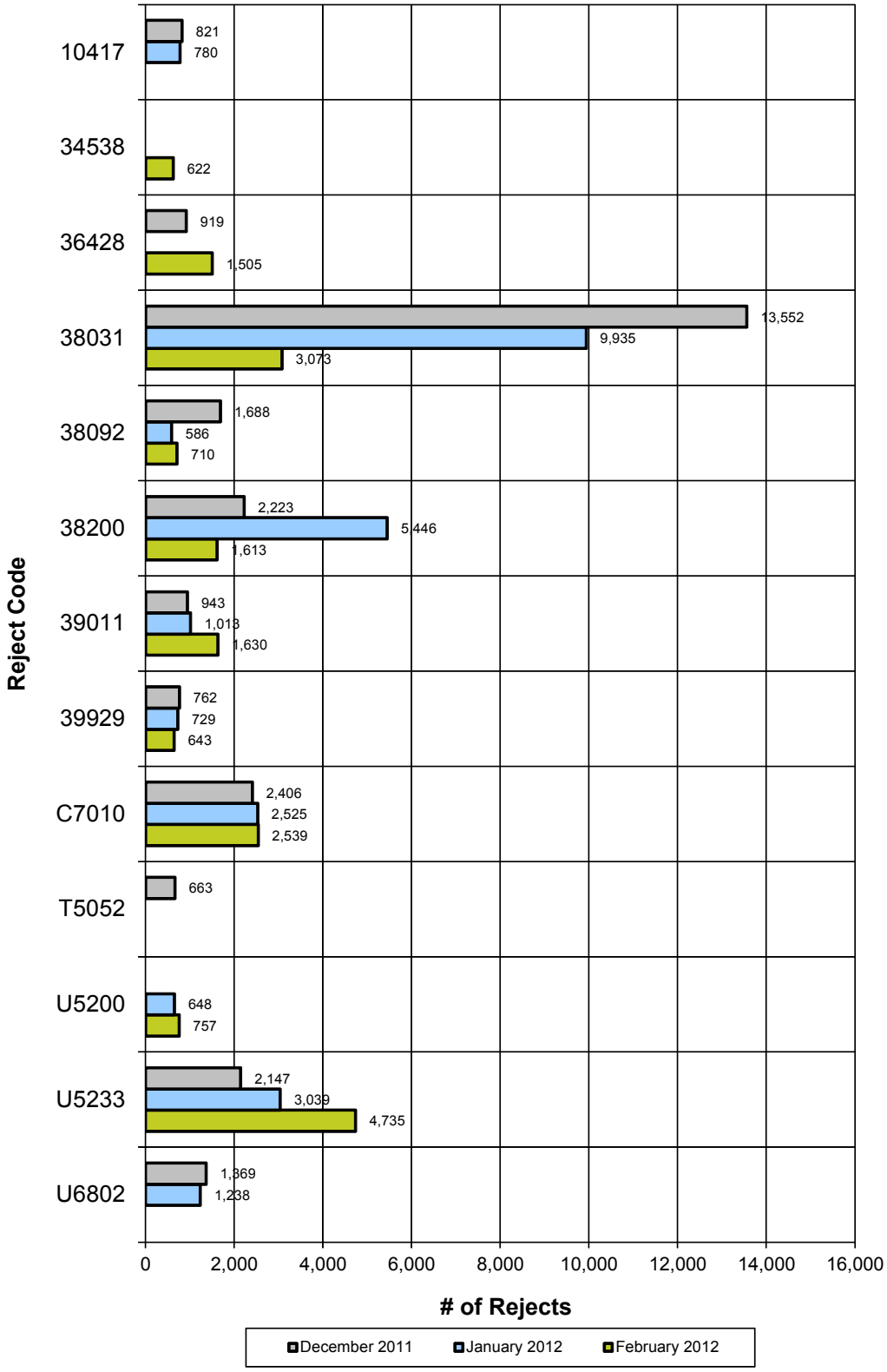
Inquiries *(continued)*

U.S. Virgin Islands Part A top inquiries for December 2011-February 2012



Florida Part A top rejects for December 2011-February 2012



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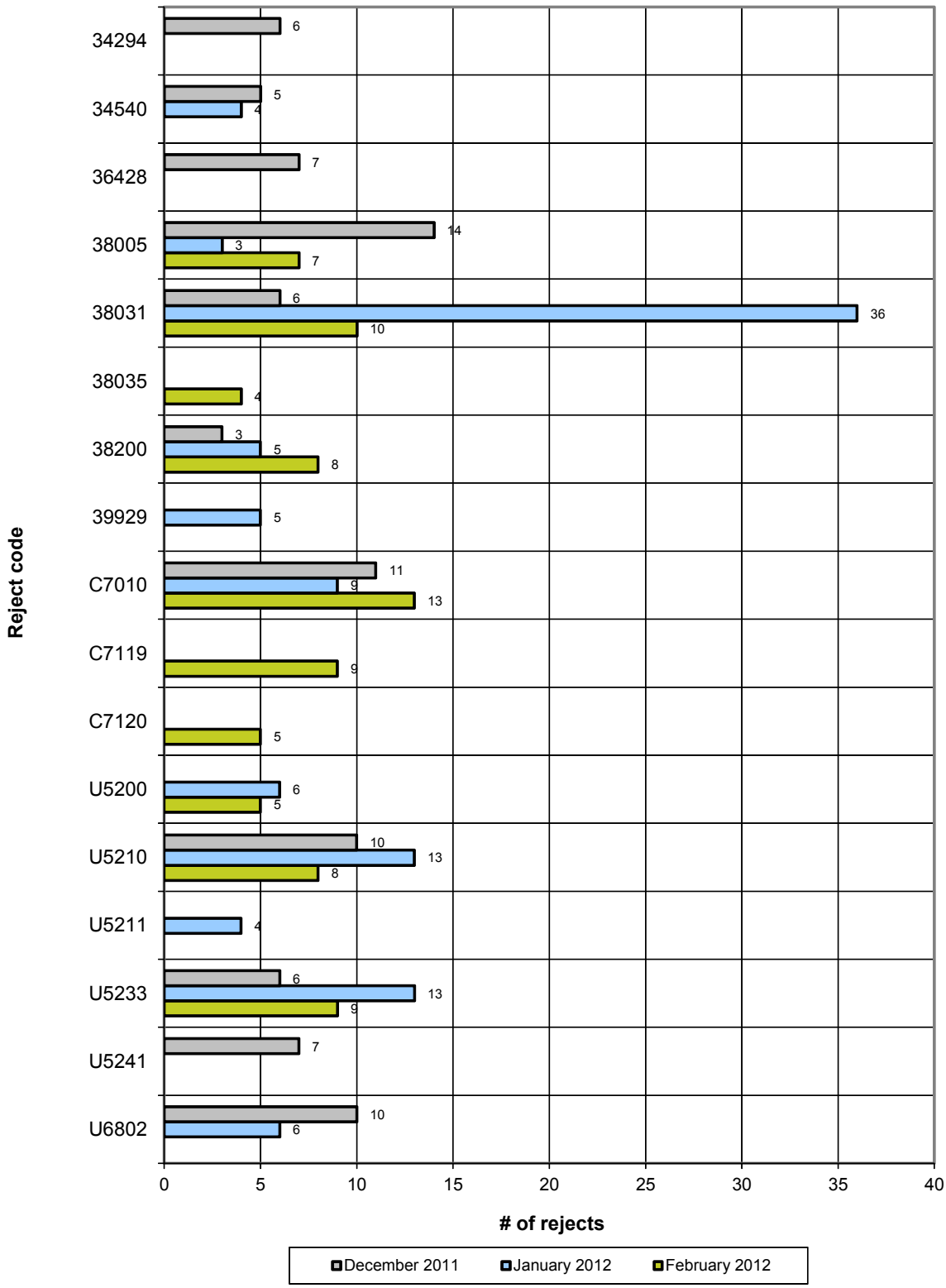
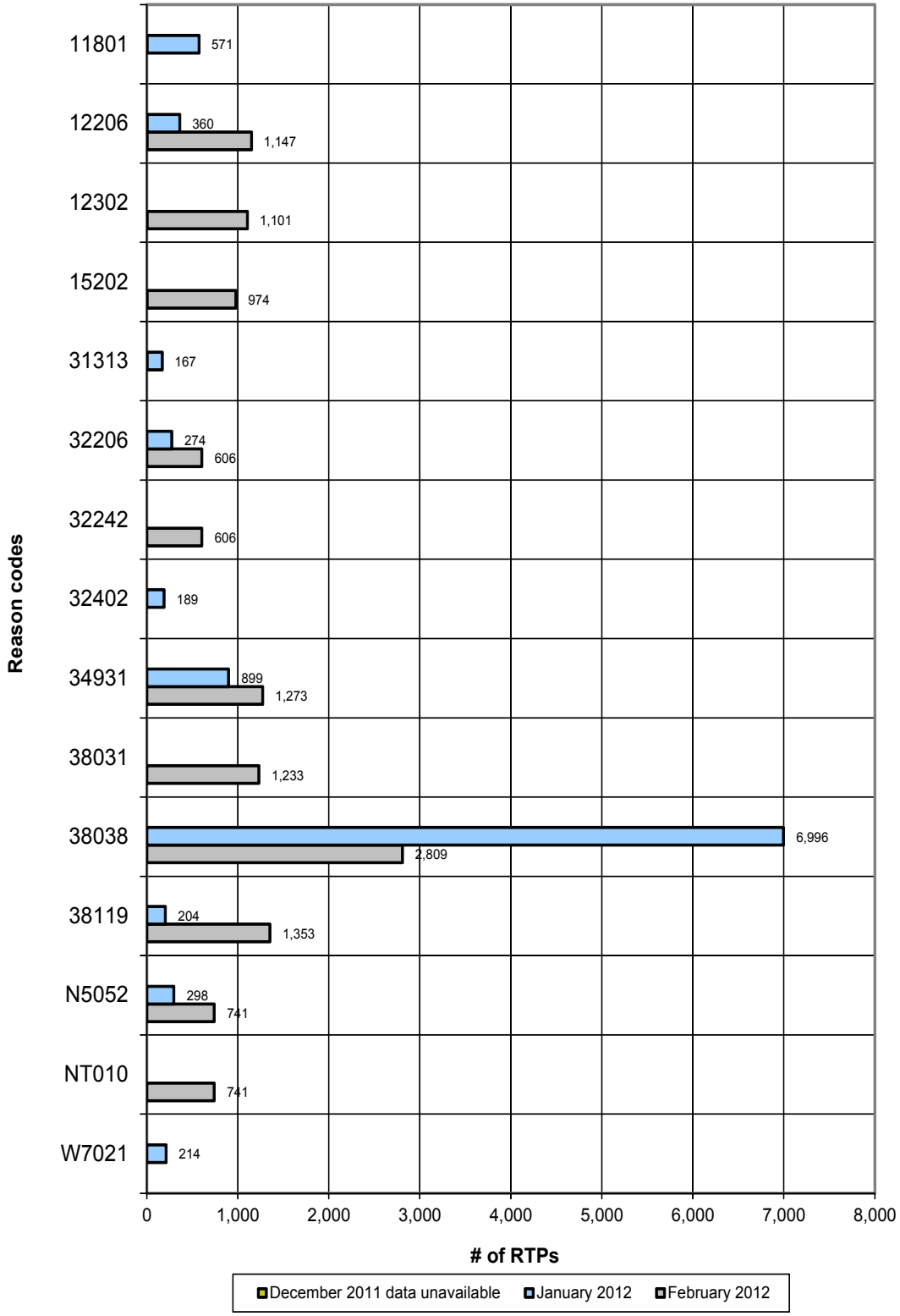
Rejects *(continued)*

U.S. Virgin Islands Part A top rejects for December 2011-February 2012



Florida Part A top return to providers (RTPs) for December 2011-February 2012



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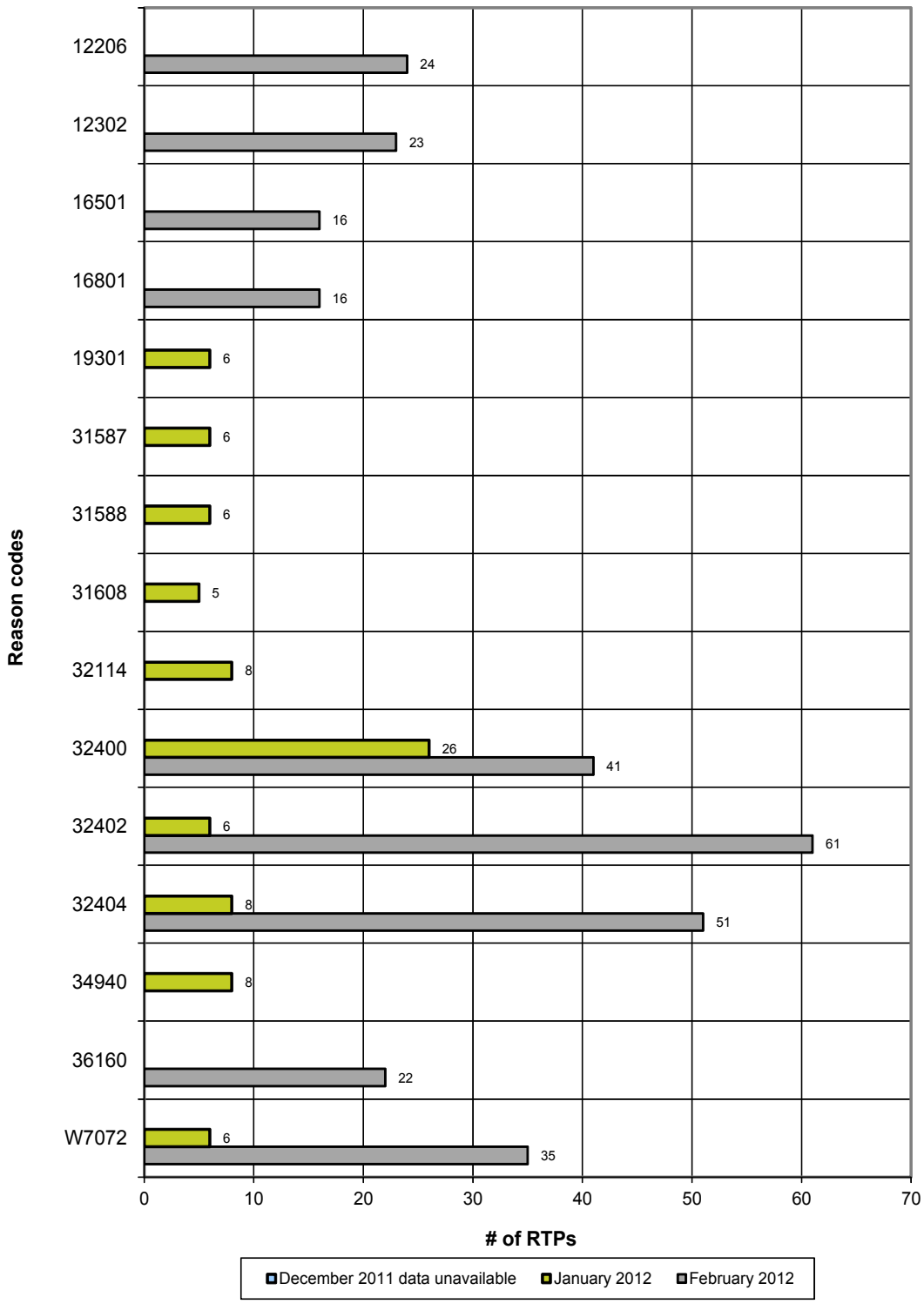
RTPs *(continued)*

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



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

Note: This article was revised on February 23, 2012, to reflect a revised change request (CR) 7672, issued on January 13, 2012. CR 7672 was revised to correct the fixed dollar threshold amount in Section 17.d of the CR and this article was revised accordingly. Also, the CR was revised to change HCPCS code Q1079 in Table 5 to show the correct code of Q0179. The CR release date, transmittal number, and the Web address for accessing the CR have also been changed. All other information is the same. This information was previously published in the January 2012 *Medicare A Connection*, Pages 55-70.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

CR 7672, from which this article is taken:

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

Go – what you need to do

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

Background

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

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

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

Physician supervision

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

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

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

(continued on next page)

January *(continued)*

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

New device pass-through categories

The Social Security Act (the Act) (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

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

Table 1 – New device pass-through code

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

Device offset from payment for C1886

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

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

Revised device offset from payment for category C1840

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

New procedure code

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

Table 2 – new procedure code

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

(continued on next page)

January *(continued)*

Billing instructions for C9732 and C1840

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

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

Billing for thermal anal lesions by radiofrequency energy

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

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

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

Cardiac resynchronization therapy payment for CY 2012

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

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

Billing for drugs, biologicals, and radiopharmaceuticals

Reporting HCPCS codes for all drugs, biologicals, and radiopharmaceuticals

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

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

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

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

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

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

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

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

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

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

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

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

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

CY 2011 HCPCS/ *CPT* code	CY 2011 long descriptor	CY 2012 HCPCS/ *CPT* code	CY 2012 long descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273***	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561**	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/ Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg

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CY 2011 HCPCS/ *CPT* code	CY 2011 long descriptor	CY 2012 HCPCS/ *CPT* code	CY 2012 long descriptor
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q0179	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

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

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

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

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

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

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

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

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

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

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

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

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

Correct reporting of biologicals when used as implantable devices

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

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

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

Payment for therapeutic radiopharmaceuticals

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

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

CY 2012 HCPCS code	CY 2012 long descriptor	Final CY 2012 APC	Final CY 2012 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K

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CY 2012 HCPCS code	CY 2012 long descriptor	Final CY 2012 APC	Final CY 2012 SI
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

Payment offset for pass-through diagnostic radiopharmaceuticals

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

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

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

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

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

CY 2012 APC	CY 2012 APC title
0308	Positron Emission Tomography (PET) Imaging
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.

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CY 2012 APC	CY 2012 APC title
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

Payment offset for pass-through contrast agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20.00 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR 6751, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made. You can find the *MLN Matters*® article associated with this CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf*.

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

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

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

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

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

CY 2012 APC	CY 2012 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Level II Endovascular Revascularization of the Lower Extremity

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CY 2012 APC	CY 2012 APC Title
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0334	Combined Abdomen and Pelvis CT with Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Clarification of coding for drug administration services

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

Provenge® administration

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

Please note that the HCPCS long descriptor for CY 2012 for HCPCS code Q2043 includes payment for the drug itself, as well "all other preparatory procedures," referring to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient. Payment for Q2043 does not include OPPS payment for drug administration.

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

Effective for claims with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening,

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and for those who screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: 1) who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting. In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

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

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

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

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

Screening for depression in adults – NCD

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

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

Table 11 – Annual depression screening

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

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

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

Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia,

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gonorrhea, syphilis, and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with Dates of Service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for high intensity behavioral counseling (HIBC) to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

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

Table 12 –STIs screening and HIBC to prevent STIs

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

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

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

Billing for intensive behavioral therapy for cardiovascular disease – NCD

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

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

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Table 13 – Intensive behavioral therapy for cardiovascular disease

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

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

Intensive behavioral therapy for obesity – NCD

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

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

Table 14 – Intensive behavioral therapy for obesity

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

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

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

Payment window for outpatient services treated as inpatient services

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

Partial hospitalization APCs

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

When a community mental health center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, w

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

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

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

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

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

Molecular pathology procedure test codes

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

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

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

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

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

Changes to OPPS Pricer logic

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

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

c) For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2012. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d) There will be no change in the fixed-dollar threshold in CY 2012. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments.

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

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

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

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

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

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

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

Coverage determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare administrative contractors

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(MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

You can find the official instruction, CR 7672, was issued to your FI, A/B MAC, or RHHI via two transmittals. The first transmittal revises the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R152BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* at *http://www.cms.gov/Transmittals/downloads/R2386CP.pdf*.

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

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

MLN Matters® Number: MM7672 Revised
Related Change Request (CR) #: CR 7672
Related CR Release Date: January 13, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2386CP and R152BP
Implementation Date: January 3, 2012

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

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 7748 which describes changes to and billing instructions for various payment policies implemented in the April 2012 OPPS update. Be sure your billing staffs are aware of these changes.

Background

CR 7748 describes changes to and billing instructions for various payment policies implemented in the April 2012 OPPS update. The April 2012 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), status indicators (SIs), HCPCS modifier, and revenue code additions, changes, and deletions identified in this CR.

Note that the April 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 7751, "April 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.1." An *MLN Matters*® article for CR 7751 will be available upon the release of that CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM7751.pdf*. The key changes in the April update are as follows:

Changes to device edits for April 2012

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and Device B are specified require that at least one each of a Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate setting.

The most current edits for both types of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at *http://www.cms.gov/HospitalOutpatientPPS/*. Failure to pass these edits will result in the claim being returned to the provider.

Effective for services furnished on or after January 1, 2012, the American Medical Association (AMA) changed the descriptor for *CPT* code *33249* to read "Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber." This has necessitated the removal of HCPCS code C1882 (Cardioverter-defibrillator, other than single or dual chamber (implantable)) from the list of those device codes required to be billed with *CPT* code *33249* on the procedure-to-device edit list, since this link is no longer clinically appropriate. CMS is making this change retroactive to January 1, 2012.

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New service (fluorescent vascular angiography)

The following new service is assigned for payment under the OPPS, effective April 1, 2012:

Table 1 – fluorescent vascular angiography

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9733	4/01/2012	Q2	0397	Non-ophthalmic FVA	Non-ophthalmic fluorescent vascular angiography	$154.87	$30.98

HCPCS code C9733 is assigned to APC 0397 (Vascular Imaging) and should be used to report fluorescent vascular angiography. C9733 describes SPY® Fluorescence Vascular Angiography and other types of non-ophthalmic fluorescent vascular angiography.

Billing for drugs, biologicals, and radiopharmaceuticals

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

For calendar year (CY) 2012, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, a single payment of ASP + 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

In the CY 2012 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2012 release of the OPPS Pricer. The updated payment rates, effective April 1, 2012 will be included in the April 2012 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/HospitalOutpatientPPS/AU/*.

Drugs and biologicals with OPPS pass-through status effective April 1, 2012

Four drugs and biologicals have been granted OPPS pass-through status effective April 1, 2012. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – drugs and biologicals with OPPS pass-through status effective April 1, 2012

HCPCS code	Long descriptor	APC	Status indicator effective 4/1/12
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	9288	G
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (I.U.)	9289	G
C9290	Injection, bupivicaine liposome, 1 mg	9290	G
C9291	Injection, aflibercept, 2 mg vial	9291	G

Additional information on HCPCS code C9291 (injection, aflibercept, 2 mg vial)

Eylea (aflibercept) is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL Eylea (NDC 61755-0005-02). As approved by the Food and Drug Administration (FDA), the recommended dose for Eylea is 2 mg every 4 weeks, followed by 2 mg every 8 weeks. Payment for HCPCS code C9291 is for the entire contents of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. As indicated in 42 CFR § 414.904, CMS calculates an ASP payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no

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payment is made for amounts of product in excess of that reflected on the FDA-approved label.

a. Updated payment rates for certain HCPCS codes effective July 1, 2011, through September 30, 2011

The payment rates for several HCPCS codes were incorrect in the July 2011 OPPS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the April 2012 OPPS Pricer, effective for services furnished on July 1, 2011, through implementation of the October 2011 update. If you have claims that were incorrectly processed based on the incorrect prices, make your contractor aware and they will adjust the claims.

Table 3 – updated payment rates for certain HCPCS codes effective July 1-September 30, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J0735	K	0935	Clonidine hydrochloride	$35.67	$7.13
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	$84.55	$16.91
J1756	K	9046	Iron sucrose injection	$0.34	$0.07
J9245	K	0840	Inj melphalan hydrochl 50 MG	$1,308.97	$261.79

b. Updated payment rates for certain HCPCS codes effective October 1-December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the April 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. If you have claims that were incorrectly processed based on the incorrect prices, make your contractor aware and they will adjust the claims.

Table 4 – updated payment rates for certain HCPCS codes effective October 1-December 31, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J0735	K	0935	Clonidine hydrochloride	$30.54	$6.11
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	$84.86	$16.97
J1742	K	9044	Ibutilide fumarate injection	$126.92	$25.38
J9245	K	0840	Inj melphalan hydrochl 50 MG	$1,280.08	$256.02

c. Correct reporting of biologicals when used as implantable devices

When billing for products that are used as either a surgically implanted or inserted biological, or as a skin substitute, hospitals should report the appropriate HCPCS code for the product. Implantable biologicals with pass-through status receive separate payment, but for those that do not have pass-through status, the OPPS payment for the implanted biological is packaged into the payment for the associated procedure. Products that can be used as either a skin substitute or as an implantable biological will only be separately paid when billed with a skin substitute application procedure (see below for further details on payment for skin substitutes). Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked, if different from the HCPCS descriptor.

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The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

d. I/OCE logic changes for skin substitutes

Hospitals are reminded that HCPCS codes describing products that can be used as skin substitutes, as listed in Table 5 below, will be separately paid only when used with one of the CPT codes describing the application of a skin substitute (15271-15278). Effective April 1, 2012, CMS is implementing logic changes to the I/OCE to ensure that separate payment is made for skin substitutes only when they are billed with a skin substitute application procedure.

Table 5 – payable skin substitute HCPCS codes for CY 2012

HCPCS code	APC	Short descriptor	Status indicator
C9358	9358	SurgiMend, fetal	K
C9360	9360	SurgiMend, neonatal	K
C9363	9363	Integra Meshed Bil Wound Mat	K
C9366	9366	EpiFix wound cover	G
C9367	9367	Endoform Dermal Template	G
Q4100	N/A	Skin substitute, NOS	N
Q4101	1240	Apligraf	K
Q4102	1241	Oasis wound matrix	K
Q4103	1242	Oasis burn matrix	K
Q4104	1243	Integra BMWD	K
Q4105	1244	Integra DRT	K
Q4106	1245	Dermagraft	K
Q4107	1246	Graftjacket	K
Q4108	1247	Integra matrix	K
Q4110	1248	Primatrix	K
Q4111	1252	Gammagraft	K
Q4112	1249	Cymetra injectable	K
Q4113	1250	Graftjacket xpress	K
Q4114	1251	Integra flowable wound matri	K
Q4115	1287	Alloskin	K
Q4116	1270	Alloderm	K
Q4118	1342	Matristem micromatrix	K
Q4119	1351	Matristem wound matrix	K
Q4121	1345	Theraskin	K
Q4122	1419	Dermacell	K
Q4124	9365	Oasis Ultra Tri-Layer Matrix	G
Q4130	N/A	Strattice TM	N

Update to Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)

CR 7748 revises the *Medicare Claims Processing Manual* (Chapter 4, Section 70.7) to include Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) which extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) regardless of bed size. The revised Section 70.7 is included as attachment to CR 7748, and the revised paragraph is as follows:

"Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) extends the outpatient hold-harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all SCHs and EACHs regardless of bed size."

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Coverage determinations

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

Additional information

The official instruction, CR 7748, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2418CP.pdf*.

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

MLN Matters® Number: MM7748
Related Change Request (CR) #: CR 7748
Related CR Release Date: March 2, 2012
Effective Date: April 1, 2012
Related CR Transmittal #: R2418CP
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.

Learn the secrets to billing Medicare correctly

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

April 2012 I/OCE specifications version 13.1

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7751, which describes changes to the integrated outpatient code editor (I/OCE) and OPPS to be implemented in the April 2012 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7751 describes changes to billing instructions for various payment policies implemented in the April 2012 OPPS update. The April 2012 I/OCE changes are also discussed in CR 7751. The full list of I/OCE specifications can now be found at *http://www.cms.gov/OutpatientCodeEdit/*. There are also numerous additions, deletions, and changes to certain ambulatory payment classification (APC) codes, status indicators (SIs), and Healthcare Common Procedure Coding System (HCPCS) codes. These are listed in the "Summary of Changes" attached to CR 7751. The Web address of CR 7751 is available in the "Additional Information" section of this article.

Key points of CR 7751 based on Appendix M of the I/OCE specifications

In addition to the routine APC and HCPCS code updates, the following key changes will be made in the April 2012 release of the I/OCE:

- Effective July 1, 2005, Medicare will add diagnosis codes 29189 and 29384 to the list of mental health (MH) diagnosis codes used for the partial hospitalization program (PHP). Edit 29 is affected.
- Effective October 1, 2005, Medicare will add diagnosis codes 32702, 32715, 32742, and 32743 to the list of MH diagnosis codes used for PHP. Edit 29 is affected.
- Effective January 1, 2012, Medicare will update the procedure/device edit requirements by removing C1882 as a required device for procedure 33249. Edit 71 is affected.
- Effective April 1, 2012, Medicare will implement logic to package a specified list of skin substitute grafts when not submitted with the associated graft application procedure code (list of codes): Criteria - For the specified skin grafts, the I/OCE will change the standard SI/APC to N/APC=0 if one of the required skin substitute graft application procedures is not present on the same date of service.
- Effective April 1, 2012, delete modifiers V8 and V9 from the list of valid modifiers. Edit 22 is affected.
- Effective April 1, 2012, implement version 18.1 of the NCCI (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected. [To bring NCCI version current with I/OCE version; effective date of NCCI = I/OCE version date].

Additional information

The official instruction, CR 7751 issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2423CP.pdf*.

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

MLN Matters® Number: MM7751
Related Change Request (CR) #: 7751
Related CR Release Date: March 9, 2012
Effective Date: April 1, 2012
Related CR Transmittal #: R2423CP
Implementation Date: April 2, 2012

Recovery auditors findings resulting from medical necessity reviews of renal and urinary tract disorders

Provider types affected

This *MLN Matters*® special edition article is intended for hospitals that bill Medicare contractors (fiscal intermediaries (FIs) or Medicare administrative contractors (MACs)) for renal and urinary tract disorders in Medicare beneficiaries.

What you need to know

Recovery auditors complete medical necessity reviews of renal and urinary tract disorders. The auditors found that the medical necessity for the inpatient admission was not supported. The claim was identified as an overpayment. This article discusses documentation and billing for inpatient status.

Problem description

When a patient is examined in the emergency department (ED), the physician decides whether the patient can safely go home or needs to stay in the hospital for further clinical evaluation and treatment. A patient can be admitted to the hospital to receive those additional services or a patient can receive observation services (OBS) as an outpatient. The purpose of observation is to provide services to determine whether the patient should be admitted as an inpatient or released from the hospital. Observation services are billed the same as all other outpatient services. The physician responsible for the patient's care can write an order for an inpatient admission changing the patient's status from outpatient to inpatient (IP) status anytime during the hospital stay. If the physician admits the patient as inpatient but wishes to change the status to outpatient, the patient must be notified prior to discharge. Providers are admitting patients as inpatients when the clinical situation supports the use of outpatient observation in accordance with Medicare manual instructions.

Guidance on how providers can avoid these problems:

Outlined below are billing directions based on physician documentation:

- The type of bill (TOB) on the claim MUST match the physician order
  - Physician orders inpatient (IP), must bill IP (11x or 12x)
  - Physician orders observation (OBS) and there is no IP order, must bill OP
  - Physician orders neither, must bill outpatient (OP)
- Focus on the OBS order
  - If OBS is ordered, the facility cannot decide that the stay should be IP and bill IP unless there is a subsequent order to admit the patient by the physician responsible for the patient's care at the hospital.
  - If OBS is ordered and the patient is subsequently admitted based on an IP order, the admission must be medically reasonable and necessary (R&N) at the time the order is written. In this case, charges for OBS are included on the IP bill.
  - If IP is ordered, and the hospital wishes to change the patient to OBS, this can done using condition code (CC) 44—if the practitioner responsible for the care of the patient agrees to the change and the patient is notified prior to discharge. Please review CMS, "Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient", *MLN Matters*® SE0622, April 2006 at *http://www.cms.gov/MLNMattersArticles/downloads/SE0622.pdf*.
  - Observation is a set of services provided to determine if the patient requires to be admitted to the hospital. It is not a status.
  - No changes to a patient's status (IP order or CC44) may be made after the patient has been discharged.

Example 1: 69 year old female presented for an elective outpatient cystoscopy, excision of extruded sling, and insertion of Aris suburethral sling for recurrent urinary incontinence and was admitted and billed as an acute inpatient after the procedure. The patient's past medical history was significant for recurrent type 1 stress urinary incontinence with possible mild intrinsic sphincter dysfunction, sling extrusion beneath bladder base, mild pelvic relaxation, hypothyroidism, obesity, and recent urinary tract infection.

(continued on next page)

Auditors *(continued)*

Past medical history and the pre-existing conditions were stable. The medical record did not document any exacerbation of pre-existing conditions or post-operative complications, that made the acute inpatient admission medically necessary.

In this case, there was no clinical evidence to suggest a need for a stay longer than 24 hours even if the surgeon wanted to watch the patient for an extended or overnight period after the procedure.

Medicare states that procedures that require less than 24 hours in the hospital should be considered outpatient. Moreover, the patient could also have been placed in observation if the physician was concerned about sending her home during the usual recovery period. If the patient's clinical status then changed, the patient could have been admitted as an inpatient at any time.

Example 2: A 73-year-old female patient presented on March 30, 2011, for a scheduled outpatient elective angioplasty of the renal artery and was admitted and billed as an acute inpatient after the procedure. The patient had a medical history of hypertension (HTN), hyperlipidemia, coronary artery disease/percutaneous cardiology intervention, chronic obstructive pulmonary disease, non-ruptured cerebral aneurysm, and diabetes mellitus. The notable events thru the patient's hospital admission: the patient's procedure was completed without any complications; an activated clotting time (ACT) level of 140 which is within normal limits; #7 arterial sheath removed without any issues by surgical house doctor no hematoma, ecchymosis, bleeding, & pedal pulses 2+; nursing assistance required for patient's initial ambulation but patient remains independent with activities of daily living (ADLs).

After a medical review of the inpatient records, the medical record did not contain documentation to support the need for an inpatient stay such as an exacerbation of a pre-existing condition or post-operative complication. However, if the physician was not comfortable sending the patient home in the normal post operative recovery period, the physician could have placed the patient in observation. If her clinical status changed and complications developed, she could have been admitted as an inpatient at that time.

Additional information

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

MLN Matters® Number: SE1210
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Educational Events

Upcoming provider outreach and educational events – May 2012

Keeping you informed: 2012 Medicare Update Seminar (Part A/B)

When: Tuesday, May 1 and 2
Time: 9 a.m. – 1 p.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** U.S. Virgin Islands

Medicare Part A "Ask-the-Contractor" teleconference

When: Tuesday, May 8
Time: 2 p.m. – 3:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Therapy cap exception process and use of the KX modifier (Part A/B)

When: Tuesday, May 22
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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

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