Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers September 2012

In this issue

Manual medical review of therapy services

Provider types affected

This *MLN Matters*® article is intended for occupational therapists, speech language therapists, physical therapists, physicians, other practitioners, in certain provider settings submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and A/B Medicare administrative contractors (MACs)) for therapy services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

All requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This includes services in these settings: Part B skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies (outpatient rehabilitation facilities (ORFs), private practices, home health agencies (TOB 34x), and hospital outpatient departments.

Caution – what you need to know

You must send a request for approval to the MAC or legacy contractor, i.e., FI, RHHI, or carrier, in advance of providing service. There are no automatic exceptions. Your MAC or legacy contractor will provide a fax number and mailing address where requests for pre-claim review can be submitted.

Go – what you need to do

Please read the *Background* and the *Additional information* sections for details. Make sure that your billing staffs are aware of these changes.

Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act, and have been extended by legislation several times.

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy cap on claims that are over the 2012 cap amounts -- $1,880 for occupational therapy services and $1,880 for

(continued on Page 58)

Contents

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.

Publication staff:
Terri Drury
Robert Petty
Mark Willett

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

Expiration of 2012 therapy cap revisions and user-controlled mechanism to identify legislative effective dates

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider action needed

This article is informational in nature and is based on change request (CR) 7881 which implements the statutory expiration date of certain provisions affecting claims for therapy services, to which the therapy caps apply.

Provisions relating to therapy caps are among a number of legislative changes that may be extended from year to year or for portions of a year. These changes may currently require a non-recurring CR to change hard coded edits in Medicare systems. Frequently, these CRs cannot be implemented quickly enough to meet the changing effective dates. Therefore, CR 7881 creates a mechanism that MACs can use to extend the effective dates of certain policies in urgent situations. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf*) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services. Previously, therapy services furnished in an outpatient hospital setting had been exempt from the application of the therapy caps.

However, MCTRJCA required original Medicare to apply the therapy caps temporarily to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, are included in calculating the cap beginning October 1, 2012.

MCTRJCA also required a manual review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The separate thresholds triggering manual medical reviews build upon the separate therapy caps - one for physical therapy (PT) and speech-language pathology (SLP) services combined and one for occupational therapy (OT) services. The count of services to which these thresholds apply began on January 1, 2012.

Unless congressional action is taken, all of these provisions expire for dates of service after December 31, 2012. Provisions relating to the therapy caps are among a number of legislative changes that may be extended from year to year, or for portions of a year.

Medicare systems currently lack the flexibility to apply policies to claims based on frequently-changing effective dates. These changes may currently require a non-recurring CR to change hard coded edits in Medicare systems, and often, these CRs cannot be implemented quickly enough to meet the changing effective dates.

Therefore, CR 7881 creates a mechanism that MACs can use to extend the effective dates of certain policies based in urgent situations. This mechanism will be first used to set the expiration dates of the MCTRJCA (Section 3005) therapy provisions.

Additional information

The official instruction, CR 7881 issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2537CP.pdf*.

If you have any questions, please contact your carriers, FIs, A/B MACs, and RHHIs at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7881
Related Change Request (CR) #: CR 7881
Related CR Release Date: August 31, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2537CP
Implementation Date: January 7, 2013

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.

2013 annual update for the HPSA bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FIs), carriers, or Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

Provider action needed

Change request (CR) 7883, from which this article is taken, alerts you that the annual HPSA bonus payment file for 2013 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2013, through December 31, 2013. These files will be posted to the internet on or about December 1, 2012. You should review *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html* each year to determine whether you need to add the AQ modifier to their claim in order to receive the bonus payment, or to see if the ZIP code area in which you rendered services will automatically receive the HPSA bonus payment. Note that Medicare contractors will continue to accept the AQ modifier for partially designated HPSA claims. Please be sure that your staffs are aware of this update.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated an annual update to the automated HPSA bonus payment file. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors each year. Contractors use this file for the automated bonus payment for claims with dates of service on or after January 1, 2013, through December 31, 2013. Contractors will continue to accept the AQ modifier for partially designated HPSA claims.

Additional information

The official instruction, CR 7883, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2526CP.pdf*.

You will find annual HPSA files (as they become available) and other important HPSA information at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html*.

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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7883
Related Change Request (CR) #: CR 7883
Related CR Release Date: August 24, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2526CP
Implementation Date: January 7, 2013

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.

Medicare demonstration allows for prior authorization for certain power mobility devices

Provider types affected

This *MLN Matters*® special edition article is intended for Medicare fee-for-service (FFS) suppliers who submit claims to the durable medical equipment Medicare administrative contractors (DME MACs) for power mobility devices (PMDs) in the demonstration states (California, Texas, Florida, Michigan, Illinois, North Carolina, and New York). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What you need to know

PMDs includes power wheelchairs and power-operated vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of DME for Medicare coverage purposes.

Power-operated vehicles (POVs or scooters): Under the mobility assistive equipment (MAE) national coverage determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform mobility-related activities of daily living (MRADLs) in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (motorized) wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare fee-for-service program. CMS is conducting a three-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines beginning with orders written on or after September 1, 2012. The demonstration will be conducted in seven states with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. These states accounted for 43 percent of the $606 million total Medicare PMD expenditures in 2010. This demonstration targets a claim type known to be susceptible to fraud and that have high rates of improper payments.

The demonstration will implement a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration states. The prior authorization request can be completed by the ordering physician/practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration states:

- Group 1 power-operated vehicles (K0800-K0802 and K0812)
- All standard power wheelchairs (K0813 through K0829)
- All group 2 complex rehabilitative power wheelchairs (K0835 through K0843)
- All group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855)

(continued on next page)

Demonstration *(continued)*

- Pediatric power wheelchairs (K0890-K0891)
- Miscellaneous power wheelchairs (K0898)

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the seven element order, the detailed product description and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within ten business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 48 hours. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non-affirmative prior-authorization decision will not be paid by Medicare.

If a second prior-authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/practitioner and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision; however, the claim will still be subject to prepayment review. Beginning for orders written on or after December 1, 2012, CMS will assess a payment reduction for noncompliance with the prior authorization process. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at *http://Go.cms.gov/PADemo*.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key points

CMS will initially conduct this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary address as reported to the Social Security Administration and recorded in Medicare's common working file (CWF). This demonstration will involve all four DME MACs. This demonstration will begin for orders written on or after September 1, 2012.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

(continued on next page)

Demonstration *(continued)*

Additional information

The "Prior Authorization of Power Mobility Device" section of the CMS Web page is at *http://Go.cms.gov/PADemo*.

MLN Matters® special edition article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf*.

The *Medicare Learning Network*® (*MLN*) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf*.

Please visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html* for the latest *MLN* educational products designed to help Medicare FFS Providers understand – and avoid – common billing errors and other improper activities.

MLN Matters® Number: SE1231
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

Medicare crossover process and Medicaid requirements for NDCs associated with Part B drugs

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for physicians, hospitals, clinics, other providers, their billing vendors or clearinghouses that regularly include line-item billing for physician-administered drugs as part of the claims that they send to Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs)).

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) outlines guidance to help reduce the amount of claims being denied and/or not accepted by state Medicaid agencies in conjunction with the national coordination of benefits agreement (COBA) Medicare claims crossover process.

CMS is providing this guidance in an effort to improve the effectiveness of the Medicare claims crossover process.

Background

Currently, many payers use both the 11-digit national drug code (NDC), reported in the 5-4-2 format, and the associated Healthcare Common Procedure Coding System (HCPCS) code for claims adjudication that include billing for physician-administered drugs. In accordance with the Deficit Reduction Act (DRA) of 2005 and its subsequent implementing regulation, as found in 42 *Code of Federal Regulations* (CFR) 447 Section 520, state Medicaid agencies must include information on individual NDCs directly related to physician-administered drugs when sending their billing to drug manufacturers to claim drug rebates under the Title XIX program. Such information is normally available to state Medicaid agencies through the national COBA Medicare claims crossover process, by which Medicare automatically transfers fully-adjudicated Medicare claims to Title 19 Medicaid agencies for their supplemental, or tertiary, payment consideration.

Through ongoing discussions with Title 19 Medicaid agencies, CMS has determined that physician offices, outpatient hospital departments, and outpatient clinics do not always include a one-to-one reporting of an NDC for each Part B drug HCPCS (e.g., J3140) code reported on incoming Medicare claims. This trend was found mostly on multi-line claims. Consequently, the Medicaid agencies are either denying the COBA Medicare crossover claims that report Part B drug HCPCS codes without corresponding NDCs, or developing the required information with physicians and outpatient hospital and clinic providers.

(continued on next page)

Crossover *(continued)*

Key points

Billing of NDCs on Health Insurance Portability and Accountability Act (HIPAA) 837 institutional claims sent to Medicare

When physician billing offices and hospital outpatient departments and outpatient clinic billing offices determine that their patients are: 1) dually entitled to Medicare and Medicaid, and 2) have received physician-administered drugs as part of a medical encounter, they should bill the physician-administered drug(s) on the resulting claims to Medicare as follows:

- For each line level reporting of a Part B physician-administered drug, continue to report the associated HCPCS (e.g., J3140) in 2400 SV202-2, with SV202-1=HC, and
- For each Part B drug HCPCS reported in 2400 SV202-2, complete the required associated 2410 LIN and CPT04 segments as follows:
  - Include the NDC in 2410 LIN03, with LIN02=N4
  - Include the quantity/unit count in 2410 CPT04, and
  - Input the needed information in 2410 CPT05 and CPT05-1

Billing NDCs on incoming CMS-1500 or UB04 hardcopy claims to Medicare

- Most physicians and providers may realize that Medicare transforms incoming CMS-1500 or UB04 hardcopy claims into their electronic equivalent HIPAA 837 professional and institutional formats as part of the Medicare claims crossover process. CMS previously issued guidance to physicians and providers about the reporting of NDCs and associated information (i.e., qualifier for NDC and qualifier for quantity/units, as well as reporting of quantity/unit count, including fractional units) on hardcopy CMS-1500 and UB04 claim formats during 2008. These directions, which remain unchanged, may be reviewed in:
  - *MLN Matters*® article MM5930, "Medicare Shared Systems Modifications Necessary to Capture and Crossover Medicaid Drug Rebate Data Submitted on Form UB 04 Paper Claims and Direct Data Entry (DDE) Claims," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5950.pdf*; and
  - *MLN Matters*® article MM5835, "Medicare Shared Systems Modifications Necessary to Accept and Crossover to Medicaid National Drug Codes (NDC) and Corresponding Quantities Submitted on CMS-1500 Paper Claims," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5835.pdf*.

Billing of NDCs via direct data entry (DDE) claims screen

- Outpatient hospital departments and outpatient clinics that bill via DDE and are experiencing non-acceptance and/or denial of Medicare crossover claims by state Medicaid agencies due to missing NDCs should contact their designated MAC or FI for assistance.

Additional information

If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1234
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: September 5, 2012
Related CR Transmittal #: NA
Implementation Date: September 5, 2012

Consistency edit to validate attending physician national provider identifier

Provider types affected

This *MLN Matters*® article is intended for institutional providers submitting claims to Medicare contractors (A/B Medicare administrative contractors (MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)) for services to Medicare beneficiaries.

Provider action needed

Effective for claims received on or after January 1, 2013, you must submit the national provider identifier (NPI) of the attending provider in the attending provider name and identifiers field (FL76) of your claims. That NPI must not be your billing NPI, unless the claim is for institutional billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the claim or a roster billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the roster claim. Make sure that your billing staffs are aware of this requirement.

Background

Institutional providers are required to indicate the attending provider name and identifiers for the patient's medical care and treatment reported on institutional claims for any services other than non-scheduled transportation claims. Additionally, institutional providers are required on outpatient claims to send the referring provider NPI and name when the referring provider for the services is different than the attending provider.

Additional information

The official instruction, CR 7902, issued to your contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2519CP.pdf*.

If you have any questions, please contact your contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7902
Related Change Request (CR) #: CR 7902
Related CR Release Date: August 17, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2519CP
Implementation Date: January 7, 2013

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.

Phase 2 of ordering/referring requirement

Note: This article was revised on September 17, 2012, to remove the word "Certified" from in front of clinical nurse specialist under Background (third bullet). All other information remains the same. This information was previously published in the June 2012 *Medicare A Connection*, Pages 3-6.

Provider types affected

This *MLN Matters*® special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries
- Part B providers (including portable X-ray services) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to RHHIs, fiscal intermediaries (who still maintain an HHA workload), and Part A/B MACs.

(continued on next page)

Ordering *(continued)*

Provider action needed

Stop – impact to you

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60-day advanced notice prior to turning on the ordering/referring edits. CMS does not have a date at this time.

Caution – what you need to know

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with phase 2 ordering/referring edits. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

Go – what you need to do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background

The Social Security Act (the Act) requires that all physicians and non-physician practitioners be uniquely identified for all claims for services that are ordered or referred. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers as follows:

- **Phase 1**: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant
- Clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name
N265 Missing/incomplete/invalid ordering physician primary identifier

(continued on next page)

Ordering *(continued)*

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least 60-day notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer

255D Referring/Ordering Provider Mismatch

289D Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is ‘32’ or ‘33’

Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code

37237 – This reason code will assign when:

- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is ‘32’ or ‘33’
- The type of bill frequency code is ‘7’ or ‘F-P’

Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, “Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements,” on April 24, 2012, permitting phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement phase 2 edits.

Additional information

A note on terminology: Part B claims use the term “ordering/referring provider” to denote the person who

(continued on next page)

Ordering *(continued)*

ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® fact sheet, "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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*.

You may find the following articles helpful in understanding this matter:

- *MLN Matters*® article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf*.
- *MLN Matters*® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf*.
- *MLN Matters*® article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)", is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf*.
- *MLN Matters*® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf*.
- *MLN Matters*® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf*.
- *MLN Matters*® special edition article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf*.
- *MLN Matters*® special edition article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf*.
- *MLN Matters*® special edition article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf*.

If you have any questions, please contact your carrier, Part A/B MAC, RHHI, fiscal intermediary, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1221 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Prohibition on balance billing qualified Medicare beneficiaries

Note: This article was revised on August 28, 2012, to clarify the section of the Social Security Act that prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing (under the "What you need to know" section). This article was previously updated on July 25, 2012, to reflect current Web addresses. All other content remains the same. This information was previously published in the October 2011 *Medicare A Connection*, Pages 8-10.

Provider types affected

All Medicare physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to qualified Medicare beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

What you need to know

Stop – impact to you

This special edition *MLN Matters*® article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers serving QMBs. All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.

Caution – what you need to know

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

Go – what you need to do

Refer to the *Background* and sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the state Medicaid agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as "balance billing."

Balance billing of QMBs is prohibited by federal law

Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. (Please note, this section of the Act is available at *http://www.ssa.gov/OP_Home/ssact/title19/1902.htm*.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect, and therefore, may be causing confusion about QMB billing.

QMBs and benefits

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the federal poverty level; and have been determined to be eligible for QMB status by their state Medicaid agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the state's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and mandatory supplemental benefits.

(continued on next page)

Balance *(continued)*

- Regardless of whether the state Medicaid agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to improve the claims process

Effective communications between you and state Medicaid agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with state Medicaid agencies and better understand the billing process for services provided to QMB beneficiaries:

1. Determine if the state in which you operate has electronic crossover processes with the Medicare coordination of benefits contractor (COBC) in place or if direct submission to the state Medicaid agency is required or available. Nearly all states participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given states and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
2. Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the state payment system.
3. Understand the specific requirements for provider registration for the state(s) in which you work.
4. Contact the state Medicaid agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

QMB eligibility and benefits

Dual eligibility	Eligibility criteria	Benefits
Qualified Medicare beneficiary (QMB only)	• Income cannot exceed 100 percent of the federal poverty level (FPL) • Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents	• Entitled to Medicare Part A • Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)
QMB plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage • Individuals often qualify for full Medicaid benefits by meeting the medically needy standards, or through spending down excess income to the medically needy level.	• Entitle to all benefits available to QMB, as well as all benefits available under the state plan to a fully eligible Medicaid recipient

For more information about dual eligible categories and benefits, please visit *http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf*.

Additional information

For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the *Medicare Learning Network*® publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)*, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf*.

For general Medicaid information, please visit the Medicaid Web page at *http://www.medicaid.gov/index.html*.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Important reminder about Medicare secondary payer laws

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and other suppliers that are taking payment from beneficiaries upon an office or hospital visit when the Medicare beneficiary has a group health plan that is primary to Medicare. The Centers for Medicare & Medicaid Services (CMS) is issuing this article as an important reminder and the article reflects no change in current Medicare policy.

Provider action needed

Stop – impact to you

This article is based on information received from Medicare contractors (carriers and Medicare administrative contractors (MACs)) indicating that physicians, providers and other suppliers are requesting a Medicare deductible, coinsurance payment, or other payments from a beneficiary prior to or at the time of services being rendered when another payer is primary to Medicare.

Caution – what you need to know

It is against the Medicare secondary payer laws to accept payment from a beneficiary upon admission or when services are being rendered when another insurer is primary to Medicare. If you are performing this practice, you must stop immediately.

Go – what you need to do

Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed-care organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare secondary payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary, if anything, after Medicare makes its payment. NOTE: In situations where you have taken payment from the beneficiary when services were rendered, the beneficiary has the right to recoup his/her payment from you when reimbursement is warranted.

Background

Section 1862(b)(2)(A)(i) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to: (i) A beneficiary entitled to Medicare on the basis of ESRD during the first 30 months of that entitlement; (ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or (iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

Additional information

If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1227
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

Implementation of award for the jurisdiction 5 Medicare administrative contractor

Background

The Centers for Medicare & Medicaid Services (CMS) is required to compete each A/B MAC workload at least once every five years. It recently did so for the J5 A/B MAC workload as well as the Title 18 legacy workload being processed by Wisconsin Physicians Service (WPS) under its Medicare Title 18 contract. CMS awarded this workload to WPS, the incumbent contractor for all of these workloads.

WPS address is:

Wisconsin Physicians Service
1751 West Broadway
Madison, WI 53713

CMS has determined that it will not need to change the current J5 A/B MAC workload numbers when the new contract is implemented. However, the reprocurement also included an existing Title 18 workload whose contractor workload number will need to be changed. This change is being made because CMS needs to identify each MAC workload using a standardized numbering system.

The workload number shall be changed and the WPS legacy Title 18 workload shall be transitioned to the J5 A/B MAC as indicated below.

Workload description: WPS Legacy
MAC workload number: 05901
Effective date: October 22, 2012
Current contractor workload no.: 52280

The following applications or business owners shall continue to accept the current J5 A/B MAC workload number as well as the new J5 A/B workload number once the above cited workload is transitioned to the J5 A/B MAC:

- CMS Analysis, Reporting and Tracking System (CMS ARTS)
- Contractor Administrative, Budget and Cost Reporting System (CAFM)
- Comprehensive Error Rate Testing System (CERT)
- Contractor Management Information System (CMIS)
- CMS Baltimore Data Center
- Coordination of Benefits Agreement program (COBA)
- Coordination of Benefits Contractor (COBC)
- Contractor Reporting of Operational Workload Data System (CROWD)
- Common Working File (CWF)
- CWF Part B Eligibility and Security Maintenance (CWF ELGE)
- Customer Service Assessment and Management System (CSAMS)
- Debt Collection System (DCS)
- Electronic Correspondence Referral System (ECRS)
- Electronic Health Records Incentive Program (EHR)
- Enterprise Data Centers (EDCs)
- Expert Claims Processing System (ECPS)
- Fiscal Intermediary Shared System (FISS)
- Health Care Information System (HCIS)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
- Health Insurance Master Record (HIMR)
- Intern and Resident Information System (IRIS)

(continued on next page)

MAC *(continued)*

- Local Coverage Determination Database (LCD)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Multi-Carrier System (MCS)
- National Data Warehouse (NDW)
- National Level Repository (NLR)
- National Part B Pricing Files
- National Provider Identifier Crosswalk (NPI)
- Next Generation Desktop (NGD)
- Part B Analytics Reporting System (PBAR)
- Physician/Supplier Overpayment report (PSOR)
- Production Performance Monitoring System (PULSE)
- Provider Enrollment, Chain, and Ownership System (PECOS)
- Provider Customer Service Program Contractor Information Database (PCID)
- Provider Inquiry Evaluation System (PIES)
- Program Integrity Management Reporting System (PIMR)
- Program Safeguard Contractor (PSC)
- Provider Overpayment Reporting System (PORS)
- Provider Statistical and Reimbursement System (PS and R)
- Quality Improvement Evaluation System (QIES)
- Recovery Auditors (RA)
- Recover Management and Accounting System (REMAS)
- Renal Management Information System (REMIS)
- System Tracking for Audit and Reimbursement (STAR)
- ZIP Code File
- Zone Program Integrity Contractors (ZPICs)

Policy

N/A

Source: Pub. 100-20, Transmittal: 1119, CR 8059

Documenting medical necessity for major joint replacement

Provider types affected

This *MLN Matters*® special edition (SE) is intended for physicians who perform major joint replacement (hip and knee) surgery on Medicare beneficiaries. This article may also be of interest to hospitals, multi-specialty clinics, and accountable care organizations.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is publishing this article as an educational guide to improve compliance with documentation requirements for major joint replacement surgery. The article presents suggestions for documenting medical necessity to avoid denial of Medicare fee-for-service (FFS) claims. The use of this guide is not mandatory and does not guarantee payment.

Background

In 2010, the President announced the goals for cutting the Medicare FFS improper payment rate by half and reducing overall payment errors by $50 billion. Medicare has initiated a number of auditing projects with the intention of reaching those goals. Multiple auditing entities including the recovery audit contractors, comprehensive error rate testing (CERT) contractors, and Medicare administrative contractors (MACs) have demonstrated very high paid claim error rates among both hospital and professional claims associated with major joint replacement surgery.

Medical records must specifically document a complete description of the patients' historical and clinical findings. Progress notes consisting of only conclusive statements should be avoided.

Key points

Document medical necessity to avoid denial of claims

CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments. To avoid denial of claims for major joint replacement surgery, the medical records should contain enough detailed information to support the determination that major joint replacement surgery was reasonable and necessary for the patient. Progress notes consisting of only conclusive statements should be avoided.

Consequently, the medical record must specifically document a complete description of the patients' historical and clinical findings. Examples of such information may include:

History

- Description of the pain (onset, duration, character, aggravating, and relieving factors)
- Limitation of activities of daily living (ADLs) – specify
- Safety issues (e.g., falls)
- Contraindications to non-surgical treatments
- Listing and description of failed non-surgical treatments such as:
  - Trial of medications (e.g., NSAIDs)
  - Weight loss
  - Physical therapy
  - Intra-articular injections
  - Braces, orthotics or assistive devices.

Physical examination

- Deformity

(continued on next page)

Joint *(continued)*

- Range of motion
- Crepitus
- Effusions
- Tenderness
- Gait description (with/without mobility aides)

Investigations

- Results of applicable investigations (e.g., plain radiographs).

Clinical Judgment

- Reasons for deviating from a stepped-care approach

Examples of medical documentation

The following examples show portions of a medical record that either support or do not support the medical necessity of the joint replacement. Please note these examples do not describe all of necessary documentation required for a joint replacement surgery or all the clinical situations that require major joint surgery. These examples are solely for educational purposes.

Example of documentation demonstrating medical necessity for joint replacement surgery

A. The hospital record for the preoperative joint replacement surgical patient includes:

History

- Present illness from onset until the present
- Current symptoms and functional limitations
- Outcomes of nonsurgical treatments, such as:
  - Medications e.g., Anti-inflammatory medication, Analgesics
  - Intra-articular injections
  - Physical Therapy and/or home exercise plans
  - Assistive devices e.g., cane, walker, braces (specify type of brace), orthotics
- Comorbidities

Physical examination

- Joint examination with detailed objective findings.

Investigations

- Preoperative imaging studies.

The hospital record for the joint replacement surgical patient includes documentation of specific conditions. For example:

- Osteoarthritis (mild, moderate, severe)
- Inflammatory arthritis (e.g., rheumatoid arthritis, psoriatic arthritis)
- Failure of previous osteotomy
- Malignancy of distal femur, proximal tibia, knee joint, soft tissues
- Failure of previous unicompartmental knee replacement
- Avascular necrosis of knee
- Malignancy of the pelvis or proximal femur or soft tissues of the hip
- Avascular necrosis of the femoral head
- Fractures (e.g., distal femur, femoral neck, acetabulum)

(continued on next page)

Joint *(continued)*

- Nonunion, malunion, or failure of previous hip fracture surgery, and
- Osteonecrosis.

B. The hospital record for the postoperative joint replacement surgical patient includes:

- Operative report for the procedure, including observed pathology
- Daily progress notes for inpatients, and
- Discharge plan and discharge orders.

Example of a medical record that may result in a DENIED claim

Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain and pain meds do not work. Therefore, she needs a total right knee replacement.

Example of a medical record with more detail and support of medical necessity

History

Mrs. Smith is a 70-year-old female who is suffering from end-stage osteoarthritis (OA) of her right knee, worsening gradually over the past 10 years. Treatment has included NSAIDs which have not effectively relieved her pain/inflammation and which have recently begun to cause her gastric distress. She has also participated in an exercise program/physical therapy for the past three months without functional improvement. Sometimes the pain keeps her awake at night. She is using a cane and is no longer able to climb the five steps to her front door. Personal safety is compromised as she had falls x 3 in attempting the stairs to her home entrance. Her knee pain and stiffness limit her ability to perform ADLs. She cannot walk from her bedroom to her kitchen without stopping to rest.

Physical examination

Vital signs: 140/90, Heart rate 78, RR 18.

Physical exam: Bilateral varus knee deformity consistent with severe osteoarthritis. Right knee extension reduced to minus 15 degrees and flexion to less than 100 degrees. Unable to rise from chair unassisted. Full motion of the right hip, no calf tenderness or ankle edema. Antalgic gait noted.

Investigations

X-ray (7/2/11): right knee shows joint space narrowing along with marginal osteophytes.

Impression

Total knee arthroplasty (TKA) indicated

Plan/Orders

Discussed risks and benefits of total joint replacement with patient. Patient understands both. Admit to inpatient care for right TKA. Forward a copy of this note to include in patients chart along with a copy of the patient's x-ray reports.

Additional information

If you have any questions, please contact your carrier, fiscal intermediary, or MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

For additional information and educational materials related to provider compliance, visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html*.

MLN Matters® Number: SE1236
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

Ordering and certifying documentation – maintenance requirements

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers and home health agencies (HHAs) submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article, based on change request (CR) 7890, informs you of instructions to Medicare contractors regarding the implementation of ordering and certifying documentation and maintenance requirements found in 42 Code of Federal Regulations (CFR) 424.516(f).

Caution – what you need to know

A provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for seven years from the date of service, and
- Provide access to that documentation upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor.

A physician who orders/certifies home health services and a physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to:

- Maintain the documentation for seven years from the date of service, and
- Provide access to that documentation upon the request of CMS or a Medicare contractor.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

Go – what you need to do

Review the description of documentation to be maintained in the Background section below. Make sure that your billing staffs are aware of these requirements for documentation.

Background

Under 42 CFR 424.516(f)(1), a provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to (1) maintain documentation (see next paragraph) for seven years from the date of service, and (2) provide access to that documentation upon the request of CMS or a Medicare contractor.

The documentation to be maintained includes written and electronic documents (including the national provider identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under 424.516(f)(2), a physician who orders/certifies home health services and the physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for seven years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician, or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

The CMS policy states that, absent a CMS directive to the contrary, the Medicare contractor will request the documentation described above if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as "provider") is not maintaining the documentation in accordance with Section 424.516(f)(1) or (2).

(continued on next page)

Certifying *(continued)*

Examples of when a request might be appropriate include, but are not limited to, the following:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has otherwise generated an alert with respect to the provider.
- The provider has been the subject of a recent zone program integrity contractor referral.
- The provider maintains an elevated surety bond amount.

If a provider fails to respond to a letter request for documentation within 30 days of the Medicare contractor's request, the contractor may revoke the provider's Medicare billing privileges and impose a one-year re-enrollment bar.

Additional information

The official instruction, CR 7890 issued to your carrier, FI, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R431PI.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7890
Related Change Request (CR) #: CR 7890
Related CR Release Date: August 31, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R431PI
Implementation Date: October 1, 2012

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

Services and items ordered or referred by other providers and suppliers

Note: This article was revised on September 19, 2012, to add the last bullet under *Background* regarding optometrists. The article also now contains a reference to *MLN Matters*® article SE1221 and all Web addresses have been updated. All other information remains the same. This information was previously published in the January 2012 *Medicare A Connection*, Pages 8-10.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

(continued on next page)

Ordered *(continued)*

Background

The Centers for Medicare & Medicaid Services (CMS) emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

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

MLN Matters® special edition articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf* and SE1212 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf*.

Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

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

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

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

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

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

MLN Matters® Number: SE1201 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Additional instructions related to screening and behavioral counseling interventions in primary care to reduce alcohol misuse (CR 7633)

Note: This article was revised on September 17, 2012, to reflect a revised change request (CR) 7791 issued on September 13. The CR transmittal number, release date, and the Web address for accessing the CR have been changed. All other information is the same. This information was previously published in the June 2012 *Medicare A Connection*, Pages 22-23.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to fiscal intermediaries (FI), carriers and A/B Medicare administrative contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

What you need to know

If a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in Medicare's claims history within a prior 12-month period, CR 7791 requires contractors to deny these claims. Be sure to inform your staff of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) may add coverage of "additional preventive services" through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >seven drinks per week or >three drinks per occasion for women, and >14 drinks per week or >four drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

In the Medicare population, Saitz (2005) defined risky use as >seven standard drinks per week or >three drinks per occasion for women and persons >65 years of age, and >14 standard drinks per week or >four drinks per occasion for men ≤65 years of age. Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 "Clinician's Guide" from the National Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12-month period. It requires contractors to deny such claims with the following specific messages:

- **Claim adjustment reason code (CARC) B15** – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remark code (RARC) M16** – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
- **Group code PR (patient responsibility)** assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed Advanced Beneficiary Notice (ABN) is on file.
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

(continued on next page)

Interventions *(continued)*

Also, remember that Medicare will only pay for up to four G0443 services within a 12-month period. Claims for G0443 that exceed that four session limit in a 12-month period will be rejected. In addition, Medicare will continue to reject incoming claims when G0442 (PROF) and G0443 (PROF) are billed on the same day on types of bills 71x, 77x, and 85x with revenue codes 096x, 097x, and 098x.

Additional information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2544CP.pdf*.

The *MLN Matters*® article MM7663, titled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7791 *Revised*
Related Change Request (CR) #: 7791
Related CR Release Date: September 13, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2544CP
Implementation Date: October 1, 2012

Extracorporeal photopheresis

Note: This article was revised September 10 and September 25, 2012, to reflect the revised change requests 7806 issued September 7 and September 24, 2012, respectively. The CR release date, transmittal number, and the Web address for accessing CR 7806 were revised. Also, the first bullet point following the table shows the ICD-10 code for V70.7. This information was previously published in the July 2012 *Medicare A Connection*, Pages 5-8.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing extracorporeal photopheresis procedures for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Provider action needed

Effective for claims with dates of service on and after April 30, 2012, Medicare will cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation, but only when provided under an approved clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. You should make sure that your billing staffs are aware of the expanded coverage provided in this NCD.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital (CAH) settings. In the procedure, some of a patient's removed white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. After UVA light exposure, the treated white blood cells are re-infused into the patient, stimulating their immune system in a series of cascading reactions. This activation of the immune system then impacts the illness being treated.

Currently, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of CTCL that has not responded to other therapy;

(continued on next page)

Extracorporeal *(continued)*

- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

On August 4, 2011, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request for a reconsideration to add coverage for extracorporeal photopheresis treatment for patients who have received lung allografts and then developed progressive BOS refractory to immunosuppressive drug treatment.

As a result of the reconsideration, effective for claims with dates of service on and after April 30, 2012, Medicare will begin to cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation; but only when provided under a clinical research study that meets specific requirements to assess its effect in the treatment of BOS following lung allograft transplantation.

NCD clinical research study requirements

This is a national coverage determination (NCD). In keeping with this NCD, any clinical research study that includes Medicare coverage of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation must be approved by meeting the requirements listed below. Additionally, consistent with section 1142 of the Social Security Act, AHRQ supports clinical research studies that CMS determines meet these standards and address the research questions.

An approved clinical research study:

1. Must address one or more aspects of the following question:

Prospectively, do Medicare beneficiaries who have received lung allografts, developed BOS refractory to standard immunosuppressive therapy, and received extracorporeal photopheresis, experience improved patient-centered health outcomes as indicated by:

   a) Improved forced expiratory volume in one second (FEV1);

   b) Improved survival after transplant; and/or

   c) Improved quality of life?

2. Must adhere to the following standards of scientific integrity and relevance to the Medicare population:

   a) Its principal purpose is to test whether extracorporeal photopheresis potentially improves the participants' health outcomes;

   b) It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c) It does not unjustifiably duplicate existing studies;

   d) Its design is appropriate to answer the research question being asked in the study;

   e) It is sponsored by an organization or individual capable of successfully executing the proposed study;

   f) It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 *Code of Federal Regulations* CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must also be in compliance with 21 CFR parts 50 and 56;

   g) All of its aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org*);

   h) It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED) coverage;

   i) It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options;

   j) It is registered on the ClinicalTrials.gov website (*http://clinicaltrials.gov*) by the principal sponsor/investigator prior to the enrollment of the first study subject;

(continued on next page)

Extracorporeal *(continued)*

k) Its protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*).

l) It explicitly discusses subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary

m) Its study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its Final Decision Memorandum (DM) on April 30, 2012.

Billing requirements

Effective for claims with dates of service on and after April 30, 2012, your carrier, FI, or A/B MAC will accept and pay for hospital outpatient and physician claims containing Healthcare Common Procedure Coding System (HCPCS) procedure code *36522* along with one of the International Classification of Diseases (ICD-9-CM or ICD-10) diagnosis codes displayed in the following table.

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for ECP coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
V70.7	Examination of participant in clinical trial	Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Please note that your claims will only be paid when they also contain all of the following:

- Diagnosis code V70.7 (as secondary diagnosis) (ICD-10 Z00.6);
- Condition code 30 (institutional claims only);
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study); and
- Value code D4 with an 8-digit clinical trial number (optional)(FIs only).

(continued on next page)

Extracorporeal *(continued)*

Additionally, should your Medicare contractor return your claims as unprocessable because they are missing: 1) Diagnosis code V70.7 (as secondary diagnosis), 2) Condition code 30 (Institutional claims only), 3) Clinical trial modifier Q0 (Institutional claims only), and 4) Value code D4 with an 8-digit clinical trial number (optional) (FIs only); they will use the following messages:

- CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- RARC M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Please keep in mind that your contractor will not retroactively adjust claims from April 30, 2012, processed prior to implementation of CR 7806. However, they may adjust claims that you bring to their attention.

Additional information

The official instruction, CR 7806, was issued in two transmittals. The first updates to the *Medicare National Coverage Determinations Manual* are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R143NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2551CP.pdf*.

MLN Matters® Number: MM7806 *Revised*
Related Change Request (CR) #: CR 7806
Related CR Release Date: September 24, 2012
Effective Date: April 30, 2012
Related CR Transmittal #: R143NCD and R2551CP
Implementation Date: October 1, 2012

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

Quarterly provider update

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

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

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

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.**

Revision to LCD

AJ2778: Ranibizumab (Lucentis®) – revision to the LCD

LCD ID number: L28977 (Florida)
LCD ID number: L29010 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was most recently revised June 14, 2011. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include a new indication approved by the Food and Drug Administration (FDA) for Lucentis® August 10, 2012, for the treatment of diabetic macular edema (DME). Also, changes were made to clarify the language in the "Limitations" section of the LCD related to chronic blepharitis versus ocular or periocular infection. In addition, the "Sources of Information and Basis for Decision" section of the LCD was also updated.

Effective date

This LCD revision is effective for claims processed **on or after September 13, 2012**, for services rendered **on or after August 10, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. 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*.

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

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

The local coverage determination (LCD) for cetuximab (Erbitux®) was most recently revised November 7, 2011. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include the following new Food and Drug Administration (FDA) approved labeled indications:

- Indication of K-Ras mutation-negative (wild-type), EGFR-expressing, metastatic colorectal cancer as determined by FDA-approved tests. Erbitux is not indicated for treatment of K-Ras mutation-positive colorectal cancer.
- Also, Cetuximab is indicated for use in combination with Folfiri for first-line treatment as determined by FDA-approved tests for this use. FDA also approved the Therascreen KRAS RGQ PCR Kit (QIAGEN Manchester, Ltd) concurrent with this cetuximab approval.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was also updated.

Effective date

This LCD revision is effective for claims processed **on or after September 11, 2012**, for services rendered **on or after July 6, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. 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*.

A22533: Lumbar spinal fusion for instability and degenerative disc conditions – revision to the LCD

LCD ID number: L32074 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for lumbar spinal fusion for instability and degenerative disc conditions was most recently revised January 1, 2012. Since that time, the LCD was revised based on an external reconsideration request. The LCD was revised to clarify language under the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after September 4, 2012**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. 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*.

Additional Information

Clarification of the proper use and billing of adenosine injections

First Coast Service Options Inc. has been made aware of a potential billing concern where providers may be purchasing generic equivalents for Adenocard® (HCPCS code J0150) for use and billing under HCPCS code J0152 (Adenoscan®) in error. As a reminder, drugs approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective when used for indications specified on the labeling, and providers are required to code services billed for Medicare reimbursement according to the most accurate code descriptor for the service they are reporting. Per the American Medical Association (AMA) 2012 HCPCS Level II coding book, the following descriptors indicate Adenocard (HCPCS code J0150) is intended for therapeutic use, and Adenoscan® (HCPCS code J0152) is intended for diagnostic use.

- HCPCS code J0150 injection national drug code (NDC): Adenocard® (adenosine injection), is for therapeutic use and is indicated for conversion to sinus rhythm of paroxysmal supraventricular tachycardia (PSVT), including that associated with accessory bypass tracts (Wolff-Parkinson-White Syndrome). Adenocard® is supplied in 6 mg (2ml) and 12 mg (4ml) prefilled syringes.
- HCPCS code J0152 injection NDC: Adenoscan® (adenosine injection), is for diagnostic use and is indicated as an adjunct to thallium-201 myocardial perfusion scintigraphy in patients unable to exercise adequately. Adenoscan® is supplied in 60 mg (20 ml) and 90 mg (30 ml) single use vials developed for individual procedures.

Please note that per the HCPCS 2012 Level II coding book, adenosine phosphate compounds should be billed using HCPCS code A9270 (Non-covered item or service).

The average sales price (ASP) based payment system is designed to align payments more closely to providers' acquisition costs. A particular NDC should therefore be billed under the HCPCS code to which that NDC is assigned. Providers are encouraged to perform a self-audit and when appropriate, submit voluntary overpayments within 45 days of this notice.

PWK is here

PWK allows for documentation to be submitted with an initial claim

Effective October 1, 2012, First Coast Service Options Inc. (First Coast) will implement the PWK (paperwork) segment of the X12N version 5010. This will allow for voluntary submission of supporting documentation with a 5010 version electronic claim.

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

Although PWK ultimately will allow electronic submission of additional documentation, the October implementation will only allow for submission of additional documentation via mail and fax (PWK 02 segment, BM [by mail] and FX [by fax] qualifier, respectively).

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

PWK Fax/mail coversheets

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

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

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

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

If the PWK segment is completed and additional documentation is needed for adjudication, First Coast will allow seven calendar "waiting" days (from the claim date of receipt) for the paperwork documentation to be faxed or ten calendar waiting days to be mailed. The seven and ten day waiting periods apply to claims for both Part A and Part B.

If the PWK data is not received within the waiting timeframe and additional documentation is needed, a development request will be sent. If documentation


FIRST COAST SERVICE OPTIONS, INC.

When Experience Counts And Quality Matters

Medicare Part A fax/mail cover sheet

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

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


FIRST COAST SERVICE OPTIONS, INC.

When Experience Counts And Quality Matters

Medicare Part B fax/mail cover sheet

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

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

(continued on next page)

PWK *(continued)*

is received after the timeframe has elapsed, the coversheet will be returned and the documentation will not be used for adjudication of the claim. Thus, the paperwork will need to then accompany our request for additional documentation to prevent possible claim denials.

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

Faxination numbers

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

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

5010 Companion Guide

Additional information on the PWK segment is available in the X12 version 5010 837I and 837P companion guides.

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

Source: Pub 100-08, Transmittal 396, Change Request 7330

CARC, RARC, MREP, and PC Print update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8029 which instructs Medicare contractors and shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that have been added since the last recurring code update. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate group code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors stop using codes that have been deactivated **on or before** the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

(continued on next page)

CARC *(continued)*

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8029, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule.

CR 8029 lists only the changes that have been approved since the last code update provided by CR 7775 (Transmittal 2442 issued April 6, 2012; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf*).

CR 8029 does not provide a complete list of CARCs and RARCs, and the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website which is updated three times a year (around March 1, July 1, and November 1).

The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

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

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

Note 1: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Note 2: CR 8029 lists only the changes approved since the last recurring code update CR once. If any change becomes effective at a future date, Medicare contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC website. If the effective date per the WPC website does not match any quarterly release date, Medicare contractors may update earlier than the effective date per WPC website for any deactivation, and later than the effective date per WPC website for any modification or new code.

CARCs

A national code maintenance committee maintains the health care CARCs, and a new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

This code set is updated three times a year, and the updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in January/February, June, and September/October.

(continued on next page)

CARC *(continued)*

The full list of CARCs can be found and downloaded from *http://wpc-edi.com/Reference* and to find out more about CARCs, see the *Medicare Claims Processing Manual* (Chapter 22, Sections 60.1 and 130.2 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf*.

New CARCs were approved by the code committee, and the following changes were made in the CARC database since the last code update provided by CR 7775. These changes must be implemented, if appropriate for Medicare, by October 1, 2012.

New CARCs

Code	Code narrative	Effective date
240	The diagnosis is inconsistent with the patient's birth weight. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012
241	Low Income Subsidy (LIS) Co-payment Amount.	6/3/2012
242	Services not provided by network/primary care providers.	6/3/2012
243	Services not authorized by network/primary care providers.	6/3/2012

Modified CARCs

Code	Code narrative	Effective date
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. Use Group Code OA.	6/3/2012

Deactivated CARCs

Code	Code narrative	Effective date
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/2013

Remittance advice remark codes

Remittance advice remark codes (RARCs) are maintained by CMS and may be used by any health plan when they apply. Medicare contractors must report appropriate remark code(s) that apply in both electronic and paper remittance advice, and COB claims. RARCs are used in a remittance advice to further explain an adjustment in conjunction with an appropriate CARC or relay general information about the adjudication process.

The remark code list is updated three times a year, and the list as posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. Medicare contractors must use the currently valid remark codes as included in the recurring update notification and/or any other CMS instruction. Medicare contractors also must get the full list of RARCs by downloading the list from the WPC website after each update. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or introduction of newly created codes that may impact Medicare.

The list of RARCs can be found at *http://www.wpc-edi.com/codes*.

For more information about remark codes

You can find out more about CARCs in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 22, Section 60.2, and 130.3 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf*.

These following changes were made in the RARC database since the last code update provided by CR 7775. The full RARC list must be downloaded from the WPC website at *http://wpc-edi.com/Reference*.

New RARCs

Code	Code narrative	Effective date
N554	Missing/Incomplete/Invalid Family Planning Indicator	7/1/2012
N555	Missing medication list.	7/1/2012
N556	Incomplete/invalid medication list.	7/1/2012

(continued on next page)

CARC *(continued)*

Code	Code narrative	Effective date
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	7/1/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	7/1/2012
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the ordering physician is located.	7/1/2012

Modified RARCs

Code	Modified code narrative	Effective date
N69	PPS (Prospective Payment System) code changed by claims processing system.	7/1/2012
N103	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.	7/1/2012

Deactivated RARCs

None

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the "Business Requirements" segment of CR 8029 for explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional information

The official instruction, CR 8029, issued to your contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2521CP.pdf*.

If you have any questions, please contact your contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8029
Related Change Request (CR) #: CR 8029
Related CR Release Date: August 17, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2521CP
Implementation Date: October 1, 2012

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

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article, based on change request (CR) 8045, explains that claim status and claim status category codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277, Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the national code maintenance committee meetings.

These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The national code maintenance committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* or *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*. Make sure that your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use. All code changes approved during the June 2012 committee meeting will be posted on or about July 1, 2012.

Additional Information

The official instruction, CR 8045, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2547CP.pdf*.

If you have any questions, please contact your FI, carrier, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8045
Related Change Request (CR) #: CR 8045
Related CR Release Date: September 14, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2547CP
Implementation Date: January 7, 2013

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.

New file reload pages available

First Coast Service Options Inc (First Coast) is pleased to announce that you may now reload remittance advices and claim file acknowledgements to your mailbox through the *http://medicare.fcso.com/* website. These new reload tools can be accessed through the "Electronic Data Interchange" (EDI) menu, under "Reload Requests."

You will need to have a valid email address and your submitter number on hand to get started.

Acknowledgments

Claim file acknowledgments may be reloaded using the following information:

- Submitter number
- File transmission date
- Either number of claims or the total file value

Note: Only acknowledgments for files received on or after September 10, 2012, can be reloaded with this tool. For prior dates, please contact Medicare EDI at 888-670-0940 option -1 for assistance.

There is an option for the 999 Implementation acknowledgements and the 277 CA (claim acknowledgment). Each request must be submitted separately. If you are not one of First Coast's electronic data trading partners, please contact either your billing service or your clearinghouse to obtain your acknowledgments.

Remittances

- 835 remittance advices may be reloaded using the following information:
- Submitter number
- Check/control number
- Check date
- Remittance amount

Each request will return only one remittance advice but multiple requests may be submitted. If you are not one of First Coast's electronic data trading partners, please contact either your billing service or your clearinghouse to obtain your electronic remittance advice. Reload requests must be initiated by that billing service or clearinghouse, not the provider.

If your request is successful, an email will be returned to you confirming the reload. If your request is unsuccessful you will not be notified; you should wait one hour before contacting Medicare EDI at 888-670-0940 option -1 for assistance.

Electronic data interchange communication requirements

To electronically interface directly with First Coast Service Options, Inc. for the purpose of either transmitting electronic media claims (EMC) or retrieving electronic data, i.e., electronic remittance advices and acknowledgements of EMC submissions, you must meet the following communication requirements:

- Capability to connect to our electronic data interchange (EDI) gateway over an analog telephone line, which excludes Internet and digital phone line connections. If a consistent loss of connection to our EDI gateway is experienced, it is recommended that you contact your telephone carrier to confirm your current phone line configuration and the options available to you.
- Software on your computer that supports the creation of communication command files and the transfer of EDI data.

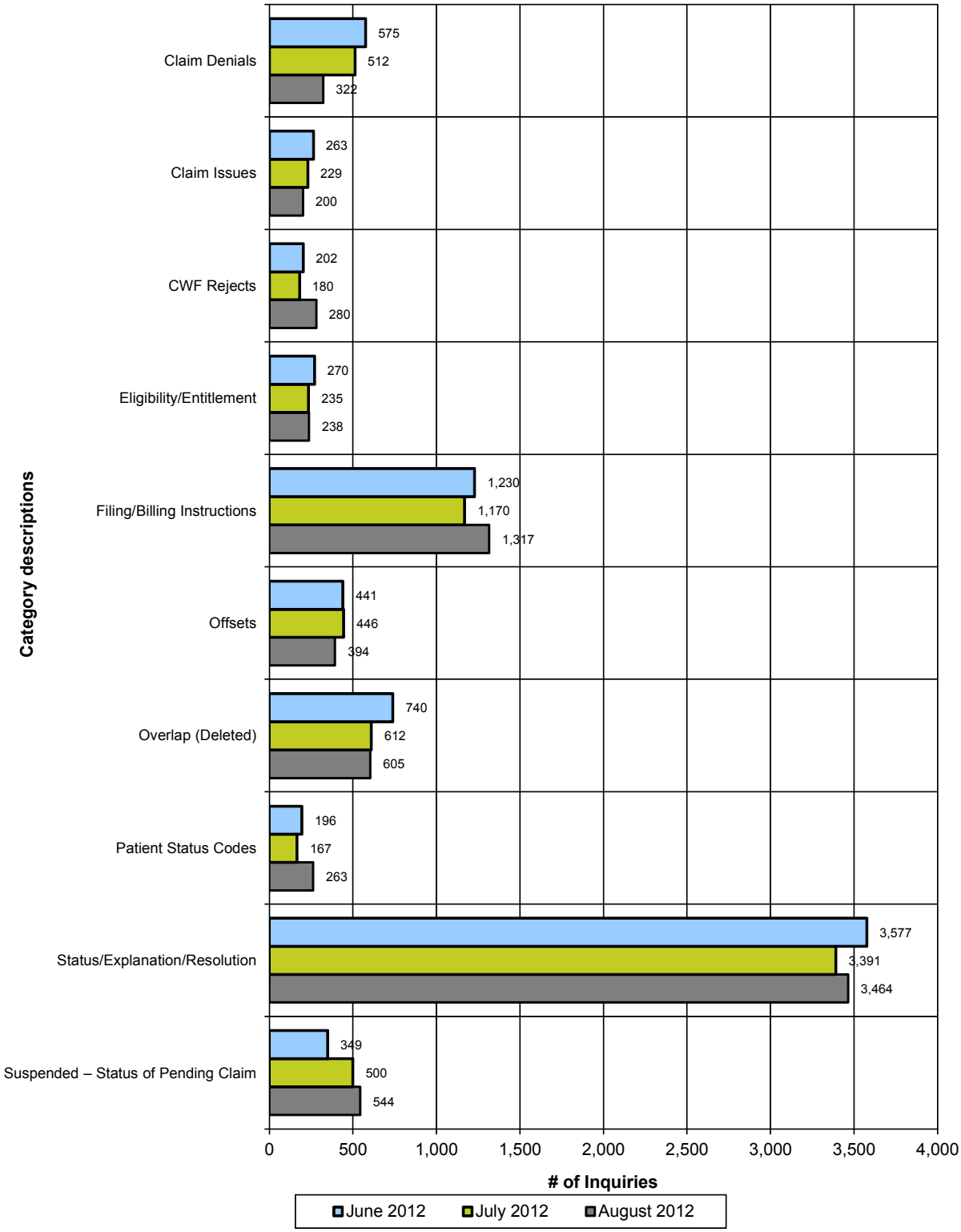
If the above communication requirements cannot be met, then a potential solution is utilization of a billing service, a clearinghouse, or a network service vendor. A current listing of the companies that have successfully passed X12N 837 5010 testing is located at: *http://medicare.fcso.com/Getting_started/206578.asp*.

Top inquiries, rejects, and return to provider claims – June-August 2012

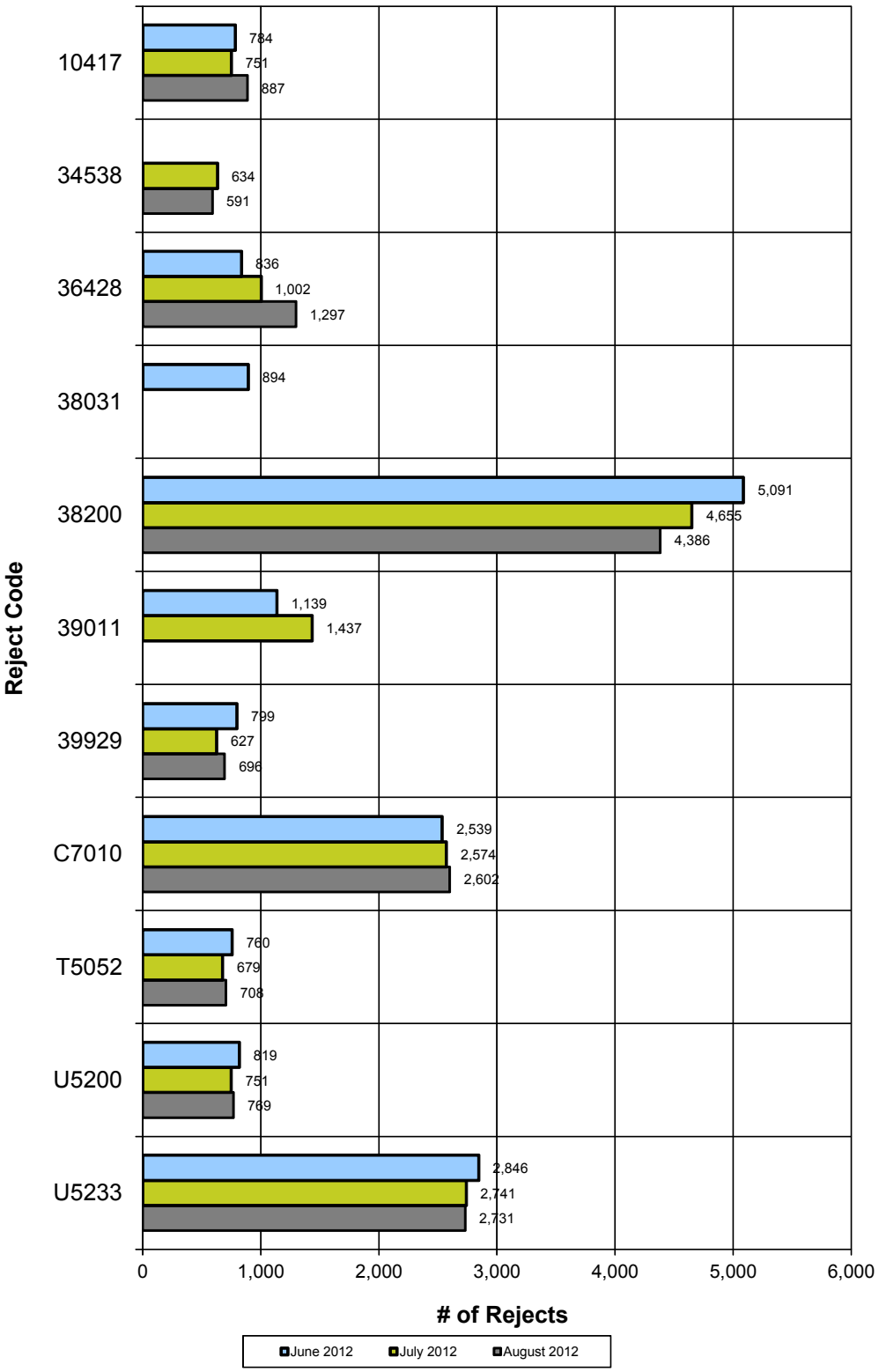
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during June through August 2012.

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*.

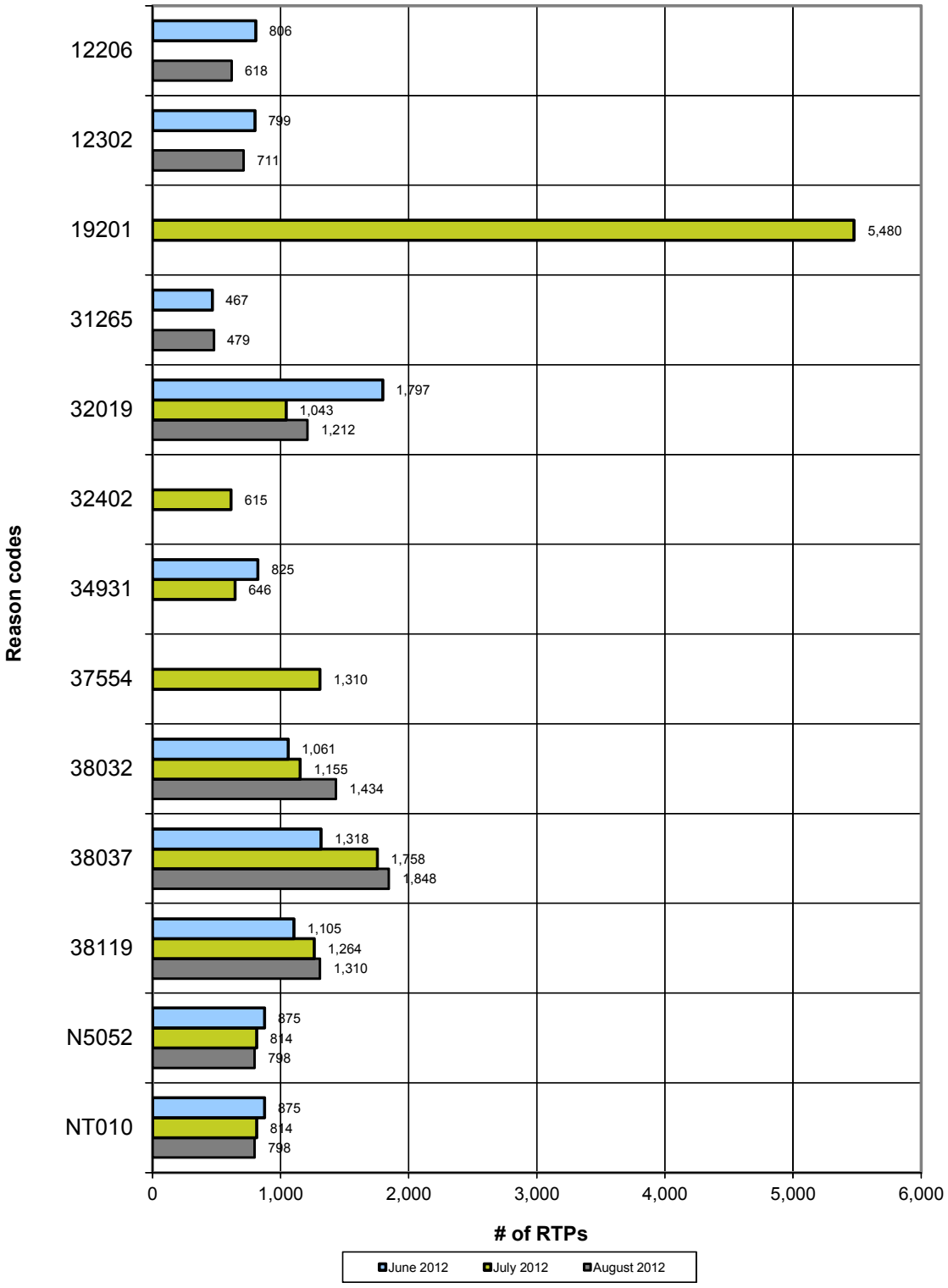
Part A top inquiries for June-August 2012



Part A top rejects for June-August 2012



Part A top return to providers (RTPs) for June-August 2012



Inpatient psychiatric facilities prospective payment system fiscal year 2013

Provider types affected

This *MLN Matters*® article is intended for providers who bill Medicare fiscal intermediaries (FI) or Part A Medicare administrative contractors (A MACs) for inpatient psychiatric services provided to Medicare beneficiaries and are paid under the inpatient psychiatric facilities prospective payment system (IPF PPS).

Provider action needed

Change request (CR) 8000, from which this article is taken, identifies changes that are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update from the fiscal year (FY) 2013 IPF PPS update notice, published August 7, 2013. These changes are applicable to IPF discharges occurring during fiscal year October 1, 2012, through September 30, 2013.

Make sure that your billing staff is aware of these IPF PPS changes for FY 2013.

Background

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services) but excludes certain pass-through costs (i.e., bad debts and graduate medical education). The Centers for Medicare & Medicaid Services (CMS) is required to make updates to this prospective payment system annually.

CR 8000 identifies the required changes as part of the annual IPF PPS update from the IPF PPS FY 2013 final rule. These changes are applicable to IPF discharges occurring during the FY October 1, 2012, through September 30, 2013.

Key points

Market basket update

For FY 2013, the Centers for Medicare & Medicaid Services (CMS) used the FY 2008-based rehabilitation, psychiatric and long-term care (RPL) market basket to update the IPF PPS payment rates (that is the federal per diem and electroconvulsive therapy (ECT) base rates).

Section 1886(s)(2)(A)(ii) of the Social Security Act (or the Act), requires the application of an "other adjustment" that reduces any update to the IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for rate year (RY) beginning in 2010 through the RY beginning in 2019. For the RY beginning in 2012 (that is, FY 2013), Section 1886(s)(3)(B) of the Act requires the reduction to be 0.1 percentage point. CMS is implementing that provision in this FY 2013 notice.

In addition, Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY. For the RY beginning in 2012 (that is FY 2013), the reduction is 0.7 percentage point. CMS is implementing that provision in this FY 2013 notice.

Specifically, CMS reduced the update to the IPF PPS base rate for FY 2013 by applying the adjusted market basket update of 1.9 percent (which includes the RPL market basket increase of 2.7 percent, an ACA required 0.1 percent reduction to the market basket update, and an ACA required productivity adjustment of 0.7 percent) and the wage index budget neutrality factor of 1.0007 to the RY 2012 federal per diem base rate of $685.01, which yields a federal per diem base rate of $698.51 for FY 2013. Similarly, applying the adjusted market basket update of 1.9 percent and the wage index budget neutrality factor of 1.0007 to the RY 2012 ECT rate of $294.91 yields an ECT rate of $300.72 for FY 2013.

PRICER updates

- The federal per diem base rate is $698.51

(continued on next page)

IPFS *(continued)*

- The fixed dollar loss threshold amount is $11,600.00
- The IPF PPS will use the FY 2012 unadjusted pre-floor, pre-reclassified hospital wage index
- The labor-related share is 69.981 percent
- The non-labor related share is 30.019 percent, and
- The ECT rate is $300.72.

Cost to charge ratio for the IPF PPS FY 2013

Cost to charge ratio	Median	Ceiling
Urban	0.496	1.7072
Rural	0.622	1.9155

CMS is applying the national median cost-to-charge ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG update

The code set and adjustment factors are unchanged for IPF prospective payment system FY 2013.

FY 2010 pre-floor, pre-reclassified hospital wage index

CMS is using the updated wage index and the wage index budget neutrality factor of 1.0007.

COLA adjustment

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition. In order to provide a full COLA for Alaska and Hawaii, CMS is adopting the FY 2009 COLA rates obtained from the OPM website (*http://www.opm.gov/oca/cola/rates.asp*). These are the same rates that were in effect for RY 2010, RY 2011 and RY 2012. The COLAs for Alaska and Hawaii are shown then as follows:

Alaska	COLA factor
City of Anchorage and 80-kilometer (50 mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50 mile) radius by road	1.23
City of Juneau and 80-kilometer (50 mile) radius by road	1.23
Rest of Alaska	1.25

Hawaii	COLA Factor
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Additional information

You can find more information about the FY 2013 update to the IPF PPS by going to CR 8000, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2520CP.pdf*.

The applicable previous year update is detailed in *MLN Matters*® article MM7367 and may be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7367.pdf*.

(continued on next page)

IPFS *(continued)*

If you have any questions, contact your contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8000
Related Change Request (CR) #: CR 8000
Related CR Release Date: August 17, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2520CP
Implementation Date: October 1, 2012

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

October 2012 update to the Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 8017 which informs Medicare contractors that, in order to reflect appropriate payment policy in line with the calendar year (CY) 2012 MPFS final rule, the MPFSDB has been updated effective October 1, 2012, and new payment files have been created. CR 8017 instructs Medicare contractors to retrieve and implement the revised payment files when they are notified that these files are available for retrieval. Contractors will also give providers 30-day notice before implementing the changes identified in CR 8017. Changes will be retroactive to January 1, 2012, unless otherwise stated in CR 8017.

CR 8017 also points out that the Office of Clinical Standards and Quality (OCSQ-CMS) has updated their national coverage determination (NCD) concerning Healthcare Common Procedure Coding System (HCPCS) code *43775* (*Lap sleeve gastrectomy*). This HCPCS code was previously a non-covered Service (N), and CR 8017 now instructs that it will be carrier-priced (C).

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for the services of physicians. In order to reflect appropriate payment policy in line with the CY 2012 MPFS final rule, the MPFSDB has been updated effective October 1, 2012.

On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA; see *http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf*) became law and suspended the automatic negative update that would have taken effect with current law. The TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012. On February 22, 2012, the TPTCCA was signed into law and extended the zero percent update to the end of the CY to December 31, 2012.

The Centers for Medicare & Medicaid Services (CMS) updated these payment files in July through CR 7844. You can review the *MLN Matters*® article, MM7844, which corresponds to CR 7844 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7844.pdf*.

CR 8017 constitutes the October amendment to those payment files, and unless otherwise stated in CR 8017, changes will be retroactive to January 1, 2012.

MLN Matters® Number: MM8017
Related Change Request (CR) #: CR 8017
Related CR Release Date: August 24, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2530CP
Implementation Date: October 1, 2012

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

FY 2013 inpatient prospective payment system and long term care hospital PPS changes

Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for acute care hospital services and long-term care hospital services.

Provider action needed

This article is based on change request (CR) 8041 which provides:

- Fiscal year (FY) 2013 updates to the acute care hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCHs) prospective payment system (PPS), and
- FY 2013 changes to the Medicare severity diagnosis related groups (MS-DRGs) grouper and Medicare code editor (MCE).

All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted. Be sure your billing staffs are aware of these changes.

Background

CR 8041 outlines changes to the inpatient prospective payment system (IPPS) for acute care hospitals and the prospective payment system (PPS) for long-term care hospitals (LTCHs) for FY 2013. Updates to the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 3 (Inpatient Hospital Billing) are also incorporated within CR 8041.

The policy changes for FY 2013 were displayed in the *Federal Register* on August 01, 2012, with a publication date of August 31, 2012.

The FY 2013 hospital IPPS final rule can be found at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html*. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to:

- The final rule (display version or published *Federal Register* version) with 1) changes to the acute care hospital IPPS and FY 2013 rates and 2) changes to the LTCH PPS and FY 2013 rates, and all subsequent published correction notices (if applicable);
- All tables
- Additional data and analysis files, and
- The impact file.

Files related to the long-term care PPS can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

All items covered in CR 8041 are effective for hospital discharges occurring on or after October 1, 2012, unless otherwise noted.

The grouper contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG grouper software package (version 30.0), effective for discharges on or after October 1, 2012. The grouper assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The MCE version 30.0, which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2012.

MS-DRG grouper and Medicare code editor changes

Users of the Medicare code editor (MCE) should be aware that there is a new edit effective October 1, 2012 (Edit 19 – Procedure inconsistent with length of stay). ICD-9-CM procedure code 9672 should only be coded on claims with a length of stay of four days or greater. The length of stay will be determined by counting the days between the “from” and “through” dates of the claim (minus any days in occurrence span code 74). Claims will be returned to provider indicating a length of stay conflict if less than four consecutive days. Systems changes were made to pass this information to the MCE.

(continued on next page)

IPPS *(continued)*

IPPS FY 2013 update

The FY 2013 IPPS Pricer is released to the FISS for discharges occurring on or after October 1, 2012. Refer to Table 1 for the FY 2013 IPPS rates and factors.

Attachment Table 1 – FY 2013 IPPS rates and factors

Description	Rates and factors
Standardized amount applicable percentage increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Hospital specific applicable percentage increase	1.018 if IQR = '1' in PSF or 0.998 if IQR = '0' or Blank in PSF
Common fixed loss cost outlier threshold	$21,821
Federal capital rate	$425.49
Puerto Rico capital rate	$207.25
Outlier offset-operating national	0.948999
Outlier offset-operating Puerto Rico	0.94476
SCH budget neutrality factor	0.998431
SCH documentation and coding adjustment factor	0.9480

Operating rates

Full-market basket and wage index > 1

Description	Rates
National labor share	$3,679.95
National non-labor share	$1,668.81
PR national labor share	$3,679.95
PR national non-labor share	$1,668.81
Puerto Rico specific labor share	$1,564.17
Puerto Rico specific non-labor share	$954.62

Full-market basket and wage index < or = 1

Description	Rates
National labor share	$3,316.23
National non-labor share	$2,032.53
PR national labor share	$3,316.23
PR national non-labor share	$2,032.53
Puerto Rico specific labor share	$1,561.65
Puerto Rico specific non-labor share	$957.14

Reduced market basket and wage index > 1

Description	Rates
National labor share	$3,607.65
National non-labor share	$1,636.02
PR national labor share	$3,679.95
PR national non-labor share	$1,668.81
Puerto Rico specific labor share	$1,564.17
Puerto Rico specific non-labor share	$954.62

Reduced market basket and wage index < or = 1

Description	Rates
National and PR national labor share	$3,251.08
National and PR national non-labor share	$1,992.59
PR national labor share	$3,316.23
PR national non-labor share	$2,032.53
Puerto Rico specific labor share	$1,561.65
Puerto Rico specific non-labor share	$957.14

Post-acute transfer and special payment policy

There are no changes to the post-acute and special post-acute payment policy or applicable DRGs for FY 2013.

See Table 5 of the FY 2013 IPPS/LTCH PPS final rule for a listing of all post-acute and special post-acute MS-DRGs at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html*.

New technology add-on payments

The following items are eligible for new-technology add-on payments in FY 2013:

- **Continue payments for the AutoLITT™** – Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

(continued on next page)

IPPS *(continued)*

- **New for FY 2013- DIFICID** – Cases involving DIFICID that are eligible for the new technology add-on payment will be identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868.
- **New for FY 2013- Zenith Fenestrated Graft** – Cases involving the Zenith Fenestrated Graft that is eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.
- **New for FY 2013- Voraxaze** – Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000.

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

Expiration of Section 508 reclassifications

Section 508 of the 2003 Medicare Modernization Act (MMA; see *http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf*) and as extended by both the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf*) and the Middle Class Tax Relief and Job Creation Act of 2012 (see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf*) is no longer in effect as of April 1, 2012.

Section 505 Hospital (out-commuting adjustment)

Attachment A of CR 8041 (Section 505) shows the IPPS providers that will be receiving a "special" wage index for FY 2013 (i.e., receive an out-commuting adjustment under section 505 of the MMA; see *http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf*).

Treatment of certain providers re-designated under Section 1886(d)(8)(B) of the Social Security Act

The *Code of Federal Regulations* (42 CFR 412.64(b)(3)(ii); see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr412_main_02.tpl*) implements the Social Security Act (Section 1886(d)(8)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. These counties are commonly referred to as "lugar counties."

Accordingly, hospitals located in "lugar counties" are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated.

A hospital that waives its "lugar" status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

Treatment of certain urban hospitals reclassified as rural hospitals under 42 CFR 412.103

An urban hospital that reclassifies as a rural hospital is considered rural for all IPPS purposes.

Note: Hospitals that are reclassified as rural under 42 CRF 412.103 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.12&idno=42*) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1)).

Medicare-dependent, small rural hospital (MDH) program expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2012. Therefore, beginning in FY 2013, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the federal rate. (CMS notes that they have revised their SCH policy to allow MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program, as explained further in this instruction.)

(continued on next page)

IPPS *(continued)*

Sole community hospital (SCH) clarification and changes to effective dates for SCH classification

The *Code of Federal Regulations* (42 CFR 412.92 (b)(2) and (b)(3); see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.2&idno=42*) address the effective dates of a classification as an SCH and the duration of this classification. Currently, a hospital's SCH classification status remains in effect without the need for re-approval unless there is a change in the circumstances under which the classification was approved. The *Code of Federal Regulations* (42 CRF 412.92(b)(3)) requires a hospital to notify the FI or MAC within 30 days of a change that could affect its classification as an SCH. The existing language at 42 CFR 412.92(b)(3) only refers to a hospital becoming aware of a "change," because it deals specifically with a situation where a hospital was appropriately classified as an SCH because it had previously met the requirements to become an SCH. However, the regulations did not explicitly address the situation where a hospital never met the requirements to be classified as an SCH, but was incorrectly classified as an SCH.

In light of the fact that CMS found a number of providers who may have been classified as SCHs incorrectly, in the FY 2013 rule, CMS discusses the current authority to recoup any overpayments associated with the incorrect SCH status, consistent with the cost report reopening rules at 42 CFR 405.1885 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=04bc29d77e11df84ab4b97b2649fb8cc&rgn=div8&view=text&node=42:2.0.1.2.5.11.33.48&idno=42*), and to cancel the hospital's classification retroactively. As a result, CMS has the discretion to reopen cost reports within the three-year reopening period and cancel a hospital's SCH status.

Additionally, effective October 1, 2012, if a hospital reports any factors or information to CMS that could have affected its initial classification as an SCH and CMS then determines that, based on the additional information, the hospital should not have qualified for SCH status, and CMS will cancel SCH status effective beginning with 30 days from the CMS' date of determination.

Current regulations state that if a hospital qualifies for SCH status, that status is generally effective beginning 30 days after CMS' written notification of approval. Due to the expiration of the MDH provision on September 30, 2012, there may be a number of hospitals currently classified as MDHs under 42 CFR 412.108 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.13&idno=42*) that believe they qualify for classification as SCHs under 42 CFR 412.92. In the FY 2013 IPPS/LTCH PPS final rule, CMS revised the regulations to provide for an exception to the effective date of SCH classification for any MDH that:

- Applies for SCH status at least 30 days prior to the expiration of the MDH provision (that is, by August 31, 2012), and
- Requests that SCH status be effective with the expiration of the MDH provision and the hospital is approved for SCH status.

The effective date of SCH status for those MDHs that comply with the application requirements and qualify for SCH status is the day following the expiration date of the MDH provision, that is, October 1, 2012.

Low-volume hospitals – criteria and payment adjustments for FY 2013

For FYs 2011 and 2012, the Affordable Care Act expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2013, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments made by the Affordable Care Act. Therefore, as specified under the regulations at 42 CRF 412.101 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=82260cc9a5cc08c88a1c188780937d5a&rgn=div8&view=text&node=42:2.0.1.2.12.7.47.6&idno=42*), effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "Subsection (d) Hospital" and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2013 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

The FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The FI/MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. For FY 2013 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see 42 CFR 412.101(b)(2)(i)). To meet the mileage criterion to qualify

(continued on next page)

IPPS *(continued)*

for the low-volume hospital payment adjustment for FY 2013 (and subsequent years), a hospital must be located more than 25 road miles (as defined at 42 CFR 412.101(a)) from the nearest "Subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/ MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/ MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2013, a hospital must meet both the discharge and mileage criteria (set forth at 42 CFR 412.101(b)(2)(i)).

For FY 2013, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2012, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2012 (through September 30, 2013). For requests for low-volume hospital status for FY 2013 received after September 1, 2012, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2013 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH, IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *https://www.qualitynet.org*. This website is expected to be updated in September 2012. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website, and FIs and A/B MACs shall update the provider file as needed. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2013 under the Hospital Inpatient Quality Reporting (IQR) Program will be available in September 2012.

Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act added Section 1886(q) to the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*) establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in **subpart I** of 42 CFR 412 (§412.150 through §412.154) as established in the FY 2013 IPPS/LTCH PPS final rule.

In the FY 2012 IPPS/LTCH PPS final rule, CMS finalized the readmission measures for acute myocardial infarction, (AMI), heart failure (HF) and pneumonia (PN) and the calculation of the excess readmission ratio, which is used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the national quality forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio is based on discharges occurring during the three year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS/ LTCH PPS final rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2012-IPPS-Final-Rule-Home-Page.html*.

In the FY 2013 IPPS/LTCH PPS final rule, CMS finalized that "Subsection (d) hospitals" are subject to the Hospital Readmissions Reduction Program, which excludes Puerto Rico hospitals. In addition, CMS has exempted Maryland hospitals from the Hospital Readmissions Reduction Program for FY 2013. In the FY 2013 IPPS/ LTCH PPS final rule, CMS established the methodology to calculate the hospital readmissions adjustment factor,

(continued on next page)

IPPS *(continued)*

what portion of the IPPS payment will be used to calculate the readmissions adjustment amount and CMS has established a process for hospitals to review their readmissions information and submit corrections to the information before the readmission rates are to be made public.

For FY 2013, the readmissions adjustment factor is the higher of a ratio or 0.99 (-1 percent). The methodology to calculate the ratio is discussed in the FY 2013 IPPS/ LTCH PPS final rule. The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount," or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH, outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2013, such as Maryland hospitals, will have a readmissions adjustment factor of 1.0000. For FY 2013, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9900. (The readmissions adjustment factors for FY 2013 are shown in Table 15 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule.) Hospitals that are not included in the Hospital Readmissions Reduction Program, such as Puerto Rico hospitals, will not have a readmissions adjustment factor.

Hospital Value-Based Purchasing Program

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), establishing the Hospital Value-Based Purchasing (VBP) Program. This program results in adjustments to base operating DRG payment amounts for discharges from subsection (d) Hospitals, for discharges beginning in FY 2013. CMS has excluded Maryland hospitals from the hospital VBP program for the FY 2013 program year. CMS will not implement the FY 2013 payment adjustments under the hospital VBP program until January 2013. The regulations that implement this provision are in Subpart I of 42 CFR 412 (§412.160 through §412.162) as established in the FY 2013 IPPS/LTCH PPS final rule.

Under the hospital VBP program, CMS will reduce base operating DRG payment amounts for subsection (d) hospitals by the applicable percent, beginning with discharges occurring in FY 2013. The applicable percent for payment reductions for FY 2013 is 1.0 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS will calculate a total performance score (TPS) for each hospital eligible for the hospital VBP program. CMS will then use a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount and the applicable percent reduction to base operating DRG payment amounts, CMS will calculate a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2013, as noted above, CMS will not implement the base operating DRG payment amount reductions or the value-based incentive payment adjustments until January 2013. Claims for discharges occurring in FY 2013 that are paid prior to this January 2013 implementation will be reprocessed by CMS as quickly as practicable.

Recalled devices

As a reminder, Section 2202.4 of the *Provider Reimbursement Manual*, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

(continued on next page)

IPPS *(continued)*

Bundled payments for care improvement initiative (BPCI) model 1

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model will propose a discount percentage which will be applied to payment for all participating hospitals' DRG over the lifetime of the initiative. Participating hospitals may gain share with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at *http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html*.

For hospitals participating in model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG (as defined earlier in this change request). IME, DSH, and outlier payments will be calculated based on the non-discounted base payments.

LTCH PPS FY 2013 update

The FY 2013 LTCH PPS rates and factors are as follows:

Description	Rates/Factors
Federal rate for discharges from 10/1/12 through 12/28/12	$40,915.95
Federal rate for discharges from 12/29/12 through 9/30/13	$40,397.96
High cost outlier fixed-loss amount	$15,408
Labor share	63.096 percent
Non-labor share	36.904 percent

The LTCH PPS Pricer has been updated with the version 30.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2012, and on or before September 30, 2013.

Short stay outlier (SSO) payment formula

The statutory five-year moratorium on the application of the "IPPS comparable per diem amount" option under the short-stay outlier (SSO) payment adjustment expires for discharges beginning on or after December 29, 2012. With the expiration of the moratorium, the existing SSO payment formula is revised for those cases where the patient's covered length of stay (LOS) is less than or equal to the "IPPS comparable threshold" for the MS-LTC-DRG to which the case is assigned. The "IPPS-comparable threshold" is defined as one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (as shown in Table 11 listed in the Addendum to the FY 2013 IPPS/LTCH PPS final rule and available at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html). If the covered LOS of an LTCH SSO case is within the "IPPS-comparable threshold", the "IPPS comparable per diem amount" (capped at the full "IPPS comparable amount") option will replace the "blend amount" option in the current SSO payment formula.

For a SSO discharge occurring on or after December 29, 2012, the Medicare payment will be based on the least of the following:

- 100 percent of the estimated cost of the case
- 120 percent of the MS-LTC DRG specific per diem amount multiplied by the covered length of stay of the particular case;
- The full MS-LTC-DRG per diem amount
- Comparing the covered length of stay for the SSO case and the "IPPS comparable threshold," one of the following:

  a) A blend of the 120 percent of the MS-LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount, for cases where the covered length of stay for the SSO case is greater than the "IPPS comparable threshold";

  b) An amount comparable to the IPPS comparable per diem amount, if the covered length of stay for an SSO case is equal to or less than one standard deviation from the geometric average length of stay for the same MS-DRG under the IPPS (the "IPPS comparable threshold").

(continued on next page)

IPPS *(continued)*

The IPPS comparable per diem amount is determined by the same methodology as the IPPS comparable per diem portion of the current "blend amount" option. For SSO cases where the covered LOS exceeds the "IPPS comparable threshold," payment is made under the existing SSO policy, as specified above.

Cost of living adjustment update for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2013. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2012, can be found in the FY 2013 IPPS/LTCH PPS final rule.

CBSA-based labor market area updates

There are no changes to the core-based statistical area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2013. The CBSAs definitions and codes that will continue to be effective October 1, 2012, can be found in Table 12A listed in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1588-F.html*.

Additional LTCH PPS policy changes for FY 2013

The five-year statutory moratorium on the full-implementation of the "25 percent threshold" payment adjustment for LTCH discharges admitted from individual referring hospitals expires for LTCH cost reporting periods beginning on or after July 1, 2012, or October 1, 2012, as applicable. In the FY 2013 IPPS/LTCH PPS final rule, CMS extended the moratorium on the implementation of the "25 percent threshold" payment policy effective for cost reporting periods beginning on or after October 1, 2012, and before October 1, 2013. For certain LTCHs and LTCH satellites with cost-reporting periods beginning on or after July 1, 2012, and before October 1, 2012, CMS also provided a supplemental moratorium effective for discharges occurring on or after October 1, 2012, and through the end of the cost reporting period. For additional details, refer to the discussion in the FY 2013 IPPS/LTCH PPS final rule.

The five-year statutory moratorium on the development of new LTCHs and LTCH satellite facilities and an increase in number of LTCH beds initially provided in section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA; see *http://www.gpo.gov/fdsys/pkg/PLAW-110publ173/html/PLAW-110publ173.htm*), will expire on December 29, 2012.

Additional information

The official instruction, CR 8041, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2539CP.pdf*.

You can find the home page for the FY 2013 hospital inpatient PPS (IPPS) final rule at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html*. The IPPS home page centralizes file(s) related to the IPPS proposed rule, and it contains links to: the proposed rule (display version or published *Federal Register* version) and all subsequent published correction notices (if applicable); all tables; additional data and analysis files; and the impact file.

Files related to the long term care PPS can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

If you have any questions, please contact your FIs and/or A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

Updated IRIS programs containing resident information

The Office of Financial Management will post two IRIS programs (version 3.1 of IRISV3 and version 1.1 of IRISEDV3) with updated files (medical school codes, residency type codes, and IRISV3 operating instructions as of August 2012) on the Centers for Medicare & Medicaid Services (CMS) website before August 31, 2012, for downloading by Medicare providers. The revised Web page address for downloading these programs is: *www.cms.gov\Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IRIS*.

These programs are used by teaching hospitals and provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

Source: TDL 12492

(continued on next page)

IPPS *(continued)*

MLN Matters® Number: MM8041
Related Change Request (CR)
Related CR Release Date: August 31, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2539CP
Implementation Date: October 1, 2012

October 2012 update of the hospital outpatient prospective payment system

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) 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) 8031 which describes changes to the OPPS to be implemented in the October 2012 update. Be sure your billing staffs are aware of these changes.

Background

CR 8031 describes changes to and billing instructions for various payment policies implemented in the October 2012 OPPS update. The October 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, status indicator (SI), and revenue code additions, changes, and deletions identified in this notification.

Note that the October 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 8035, "October 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.3." Upon release of CR 8035, an *MLN Matters*® article will be available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8031.pdf*.

The key changes in the October 2012 update to the hospital OPPS are as follows:

Outpatient payment for laparoscopic bariatric surgery

A revision is being made in the "Medicare Claims Processing Manual" (Chapter 32, Section 150.8) to indicate that, effective January 1, 2012, laparoscopic bariatric surgery procedures described by *Current Procedural Terminology* (*CPT*) code *43770* (*Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)*) are payable when performed in hospital outpatient departments.

Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price, effective October 1, 2012

In the calendar year (CY) 2012 OPPS/ambulatory surgical center (ASC) final rule with comment period (see *http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf*), CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter average sales price (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 October 2012 release of the OPPS PRICER. The updated payment rates, effective October 1, 2012, will be included in the October 2012 update of the OPPS Addendum A and Addendum B, which are posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

(continued on next page)

OPPS *(continued)*

b. Drugs and biologicals with OPPS pass-through status

Effective October 1, 2012, two drugs and biologicals have been granted OPPS pass-through status. These items, along with their descriptors and APC assignments, are identified in Table 1.

Table 1 – Drugs and biologicals with OPPS pass-through status, effective October 1, 2012

HCPCS code	Long descriptor	APC	Status indicator effective 10/1/12
C9292	Injection, pertuzumab, 10 mg	9292	G
C9293	Injection, glucarpidase, 10 units	9293	G

c. Updated payment rates for certain HCPCS codes, effective July 1, 2012, through September 30, 2012

The payment rates for three HCPCS codes were incorrect in the July 2012 OPPS PRICER. The corrected payment rates are listed in Table 2 and have been installed in the October 2012 OPPS PRICER, effective for services furnished on July 1, 2012, through implementation of the October 2012 update. Note that your Medicare contractor will, if you request it, adjust claims for these services where the dates of service are on or after July 1, 2012, but prior to October 1, 2012, and where the incorrect payment rates were applied.

Table 2 – Updated payment rates for certain HCPCS codes, effective July 1, 2012, through September 30, 2012

HCPCS code	Status indicator (SI)	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
C9368	G	9368	Grafix core	$160.66	$31.53
C9369	G	9369	Grafix prime	$51.84	$10.17
Q2045	K	1414	Human fibrinogen conc inj	$0.89	$0.18

CY 2012 transitional outpatient payments

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009, through December 31, 2009, to SCHs with 100 or fewer beds, per CR 6320, Transmittal 1657.

Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole community hospitals (SCHs) and essential access community hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010, through December 31, 2010, and these providers will receive TOPs payments at 85 percent of the hold harmless amount through December 31, 2010. (**Note**: EACHs are considered SCHs for purposes of the TOPs adjustment.) Cancer and children's hospitals are permanently held harmless under Section 1833(t)(7)(D)(ii) of the Social Security Act.

Harmless provision from January 1, 2011, through December 31, 2011, for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount, and to all SCHs and EACHs regardless of bed size at 85 percent of the hold harmless amount from January 1, 2011, through December 31, 2011.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 as amended by Section 3002 of the Middle Class Tax Relief and Jobs Creation Act, extended through December 31, 2012, the hold harmless provision for a rural hospital with 100 or fewer beds at 85 percent of the hold harmless amount. Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 also extended through February 29, 2012, the hold harmless provision to SCH and EACHs, without the bed size limitation at 85 percent of the hold harmless amount. Section 3002 of the Middle Class Tax Relief and Jobs Creation Act extended through December 31, 2012, the hold harmless provision to SCHs and EACHs that have no more than 100 beds at 85 percent of the hold harmless amount.

For CY 2012, small rural hospitals with 100 or fewer beds and sole community hospitals (and essential access community hospitals) with 100 or fewer beds remain eligible for a TOPS adjustment. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

(continued on next page)

OPPS *(continued)*

Additional information

The official instruction, CR 8031, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2531CP.pdf*.

If you have any questions, please contact your FIs and A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8031
Related Change Request (CR) #: CR 8031
Related CR Release Date: August 24, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2531CP
Implementation Date: October 1, 2012

Long-term care hospital announcements and updates

The Centers for Medicare & Medicaid Services (CMS) would like to share several important long-term care hospital (LTCH) related items of note.

LTCH software update

The CMS LASER (LTCH Assessment Submission Entry Reporting) software is now posted on the *QIES Technical Support Office* website. The LASER software will also be posted on the CMS *LTCH Quality Reporting Program (QRP)* website soon. Please check the website frequently, and CMS will send notification when it has posted.

LTCH training updates

CMS has posted the last two new recorded training sessions for LTCHs on the *Quality Improvement and Evaluation System (QIES) Technical Support Office (QTSO)* website:

- **The LTCH Assessment Submission Process** – provides the necessary instructions for submitting the LTCH CARE Data Set to the QIES ASAP Submission System, beginning October 1, 2012.
- **CASPER Reports for LTCHs** – provides information about accessing and interpreting the ASAP system-generated LTCH Provider Final Validation Report, identifies other reports available to LTCHs, and gives an overview of the basic functionality of the CASPER Reporting application.

With the addition of the above two WebEx training sessions, all of the LTCH CARE Data Submission and LASER trainings are now posted. CMS wants to ensure that LTCHs are aware of the following WebEx technical trainings related to the LTCH CARE Data Submission and LASER that are available for download on the *QIES Technical Support Office (QTSO)* website:

Data Submission Trainings available on the *QTSO e-University* Web page

- CMSNet and QIES User ID Registration Training
- LTCH Assessment Submission Process
- LTCH Assessment and Validation Reports

LASER Trainings available on the *QTSO LASER Download* Web page

- LASER Login Process

(continued on next page)

Announcements *(continued)*

- LASER Patient and Assessment Entry
- LASER Import and Export Process
- LASER Reports
- LASER Demonstration Version of the tool

These recordings can be also be accessed via the *e-University page on the QTSO* website. Please contact the QTSO Help Desk at (800) 339-9313 or *help@qtso.com* if you have questions.

Additional LTCH-related updates

An errata document titled *LTCH QRP Manual Errata Sheet* was posted in September 2012.

The presentation slides from the August 30, 2012, LTCH special open door forum (SODF) where Section M of the LTCH QRP Manual was reviewed and related *FAQs are available in .zip file format*. The written transcript and audio file from this LTCH SODF are *available in PDF document format*. It is also accessible on the *CMS Special Open Door Forums* Web page.

The next LTCH SODF will be held on Thursday, September 20, 2012, from 2:30-4pm. Please continue to check the *CMS LTCH Quality Reporting Program (QRP)* website and the *CMS Special Open Door Forums* Web page for updates, call-in information, conference materials, and agenda items related to SODF calls.

Source: CMS PERL 201209-05

Find out first: Subscribe to First Coast *eNews*

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

2013 Annual update of HCPCS codes for SNF consolidated billing

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 8037 could impact your payments.

Caution – what you need to know

This article is based on CR 8037 which provides the 2013 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility consolidated billing (SNF CB) and how the updates affect edits in Medicare claim processing systems.

By the first week in December 2012:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (titled "2013 Carrier/A/B MAC Update") will be posted at *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*, and
- Providers who bill fiscal intermediaries or A/B MACs are advised that new Excel and PDF files (titled "2013 FI/A/B MAC Update") will be posted to *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

Go – what you need to do

It is important and necessary for you to read the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 110.4.1 (Annual Update Process) for carriers and A/B MACs, and Section 20.6 (SNF CB Annual Update Process for Fiscal Intermediaries) for FI and A/B MACs. You can find this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 8037 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2542CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8037
Related Change Request (CR) #: CR 8037
Related CR Release Date: September 7, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2542CP
Implementation Date: January 7, 2013

Therapy *(continued from page 1)*

the combined services for physical therapy and speech-language pathology. Use of the KX modifier indicates that the services are reasonable and necessary and that there is documentation of medical necessity in the patient's medical record.

MCTRJCA also established a requirement for manual medical review of claims over $3,700.

In mid-September 2012, CMS will mail a letter to beneficiaries who have received therapy services in Calendar Year (CY) 2012 over $1,700. The CMS letter will inform them of the $1,880 therapy cap, the exceptions process and that, if services over the cap do not qualify for the exception as medically necessary, that they will be responsible for the charges.

Request for Approval and Review Process

You must send a request for approval to the MAC or legacy contractor in advance of providing service. The MAC or legacy contractor will provide a mailing address and may provide a fax number where requests for pre-claim review can be submitted. Pre-claim reviews will not be reviewed any sooner than 15 days before the start of each Phase for providers within that phase.

The request must contain the following information:

- Beneficiary last name
- Beneficiary first name
- Beneficiary middle initial
- Beneficiary Medicare claim number (HICN)
- Beneficiary date of birth
- Beneficiary address and telephone number
- Name of provider certifying plan of care
- Address of provider certifying plan of care
- Telephone and fax number of provider certifying plan of care
- Provider number (national provider identifier (NPI)) of physician/non-physician practitioner (NPP) certifying plan of care
- Name of performing provider
- Address of performing provider
- Performing provider number (NPI)
- Telephone and fax number of performing provider
- Number of treatment days requested
- Expected date range of services
- Date of submission

A *cover/transmittal sheet* containing the following information and documentation must be sent:

- Cover sheet
- Justification
- Evaluation or reevaluation(s) for plan(s) of care
- Certification(s) of the plan(s) of care, where available
- Objectives and measurable goals and any other documentation requirements of the local coverage determinations (LCDs)
- Progress reports
- Treatment notes
- Any orders, if applicable, for the additional therapy services
- Any additional information requested by the Medicare contractor

You may request preapproval of up to 20 treatment days of services.

The contractor will make a decision and inform (by telephone, fax, or letter (if by letter, the letter must be postmarked by day 10)) the provider and beneficiary within 10 business days of receipt of all requested documentation. If the contractor cannot make a decision with 10 days, the therapy will be considered approved. The letter will indicate that the approval was made because of time constraints and not on the information provided to the contractor.

The contractors will use the coverage and payment policy requirements contained in the *Medicare Benefit Policy Manual*, Chapter 15, Section 220 (available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*) and any applicable local coverage decision policies when making decisions as to whether a service will be preapproved.

If the decision is non-affirmative, the letter communicating the decision will be detailed. If the request was non-approved, you may submit additional requests and provide additional information for consideration.

Contractors shall develop a methodology to identify pre-approval requests that have been submitted for pre-approval and match them to submitted claims for specific periods of time. Contractor shall inform the provider of the tracking mechanism being used for pre-approval requests (either approved or denied) and instructions on how to submit the claim. Contractors shall use the tracking mechanism to identify that the claims were preapproved or non-approved.

Pre-authorization itself is not a guarantee of payment. Retrospective reviews of claims receiving preapproval may still be performed. Any claims submitted without the pre-approval notice from providers in the respective phase will be subject to pre-payment review. If you or the beneficiary wishes to appeal a decision, you may provide the service. The MAC or

(continued on next page

Therapy *(continued)*

legacy contractor will, upon receipt of the claim, deny the claim. Then you or the beneficiary may file an appeal.

CMS will notify beneficiaries when they reach the $1,700 level by September 1, 2012, by letter.

Phased implementation

Implementation will occur in three phases. The requirement for pre-approval of all therapy services shall apply to specifically identified providers on the effective date determined by CMS for the phase. CMS will publish the list of providers (by NPI number only) and the phase to which they are assigned. If CMS publishes a list and a provider is not on the list, then that provider shall be deemed to be in phase III. Contractors will post the list of NPI numbers CMS provides on their websites.

CMS will publish a list of providers and the respective phases in which they are placed. In addition, CMS shall send a mailing to every provider subject to the therapy manual medical review threshold notifying them of the respective phase they have been placed into. CMS is implementing this process in phases in order to ensure a smooth transition to the new process. Effective dates for the phases are:

- **Phase I**: October 1, 2012 – December 31, 2012
- **Phase II**: November 1, 2012 – December 31, 2012
- **Phase III**: December 1, 2012 – December 31, 2012

Claims suspended because of the cap will be automatically approved unless the provider is being reviewed in phase I, phase II, or phase III.

Contractors will notify providers by posting on their website when they have stopped doing the reviews.

Out of sequence claims – post-pay review not required

Medicare has a 12-month claim filing limitation. Therefore, claims may be received and processed in a sequence different than that of the services provided. When this occurs, a contractor is not required to conduct post-payment review on claims that would have been subjected to the $3,700 manual medical review threshold had the claims been received and processed in the order provided.

For example, a beneficiary was in a SNF and exhausted their SNF benefit days under Part A. The beneficiary continued to receive therapy services under Part B totaling $3,600 (all dates of service before October 1, 2012). The beneficiary was then discharged from the SNF and received therapy services from an independently practicing PT totaling $1,800. The independent PT billed in November 2012 for services provided after October 1, 2012. The MAC received the claims and processed them. After these claims were processed the MAC received the SNF Part B claims totaling $3,600 and processed them. Had these claims been received in advance of the independent PT services, the independent PT would have been required to have the services approved in advance. In circumstances such as this example, the contractor is not required to perform post-payment review on the $1,800 provided by the independent therapist.

Additional information

The official instruction, CR 8036, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8036
Related Change Request (CR) #: CR 8036
Related CR Release Date: September 25, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R1124OTN
Implementation Date: October 1, 2012

Medicare Part B outpatient therapy cap and exceptions process extended through December 31, 2012

The Middle Class Tax Relief and Job Creation Act of 2012 (H.R.3630) was signed into law on February 22, 2012; extending the Medicare Part B outpatient therapy cap exceptions process through December 31, 2012.

The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1,880 for 2012, and the combined cap for physical therapy (PT) and speech-language pathology services (SLP) is also $1,880 for 2012. This is the annual per-beneficiary therapy cap amount determined for each calendar year. Similar to the therapy cap, Congress established a threshold of $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. All therapy services rendered above $3,700 are subject to manual medical review, and certain providers will be required to submit a request for an exception.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private practices
- Part B skilled nursing facilities
- Home health agencies (TOB 34x)
- Outpatient rehabilitation facilities (ORFs)
- Rehabilitation agencies (comprehensive outpatient rehabilitation facilities [CORFs])
- Hospital outpatient departments (HOPDs) – beginning October 1, 2012, until December 31, 2012

Helpful information

Click *here* to find out when which phase you're in; if you're not on the list, you're in Phase III.

Phase I begins October 1
Phase II begins November 1
Phase III begins December 1

Make the process easier by using our *interactive pre-approval form*. Simply fill it out online, print it , and fax (preferred) or mail it.

The law requires an exceptions process to the therapy cap that allows providers to receive payment from Medicare for medically necessary therapy services above the therapy cap amount. Beginning on October 1, 2012, some therapy providers will be required to submit requests for exceptions (pre-approval for up to 20 therapy treatment days for beneficiaries at or above the $3,700 threshold). The $3,700 figure is the defined threshold which triggers the requirement for an exception request. This requirement will not be imposed on all therapy providers at one time, it will be phased in, and therapy providers will be assigned to one of three groups or phases. The requirement to submit an exception request will be imposed on the dates listed below depending on which of the three groups or phases to which providers have been assigned.

- Phase I – October 1 to December 31, 2012
- Phase II – November 1 to December 31, 2012
- Phase III – December 1 to December 31, 2012

If you are a provider of physical therapy, speech-language pathology services, or occupational therapy services, you may receive a letter titled "Notification of Request for Exception Requirements for Therapy," indicating your assigned phase.

You can find your assigned phase *here*. If you do not find your NPI number on the list, then you are in Phase III.

If you have questions, please contact your local Medicare administrative contractor's (MAC's) customer service department. You can find your local MAC on the *provider compliance interactive map*.

For more information on the Medicare Part B outpatient therapy cap and exceptions process visit the *Medical Review and Education website*.

Source: CMS PERL 201209-01

Prepayment review for therapy services

Effective October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) has implemented a $3,700 therapy threshold.

Pre-approval process

Providers may avoid automatic pre-payment review by requesting preapproval of the services before they are rendered. Providers may request up to 20 treatment days per discipline. A decision letter will be provided to both the beneficiary and the provider for each request. The decision to allow or deny services will be made using all available information and based on Section 220 of the *Medicare Benefit Policy Manual* as well as First Coast's *Therapy and Rehabilitation Services* local coverage determinations. Contractors will have up to ten business days to make a decision on each pre-approval request. The ten days begin when the request has been received at the contractor. If the request is not processed within ten days, the request is considered automatically approved. If this occurs First Coast will send a decision letter advising of this instance.

First Coast will establish provider- and beneficiary-specific editing based on each of the phases to closely monitor this process. All requests will be tracked via an internal database. All claims submitted for dates of services October 1, 2012, through December 31, 2012, without a pre-approval request will result in a request for supporting documentation for clinical review. All requests for preapproval must include a copy of the *Request for pre-approval of therapy services above the $3700 threshold* coversheet. The coversheet must be completed in its entirety. **Requests may not be submitted more than 15 days prior to the beginning of each phase**. Although you have the option of faxing or mailing the request, **we strongly recommend faxing**. The decision letter will advise if the pre-approval request is approved or denied: The decision letter will include the number of treatment days allowed, or if denied, a detailed explanation. The letter will be returned via the same method it was received.

Note: If the pre-approval request is denied and an initial evaluation was performed, Medicare will allow the evaluation (i.e. *CPT* codes *92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003,* and *97004*).

Additional information

Additional information regarding the new $3700 therapy threshold is available at:

- The "Medical Review and Education" Web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html*
- Change request 8036, transmittal 1117 dated August 31, 2012, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1124OTN.pdf*

First Coast local coverage determinations

The local coverage determinations (LCDs) listed below may be found using *First Coast's LCD lookup*.

- Therapy and Rehabilitation Services LCD
  - L28992 (Florida Part A), L29024 (Puerto Rico, U.S. Virgin Islands Part A)
  - L29289 (Florida Part B) L29399 (Puerto Rico, U.S. Virgin Islands Part B)
- THERSVCS LCD
  - L32807 (Florida Part B)

Limitation information

Therapy cap limitation information is obtained via the applicable eligibility system (HETS for Part B, ELGA for Part A). Additional information on each screen is below:

- **HIPAA Eligibility Transaction System (HETS)** – the *HIPAA Eligibility Transaction System (HETS) User Interface (UI) User Guide* at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS-UI-User-Guide.pdf#page=31*.
- **CWF PART A Eligibility System (ELGA)** – the *Medicare Part A Direct Data Entry (DDE) Training Manual* at *http://medicare.fcso.com/Direct_data_entry/139884.pdf#page=32*.

Source: Publication 100-04, transmittal 1124, CR 8036

(continued on next page

Prepayment *(continued from Page 61)*

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Request for pre-approval of therapy services above the $3700 threshold

Providers are expected to submit the following types of documentation for therapy services:

1. Evaluation and certified plan of care
2. Certification/re-certification
3. Clinician-signed progress reports
4. Treatment encounter notes
5. Justification (explanation of medical necessity)

If all required documentation is not attached, a decision will be made based on the information received. All subsequent requests based on a prior denial of pre-approval must contain new or additional information. Documentation must be provided that is sufficient to support medical necessity for the additional treatment days, which shall be in accordance with the *Medicare Benefit Policy Manual* (Pub 100-02, Chapter 15, Section 220) and the First Coast Service Options Inc. (First Coast) local coverage determination (LCD) for rehabilitation therapy services. Please do not contact the customer service call center for a status of your request. A decision will be faxed or mailed within 10 business days of receipt of your request.

Request is for: (check only one; submit a separate request for each type of therapy)

◯ Physical therapy ◯ Occupational therapy ◯ Speech language pathology

Date of request: From: To:

Beneficiary name First: MI: HIC number:

Last: Suffix (Jr, Sr, III, etc.):

Beneficiary address: DOB:

Number of treatments being requested for this request (not to exceed 20)

Primary diagnosis code (list only one)

Secondary/additional diagnosis codes 1. 2.

Is this the first request for this patient ? ◯ Yes ◯ No

Facility/entity or provider group name: PTAN:

Performing provider name: Performing provider NPI/PTAN:

Name and telephone number of the person to contact regarding this request:

Fax number or mailing address for return decision:

You may fax to: (preferred)

Medicare Part **A**

◯ Florida: 904-361-0542

◯ PR/UVSI: 904-361-0786

Medicare Part **B**

◯ Florida: 904-361-0582

◯ PR/UVSI: 904-361-0821

OR mail to:

First Coast Service Options Inc.
532 Riverside Ave., 19T
Jacksonville, FL 32202-4914

CMS CENTERS for MEDICARE & MEDICAID SERVICES

www.fcso.com

First Coast Service Options Inc.

Educational Events

Upcoming provider outreach and educational events – October 2012

Keeping you informed: 2012 Medicare update seminar Part II

When: Tuesday, October 16
Time: 9:00 a.m.-noon ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** U.S. Virgin Islands

Keeping you informed: 2012 Medicare update seminar Part II

When: Wednesday, October 17
Time: 1:00-4:00 p.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** 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 First Coast 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*.

Educational Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News is an official *Medicare Learning Network*® (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who will then disseminate the e-News to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS is conducting a pilot from August 1-September 30, 2012. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': August 22, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-22e-News.pdf*
- CMS e-News for Wednesday, August 29, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-29-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 5, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-05e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 12, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-12-e-News.pdf*
- 'CMS Medicare FFS Provider e-News': September 19, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-19-e-News.pdf*

Source: CMS PERL 201208-09, 201208-12, 201209-02, 201209-03, 201209-07

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