Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

February 2013

In this issue

Doctors and patients benefit from electronic health record incentive program

In addition to the financial rewards they are receiving from the federal government, health care providers in Florida, Puerto Rico, and the U.S. Virgin Islands enrolled in the Medicare electronic health record incentive programs are already seeing improvements in the health of their patients.

In 2009, Congress passed and President Obama signed into law the Health Information for Clinical and Economic Health Act of 2009 (HITECH), which established a financial incentive program to encourage health professionals, hospitals, and critical access hospitals to convert patient record keeping from paper systems to computers, or electronic health records (EHR).

The incentive program, administered by the Centers for Medicare & Medicaid Services (CMS), pays cash bonuses to health providers as they implement certified EHR technology in their practices over three stages. To qualify, providers must be enrolled to serve Medicare patients.

While medical providers are getting bonuses for adopting technology, it may be their patients who are receiving bigger benefits. From increases in vaccines to prevent illness to the reduction of drug interactions, patients who see providers using EHRs are enjoying improved health thanks to the adoption of EHRs in their provider's practice.

Quality of care improvements

"The biggest difference is improvement of quality of care. By that, I mean patients are getting their flu vaccines, Tdap, shingles vaccine, pneumonia vaccines, mammograms, DEXA scans and colonoscopies," said Karl Hempel, MD, a physician who practices with Tallahassee Primary Care Associates (TPCA).

Dr. Hempel attributes this level of improvement to one of the "meaningful use" requirements established in the first phase of the EHR incentive program. For medical practices to establish "meaningful use" a percentage of patients must receive a clinical summary of their care.

Dr. Hempel refers to his practice's clinical summaries as patient report cards. "Every patient who comes in regardless of the reason gets a list of any recommended vaccines or procedures on a 'patient report card.' This report card is created by software that mines data in the electronic health records. This would take me 10-20 minutes or longer to look through a paper chart and provide these written recommendations for the patients. The patients needing vaccines receive them before I even enter the room," Dr. Hempel said.

TPCA was one of the first medical practices in Northern Florida to enroll in the Medicare EHR incentive program.

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Publication staff:
Terri Drury
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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EHR *(continued from front page)*

In December 2011, the Center for the Advancement of Health IT named Dr. Hempel a "Meaningful Use Vanguard" for his practice's effort in converting patient records to electronic health records.

What is "meaningful use?"

"Meaningful use" is defined as the extent to which a provider uses electronics records to conduct their clinical practice such as issuing prescriptions or ordering medical tests, tracking patient health status, or submitting clinical quality measures through electronic systems.

"Providing a clinical summary is one of the requirements for meaningful use," says Kenneth Dunn, Meaningful Use Manager for the South Florida Regional Extension Center (SFREC).

"These summaries are helping to improve compliance with taking medication. With the Medicare population, the summaries are also excellent information for family members and care givers to review with patients after they return home."

The SFREC received a grant from the Department of Health and Human Services in 2010 to assist over 3,000 health care providers with adoption of EHRs in their practice.

Mr. Dunn says the process is not complicated as some practices would believe at the outset. "Most meaningful use measures are already being collected. What changes is how the data is being collected. EHR improves the way offices collect and recall patient information eliminating several steps in the process," Dunn said.

Mr. Dunn points to the administrative improvements offices experience once they implement EHRs. "Many practices who implement EHR are eliminating follow up appointment cards by recording the date and time for their next appointment on the clinical summary," he said.

"Physicians are no longer working with the "super bill." They are able to select from the E/M codes within the patient visit. Once the data is collected it's in the system requiring little or no additional administrative steps for billing staff to handle."

While improvements in the quality of care for patients and administrative efficiencies in their offices are getting notice, health care practices are also benefitting in a big way from incentive payments from CMS for converting to electronic health records.

Since January 2011, 180,000 health care providers have received $10.3 billion in payments for participating in the EHR incentive programs. This includes nearly 14 thousand individual providers and 91 hospitals in Florida. Individual health practitioners eligible for the program include physicians, dental practitioners, podiatrists, optometrists and chiropractors. These providers in Puerto Rico and the U.S. Virgin Islands are eligible; however, hospitals in these locations are prohibited from receiving the EHR incentives.

Under rules established by CMS, each eligible health professional (EP) can receive payments of $18,000 this year and up to $44,000 over five years under the Medicare EHR incentive program. Additional cash incentives are available for providers of health services in a health professional shortage area. Eligible providers may still register for the incentive programs and earn up to $39,000 in payments for participation for 2013-2016.

"The biggest difference, with EHR, is improvement of quality of care."

- Karl Hempel, MD,

Tallahassee Primary Care Associates

To receive incentive payments in 2013 and avoid pay cuts in 2015, providers must also attest to demonstrated "meaningful use" of certified EHR technology. Beginning in 2015, health professionals enrolled in Medicare who do not successfully demonstrate "meaningful use" of electronic health records in their clinical practice could see Medicare a reduction in payment for services to Medicare beneficiaries.

For more information about getting started in the incentive program, *click here.*

CMS has also initiated an incentive program for hospitals to implement electronic health records. Hospitals could earn between $2 million and $6 million in payments through 2015. Ninety-one Florida hospitals have received payments through the EHR incentive program. Hospitals in U.S. held territories including Puerto Rico and the U.S. Virgin Islands are not eligible for the incentives.

Sources

The Centers for Medicare & Medicaid Services - EHR Incentive Program
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Community Health Centers Alliance
http://www.chcalliance.org/

South Florida Regional Extension Service
http://www.southfloridarec.org/

Tallahassee Primary Care Associates
http://www.tallahasseeprimarycare.com/

Updates to claims processing for religious nonmedical health care services

Provider types affected

This *MLN Matters*® article is intended for religious nonmedical health care institutions (RNHCIs) billing their Medicare administrative contractor (MAC) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8186 and updates instructions regarding RNHCI billing to reflect changes in Medicare contracting as well as changes in the UB-04 claim form and code sets.

It also provides clarification regarding coding RNHCI claims when the beneficiary has exhausted their inpatient benefit days.

Background

Several sections of Chapter 3 of the "*Medicare Claims Processing Manual*" relating to RNHCI claims has not been updated since 2006. Since that time, the processing of RNHCI claims was shifted from a specialty fiscal intermediary (FI) to a specialty workload under one MAC jurisdiction. There were also changes to the UB-04 code sets, including the transition of utilization day fields to value codes. CR 8186 updates the sections to ensure they reflect the current environment.

Additionally, the Centers for Medicare & Medicaid Services (CMS) is including additional education regarding how to code claims in situations where the beneficiary's inpatient benefits are exhausted.

Key Points

The following key points highlight the updates related to RNHCIs outlined in Chapter 3 of the "*Medicare Claims Processing Manual*." (You may review the manual changes in their entirety by reading the official instruction issued by CR 8186. A link to CR 8186 is in the *Additional information* section of this article.)

All submissions regarding RNHCI services are processed by a single Medicare contractor as a specialty workload. Currently, this specialty workload is part of MAC Jurisdiction 10.

The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RNHCI's CMS certification number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

In addition, CR 8186 outlines the required data elements on claims for RNHCI services; the following bullets highlight the revisions:

- If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI must indicate whether the beneficiary elects to use lifetime reserve days. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68. If the beneficiary elects not to use lifetime reserve days, the RNHCI must report condition code 67.
- Occurrence codes are two alphanumeric digits, and are reported with a corresponding date. If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20. If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI reports occurrence code A3.
- If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI, the RNHCI reports occurrence span code 74.
- For covered days use value code 80 to enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as non-covered, the day of discharge, and the day of death. Covered days are always in terms of whole days rather than fractional days.
- As a result, the covered days do not include the day of discharge, even where the discharge was late in the day. Also, the RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an employer group health plan (EGHP) for an end-stage renal disease (ESRD) beneficiary or employed beneficiaries and spouses age 65 or over. The specialty MAC will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment. For non-covered days the RNHCI must use value code 81 to enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Non-covered days include:
    - Days not falling under the guarantee of payment provision.
    - Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;
    - Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were

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Religious *(continued)*

exhausted or the beneficiary elected not to use them;

- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the Veterans Administration;
- Days after the date covered services ended, such as non-covered level of care;
- Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI;
- Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are non-covered.

The RNHCI enters in "remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for each category of non-covered days (e.g., "five leave days").

Day of discharge or death is not counted as a non-covered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

For coinsurance days the RNHCI must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 91st day for this billing period.

For lifetime reserve days the RNHCI must use value code 83 to enter the number of lifetime reserve days the beneficiary elected to use during this billing period.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Additional information

The official instruction, CR 8186 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2654CP.pdf* on the CMS website.

To review *MLN Matters*® article MM5383, Revision of Interim Payment Methodology for RNHCI Clarifying Existing Policy on Training of Religious Nonmedical Nursing Personnel, Claims not Billed to the RNHCI Specialty Contractor, and Statutory End of Coverage for RNHCI Items and Services Furnished in the Home, you may go to: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5383.pdf* on the CMS website.

If you have any questions, please contact your 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* on the CMS website.

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Expansion of Medicare telehealth services for 2013

Note: This article was revised February, 7, 2013, and February 13, 2013, to add HCPCS code G0459 to the list of Medicare telehealth services for CY 2013 to allow telehealth services previously reported by CPT® code 90862 to inpatients to continue to be reported and to change the implementation date to January 25, 2013. All other information remains the same. This information was previously published in the December 2012 Medicare A Connection, Pages 14-15.

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), and/or A/B Medicare administrative contractors (A/B MACs) for telehealth services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7900 which updates the list of Medicare telehealth services in the "*Medicare Benefit Policy Manual*" and the "*Medicare Claims Processing Manual.*"

What you need to know

In the 2013 physician fee schedule proposed rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 healthcare procedural coding system (HCPCS) update will replace several *Current Procedural Terminology*® (*CPT*®) codes related to psychotherapy services and a number of these services are on the list of approved telehealth services. Therefore, CR 7900 updates the list of approved telehealth services to reflect these code changes and it replaces several *CPT*® codes related to psychotherapy services. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation *CPT*® codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners were instructed to bill a new or established patient office/outpatient visit *CPT*® code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

CMS has approved the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl* on the Internet). Payment for these services is subject to the provisions of 42 CFR 414.65 (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl*).

In the calendar year 2013 PFS proposed rule with comment period, CMS is proposing to add eight codes to the list of Medicare distant site telehealth services. Additionally, the 2013 HCPCS update will replace several *CPT*® procedure codes related to psychotherapy services, and a number of these services are on the list of approved telehealth services. The established policy for these telehealth services has not changed.

CMS is proposing to add the eight services contained in the following table to the list of Medicare telehealth services for 2013. CR 7900 instructs that the HCPCS codes for these services should be added to the List of Medicare Telehealth Services:

New HCPCS and code descriptor

G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and brief intervention, 15 to 30 minutes

G0397: Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST) and intervention greater than 30 minutes

G0442: Annual alcohol misuse screening, 15 minutes

G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.

G0444: Annual depression screening, 15 minutes.

G0445: High-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.

G0447: Face-to-face behavioral counseling for obesity, 15 minutes.

CR 7900 also adds relevant policy instructions to the manuals regarding the addition of these codes.

The following *CPT*® codes should be added to the List of Telehealth Services to replace codes that will be deleted for 2013:

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Telehealth *(continued)*

- *CPT*® codes *90832, 90833, 90834, 90836, 90837, 90838* to report individual psychotherapy services, reported with *CPT*® codes *90804 – 90809* prior to 2013; and
- *CPT*® codes *90791*, *90792* to report psychiatric diagnostic interview examination, reported with *CPT*® code *90801* prior to 2013.
- HCPCS code G0459 to report telehealth services previously reported by deleted *CPT*® code *90862* when furnished to inpatients. Services furnished to outpatients can be reported with appropriate E/M codes currently on the list of telehealth services.

CR 7900 revises the "*Medicare Claims Processing Manual*" (Chapter 12, Section 190.3 (List of Medicare Telehealth Services)) and the "Medicare Benefit Policy Manual" (Chapter 15, Section 270.2 (List of Medicare Telehealth Services)) which are included as attachments to CR 7900.

Additional information

Further information regarding telehealth services is available at *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

You can also find information about submitting requests for adding services to the list of Medicare telehealth services at *https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.html*.

The official instruction, CR 7900, was issued to your FI, carrier, or A/B MAC via two transmittals. The first updates the "*Medicare Benefit Policy Manual*" and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167BP.pdf* on the CMS website. The second transmittal updates the "*Medicare Claims Processing Manual*," which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2657CP.pdf* on the CMS website.

If you have any questions, please contact your FI, carrier and/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* .

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Seniors among groups hardest hit by flu this season

It has been recognized for many years that people 65 years and older are at greater risk of serious complications from influenza compared with young, healthy adults. A high percentage of seasonal influenza-related deaths and hospitalizations occur each year in people 65 years and older.

Due to the severe impact the current influenza season is having on people 65 and older in the United States, the Centers for Disease Control and Prevention (CDC) is increasing communications to clinicians caring for seniors as well as people 65 and older. The CDC is particularly concerned that these high-risk persons both seek care and receive treatment for influenza infection with antiviral medications promptly.

Dr. Alicia Fry, with CDC's Influenza Division, reminds everyone to take everyday actions to keep from getting sick with the flu. "The most important of these everyday actions is staying away from others who are or may be sick," Fry says. "There is a lot of flu out there right now," says Fry. "So if your grandchildren or other family members are sick with flu-like symptoms, consider waiting to see them until they recover."

Additional information

Review the published material in its entirety at:

2012-2013 CDC Influenza Update for Geriatricians and Other Clinicians Caring for People 65 and Older

Flu Season Continues; Seniors Hit Hard

Seniors among Groups Hardest Hit by Flu this Season

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Correct claims submission when secondary payers are involved

Provider types affected

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

Provider action needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare secondary payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "*MSP Manual*" in Chapter 3, Section 20.2.1 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf* on the CMS website. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first.

After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident belated claims

If the beneficiary has an open MSP liability (L), no-fault (NF), or workers' compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment. To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.
2. If the beneficiary has both a group health plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

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Secondary *(continued)*

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the coordination of benefit contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

Key Points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.

Additional information

Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claims processing contractor at their toll-free number found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the Medicare Coordination of Benefits process, visit the Medicare coordination of benefits Web page at *http://www.cms.hhs.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html* on the CMS website.

The *Medicare Learning Network* (*MLN*) has a Medicare secondary payer fact sheet for provider, physician, and other supplier billing staff (ICN 006903) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf* on the CMS website.

This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

New mailing address for percutaneous transluminal angioplasty approval

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8199, which updates the address identified in the national coverage determination (NCD) to which facilities must send their approval request letters and recertification letters. Make sure that your staffs are aware of this update.

Background

Effective March 17, 2005, facilities wishing to receive Medicare coverage for carotid artery stenting (CAS) procedures performed on patients at high risk for adverse events from carotid endarterectomy (CEA) were required to submit written documentation attesting to meeting the minimum facility standards identified in Section B4 of the NCD for Percutaneous Transluminal Angioplasty (PTA) (See *Medicare National Coverage Determination Manual*, Section 20.7, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.)

The NCD also requires facilities to submit recertification letters to CMS every two years. CR 8199 serves to update the address identified in the NCD to which the approval request letters and recertification letters must be sent. The address has been changed to:

Director, Coverage and Analysis Group

7500 Security Boulevard, Mailstop S3-02-01

Baltimore, MD 21244

All other aspects of this NCD remain the same.

Additional information

The official instruction, CR 8199, 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/R151NCD.pdf* on the CMS website.

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* on the CMS website.

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Related CR Transmittal #: R151NCD
Implementation Date: March 11, 2013

Bariatric surgery NCD and addition of laparoscopic sleeve gastrectomy

Note*:* This article was revised January 30, 2013, to update the CR release date, implementation date, and transmittal numbers. The Web addresses for accessing the transmittals has also been updated. All other information remains the same. This information was previously published in the November 2012 Medicare A Connection, Pages 18-19.

Provider types affected

This *MLN Matters*® article is intended for physicians, suppliers, and providers billing Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services related to bariatric surgery for Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8028, which provides that, effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2
- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

You may bill stand-alone LSG with healthcare common procedure coding system (HCPCS) code *43775* (*Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy*), which appears on the October 2012 Medicare physician fee schedule update.

Effective for discharges on or after June 27, 2012, inpatient hospital claims may be submitted with stand-alone LSG International Classification of Diseases (ICD-9) procedure code 43.82 (Laparoscopic sleeve gastrectomy covered at contractor's discretion). Please make sure that your billing staffs are aware of this change.

Background

In 2006, the Centers for Medicare & Medicaid Services (CMS) released a final national coverage determination (NCD) on bariatric surgery for the treatment of morbid obesity (see the *NCD Manual*, Section 100.1, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf*).

For Medicare beneficiaries who have a body mass index (BMI) ≥ 35 kg/m2, at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- Open and laparoscopic Roux-en-Y Gastric Bypass (RYGBP)
- Laparoscopic Adjustable Gastric Banding (LAGB)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)

In addition, the NCD stipulates that the above bariatric procedures are to be covered only when performed at facilities that are:

- Certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center, or
- Certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006).

Due to lack of evidence at the time, the 2006 NCD specifically did not cover open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding. In 2009, CMS updated the NCD to include type 2 diabetes mellitus as a co-morbidity.

In September 2011, CMS re-opened the NCD to determine whether new and emerging evidence supported inclusion of LSG as a reasonable and necessary bariatric surgery under Sections 1862 (a)(1)(A) and 1862 (a)(1)(E) of the Social Security Act. Open sleeve gastrectomy was not considered and remains non-covered.

Effective for claims with dates of service on or after June 27, 2012, Medicare contractors acting within their respective jurisdictions may determine coverage of stand-alone LSG for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2

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Surgery *(continued)*

- The beneficiary has at least one co-morbidity related to obesity
- The beneficiary has been previously unsuccessful with medical treatment for obesity

Note: Medicare contractors will not search their files to reprocess claims processed prior to implementation of CR 8028. However, upon implementation, the contractors will adjust claims that you bring to their attention.

Additional information

The official instructions regarding this change, CR 8028, was issued to your FI, carrier, or A/B MAC via two transmittals. The first transmittal revises the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R150NCD.pdf*.

The second updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2641CP.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: MM8028
Related Change Request (CR) #: CR 8028
Related CR Release Date: January 29, 2013
Effective Date: June 27, 2012
Related CR Transmittal #: R150NCD, R2641CP
Implementation Date: February 28, 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.

Providers advised to review the use of insulin pens

According to CMS, patients continue to be placed at risk of blood-borne pathogen exposure through inappropriate use of insulin pens by more than one patient. CMS cited the example of a facility in Buffalo, New York, which mailed letters to 1,915 patients informing them of a potential exposure from another patient's insulin pen.

According to the Food and Drug Administration, insulin pen cartridges may contain blood after a single injection.

Once injected, the pens potentially become contaminated from the back flow of blood into the insulin reservoir. The pens are designed for use by one patient, though they contain multiple doses of insulin.

CDC recommendations

The Centers for Disease Control and Prevention (CDC) recommends the following steps to prevent transmission of blood-borne infections with the use of insulin pens:

- Insulin pens containing multiple doses of insulin are meant for single use only. Even when the needle is changed, the pens must never be used for more than one person.
- Labeled each pen with the patient name or other identifiers to verify that the correct pen is being used.
- Regularly review policies and procedures and educate care giving staff about the safe use of insulin pens.
- Promptly notify and offer appropriate follow-up care including blood-borne pathogen testing for any patients exposed to multiple use of insulin pens.

For more information, see the here is the link to the *CMS advisory letter on use of insulin pens.*

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

2013 physician fee schedule final rule includes policy changes for telehealth and new data collection requirements

Note: This article was revised on February 7, 2013, to reflect the revised change request (CR) 8191 issued on February 6. The transmittal number, CR release date, Web address for the CR, and the implementation date were revised. All other information remains the same. This information was previously published in the January 2013 *Medicare A Connection*, Pages 6-7.

Provider types affected

This *MLN Matters*® article is intended for physicians and non-physician practitioners submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), or A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8191, on which this article is based, summarizes the policies in the calendar year (CY) 2013 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year. You should make sure that your staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2012, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) who are paid under the MPFS in CY 2013.

The final rule addresses:

- Medicare public comments on payment policies that were originally displayed on July 6, 2012, and published in the *Federal Register* on July 30, 2012: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013;" and
- Interim final values established in the CY 2013 MPFS final rule with comment period (originally displayed on November 1, 2012, and published in the *Federal Register* on November 16, 2012). It assigns interim final values for new and revised codes for CY 2013; and requests comments on these values, which it will accept until December 31, 2012.

Since publication of the final rule, Congress has averted the statutorily required reduction in Medicare's physician fee schedule through the American Taxpayer Relief Act of 2012. A separate CR addresses revisions required by that legislation.

Summary of policies in the CY 2013 MPFS

1. Payment increases to primary care physicians in 2013

The 2013 MPFS includes a new policy to pay a physician or non-physician practitioner to coordinate a patient's care in the 30 days following a hospital or skilled nursing facility (SNF) stay. CMS believes that recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients, and help reduce patient readmissions.

2. Implementation of the physician value-based payment modifier

The rule's changes in care coordination payment and other changes are expected to increase payment to family practitioners by seven percent and other primary care practitioners between three and five percent.

The 2013 MPFS continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate.

The value modifier provides differential Medicare payments to physicians based on a comparison of the quality and cost of care furnished to beneficiaries.

The statute allows CMS to phase in the value modifier over three years, from 2015 to 2017.

For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the physician quality reporting system (PQRS).

For physicians and groups of physicians who elect to participate in 2015, common sense incentives will

(continued on next page)

Physician *(continued)*

improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less.

The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule, which you can find at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

3. Aligning quality reporting across programs

The 2013 MPFS continues CMS' efforts to align quality reporting across programs in order to reduce burden and complexity. It makes changes to the PQRS and the electronic prescribing (eRx) incentive program (the two quality reporting programs applicable to the MPFS) and updates the *Medicare Electronic Health Records (EHR) Incentive Pilot Program*. These changes will simplify reporting and align the various programs' quality reporting approaches so they support the National Quality Strategy.

4. Enhancing the physician compare website

The 2013 MPFS lays out the next steps to enhance *the physician compare website*, including posting names of practitioners who (as part of the *Million Hearts campaign*) successfully report measures to prevent heart disease. Please note that these are recommended measures under PQRS as well.

5. Expanding access to services that non-physicians practitioners can provide

The 2013 MPFS expands access to services that can be provided by non-physician practitioners. It allows Medicare to pay:

1) certified registered nurse anesthetists (CRNAs) for providing all services that they are permitted to furnish under state law (i.e. to the full extent of their state scope of practice); and

2) For portable X-rays ordered by nurse practitioners (NPs), physician assistants (PAs) and other non-physician practitioners.

6. Payment for molecular pathology services

The 2013 MPFS explains how Medicare will pay for molecular pathology services—the next innovation of clinical laboratory tests that will foster the development of personalized medicine. These tests will be paid under the clinical laboratory fee schedule (CLFS), with the 2013 payment set by the gap filling method.

7. Face-to-face encounter as a condition of payment for certain items

The 2013 MPFS requires a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items for orders written on, or after, July 1, 2013.

8. Implementation of a claims-based data collection strategy

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires CMS to implement a claims-based data collection strategy on January 1, 2013; to gather information on:

1. Beneficiary function and condition
2. Therapy services furnished, and
3. Outcomes achieved. CMS will use this information to assist in reforming the Medicare payment system for outpatient therapy services.

Details about this data collection can be found in CR 8005. You can find the associated *MLN Matters*® articles, MM8005, "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services – Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf*.

9. Multiple procedure payment reduction (MPPR)

Also for CY 2013, a multiple procedure payment reduction (MPPR) will apply a 25 percent reduction to the technical component (TC) of the second and subsequent diagnostic cardiovascular service, and a 20 percent reduction to the TC of the second and subsequent diagnostic ophthalmology service; furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day.

CR 7848 discusses this 2013 MPPR in full detail, and you can find the associated *MLN Matters*® article: MM7848, "Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf*.

10. Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent CY, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2013 is 0.8 percent. Therefore, for CY 2013, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80

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Physician *(continued)*

percent of the lesser, of the actual charge, or $24.43 as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

More information on CY 2013 changes in telehealth can be found in CR 7900. You can review the associated *MLN Matters*® article: MM7900, "Expansion of Medicare Telehealth Services for Calendar Year (CY) 2013," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7900.pdf*.

Additional information

For more information and access to the CY 2013 final rule, go to the "Physician Fee Schedule" available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

The official instruction, CR 8191, issued to your FI, carrier, or A/B MAC regarding this change may be viewed *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2653CP.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: MM8191 *Revised*
Related Change Request (CR) #: CR 8191
Related CR Release Date: February 6, 2013
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Related CR Transmittal #: R2653CP
Implementation Date: January 25, 2013

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Free online adult vaccine finder

The *HealthMap Vaccine Finder*, managed by HealthMap, a division of Boston Children's Hospital and Harvard Medical School, lists more than 50,000 locations across the country that offer flu vaccination. Consumers can search for places they can get a flu vaccination within or near their ZIP code. Over 125,000 consumers have already used this helpful site since August 2012. The website has now expanded to include 10 adult vaccines.

How to register your location

If you are interested in letting the public know about vaccines offered at your practice or clinic, you may register your location at *https://flushot.healthmap.org/admin/signup/*. Once you have registered on the site, you may upload your information for consumers to access about vaccination locations in your area. You may also add other consumer-friendly information such as office hours, contact information, and patient age requirements. The use of the website is free to consumers as well as to providers of adult immunization services.

Note: In 2012, Google passed the baton to HealthMap when they retired Google's flu vaccine finder. Google has worked closely with HealthMap as they've created the new HealthMap Vaccine Finder.

If you have previously provided data to Google flu vaccine finder, you will need to register and upload your location data to HealthMap.

Information contained within this article was previously released in an edition of the weekly "CMS Medicare FFS Provider e-News."

Puzzled about your enrollment status?

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

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

Revisions to LCDs

Advance beneficiary notice

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

Revisions to LCDs

A93975: Duplex scanning – revision to the LCD

LCD ID number: L28830 (Florida)

LCD ID number: L28863 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scanning was most recently revised October 1, 2011. Since that time, the LCD was revised based on an external reconsideration request.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indication for *CPT*® codes *93975* and *93976*: "To evaluate patients diagnosed with hypertensive and normotensive renovascular disease with impaired renal function."

The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM diagnosis code ranges 403.90-403.91 and 585.1-585.5 for *CPT*® codes *93975* and *93976*.

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

Effective date

This LCD revision is effective for services rendered **on or after February 28, 2013**.

First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (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.

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

AJ9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the LCD

LCD ID number: L28837 (Florida)

LCD ID number: L28870 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was most recently revised October 1, 2011. Since that time, the LCD was revised based on an external reconsideration request. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes 209.31-209.36 and 209.75 for HCPCS code J9181. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indications:

- For Merkel cell carcinoma in combination with carboplatin or cisplatin as a consideration for adjuvant treatment with or without radiation therapy for N+ disease
- For Merkel cell carcinoma in combination with carboplatin or cisplatin as treatment for distant metastatic disease or disseminated recurrence with or without surgery or radiation therapy

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

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2013.** 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.

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

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes. Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

Revisions to LCDs

AJ2505: Pegfilgrastim (Neulasta®) – LCD revision

LCD ID number: L28946 (Florida)

LCD ID number: L28967 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was most recently revised October 1, 2010. Since that time, the LCD was revised based on an external reconsideration request.

The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes 209.31-209.36 and 209.75 for HCPCS code J2505.

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2013**. 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.

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

AJ9045: Carboplatin (Paraplatin®, Paraplatin-AQ®) – LCD revision

LCD ID number: L28791 (Florida)

LCD ID number: L28796 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was most recently revised October 1, 2009. Since that time, the LCD was revised based on an external reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for off-labeled indications was updated to add "Thymic carcinoma". The "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-9-CM diagnosis code 164.0 for HCPCS code J9045. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after February 22, 2013**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (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.

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

AJ9265: Paclitaxel (Taxol®) – LCD revision

LCD ID number: L28943 (Florida)

LCD ID number: L28964 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for paclitaxel (Taxol®) was effective for services rendered on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9).

Since that time, the LCD was revised based on an external reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for off-labeled indications was updated to add "Thymic carcinoma."

The "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-9-CM diagnosis code 164.0 for HCPCS code J9265. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after February 22, 2013**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (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.

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

Modification of payment window edit in the common working file

Provider types affected

This *MLN Matters*® article is intended for certain hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for diagnostic services (including clinical diagnostic laboratory tests services) to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 8046, informs you that the Centers for Medicare & Medicaid Services (CMS) will modify the payment window edit in Medicare's common working file (CWF) to update the diagnostic service list. Currently, CWF looks at a listing of diagnostic services that contains terminated or revised healthcare common procedure coding system (HCPCS) codes.

This CR will modify the list to allow CWF to edit diagnostic services correctly. Effective April 1, 2013, CR 8049 includes in the diagnostic payment window edits HCPCS codes *93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572*, G0275, and G0278 submitted for revenue codes 0481 and 0489. Make sure that your billing staffs are aware of this update.

Background

Effective for services furnished on or after January 1, 1991, diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within three days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

This provision does not apply to ambulance services

and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities (SNFs), home health agencies (HHAs), and hospices are excluded from the payment window provisions.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Also, the 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or federally qualified health center (FQHC) all-inclusive rate.

Additional information

The official instruction, CR 8046, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1169OTN.pdf* on the CMS website.

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

MLN Matters® Number: MM8046
Related Change Request (CR) #: CR 8046
Related CR Release Date: January 31, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1169OTN
Implementation Date: July 1, 2013

Adjustment to FISS consistency edit to validate attending physician NPI

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8171 which informs Medicare contractors about the changes to previously implemented consistency edits to enforce the correct billing of the attending provider NPI on claims with bill type 71x. Make sure that your billing staffs are aware of these changes. See the *Background and Additional information* sections of this article for further details regarding these changes.

Background

In CR 7902, the Centers for Medicare & Medicaid Services (CMS) previously implemented consistency edits to enforce the correct billing of the Attending Provider NPI on claims.

The article for CR 7902 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7902.pdf* on the CMS website. The edits established did not take into consideration sole proprietors who must enroll under their type-1 individual NPI, therefore making their billing NPI the same as the attending NPI. CMS is now updating the consistency edits so they will not apply to rural health clinics who enrolled under their type-1 individual NPI.

If you are a physician/practitioner who has a sole proprietorship, you must obtain an NPI for yourself as an Entity type 1 (Individual). There is no separate NPI for the sole proprietorship. When you or your sole proprietorship are billing Medicare, you may use only your NPI (once you have one), to identify yourself as the billing/pay-to-provider and as the rendering provider. CMS has found numerous RHC providers who bill institutional claims that qualify to use the type 1 NPI as the billing provider and as the attending physician NPI. Implementation of this edit modification will allow their claims to process without delay.

Additional information

The official instruction, CR 8171, issued to your FI, RHHI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2648CP.pdf* on the CMS website.

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

MLN Matters® Number: MM8171
Related Change Request (CR) #: CR 8171
Related CR Release Date: February 1, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2648CP
Implementation Date: July 1, 2013

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Annual update of HCPCS codes for home health consolidated billing

Provider types affected

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

Provider action needed

This article announces that change request (CR) 8043 is a recurring update notification that provides the annual home health (HH) consolidated billing update, effective January 1, 2013. Make sure your billing staffs are aware of these changes.

Background

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

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

Effective January 1, 2013, the following HCPCS code is added to the HH consolidated billing supply code list:

- A4435 - Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each. In addition, there are 3 codes on the supply code list for which long descriptions are being modified to remove the words "pad size". They are as follows:
- A6021 - Collagen dressing, sterile, size 16 sq. in. or less, each
- A6022 - Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each
- A6023 - Collagen dressing, sterile, size more than 48 sq. in., each

Additional information

The official instruction, CR 8043, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2527CP.pdf* .

More information on HH consolidated billing is in the "Medicare Claims Processing Manual," Chapter 10, Section 20, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf* on the CMS website. If you have any questions, please contact your FI, RHHI, carrier, DME MAC, 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* on the CMS website.

MLN Matters® Number: MM8043
Related Change Request (CR) #: CR 8043
Related CR Release Date: September 7, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2527CP
Implementation Date: January 7, 2013

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Standardizing operating rules for code usage in remittance advice

Provider types affected

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

What you need to know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) electronic funds transfer (EFT) & electronic remittance advice (ERA) operating rule set for code usage in electronic funds transfer (EFT) & electronic remittance advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (administrative simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at *http://aspe.hhs.gov/admnsimp/pl104191.htm#1173*.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to electronic data interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at *http://www.ncvhs.hhs.gov/*.)

Note: The same rules will also apply to standard paper remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA Operating Rule Set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT operating rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;

(continued on next page)

CORE *(continued)*

- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

Business Scenarios

The CORE Phase III ERA/EFT operating rules define four business scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or federal/state mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: *Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule)*, that is an attachment to CR 8182.

This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future. Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan

This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable. This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare remit easy print (MREP) and PC Print software will be modified as necessary.

Additional information

The official instruction, CR 8182, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1187OTN.pdf* on the CMS website

You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, 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* on the CMS website.

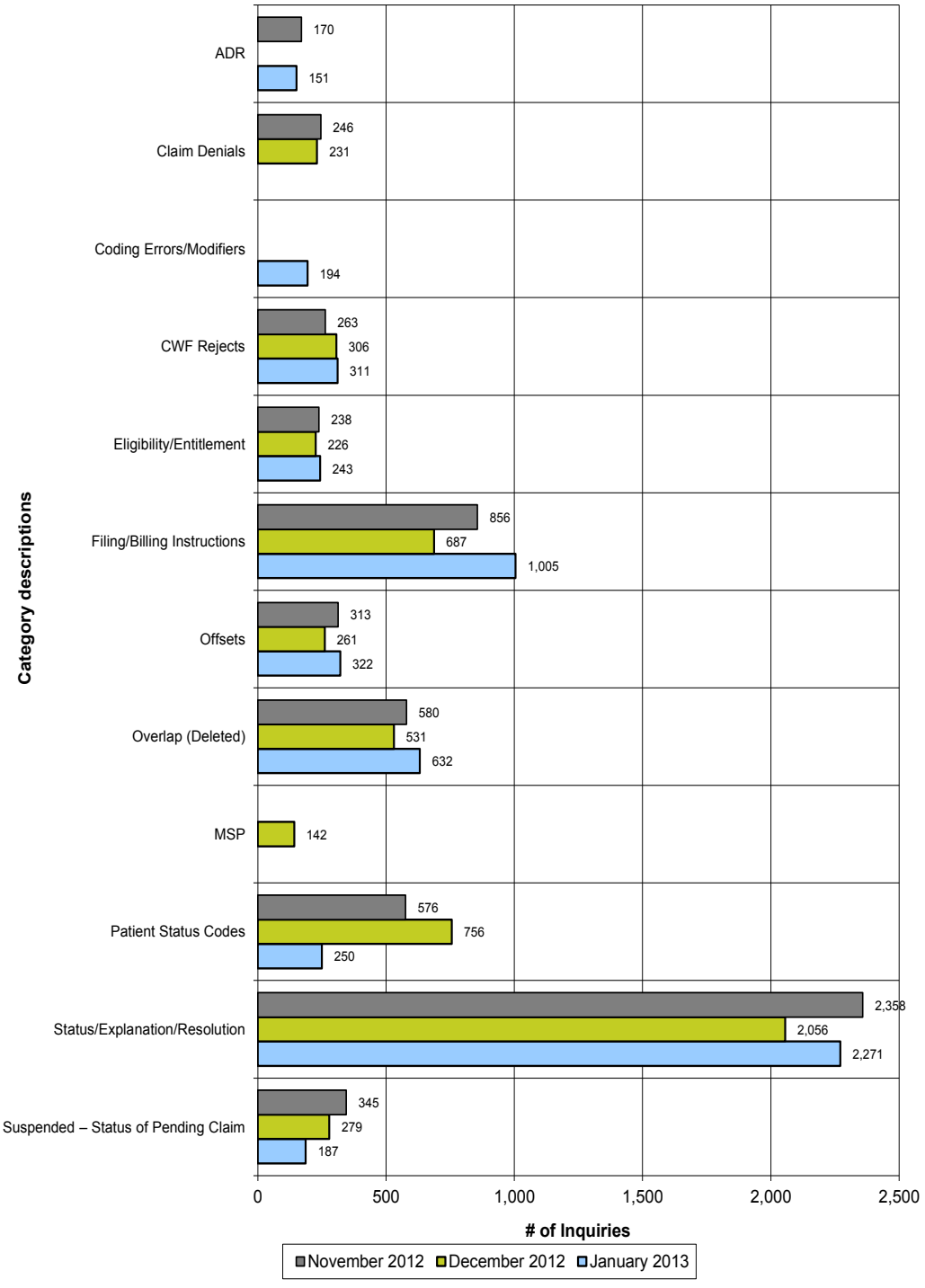
MLN Matters® Number: MM8182
Related Change Request (CR) #: CR 8182
Related CR Release Date: February 8, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1187OTN
Implementation Date: October 7, 2013

Top inquiries, rejects, and return to provider claims November 2012 - January 2013

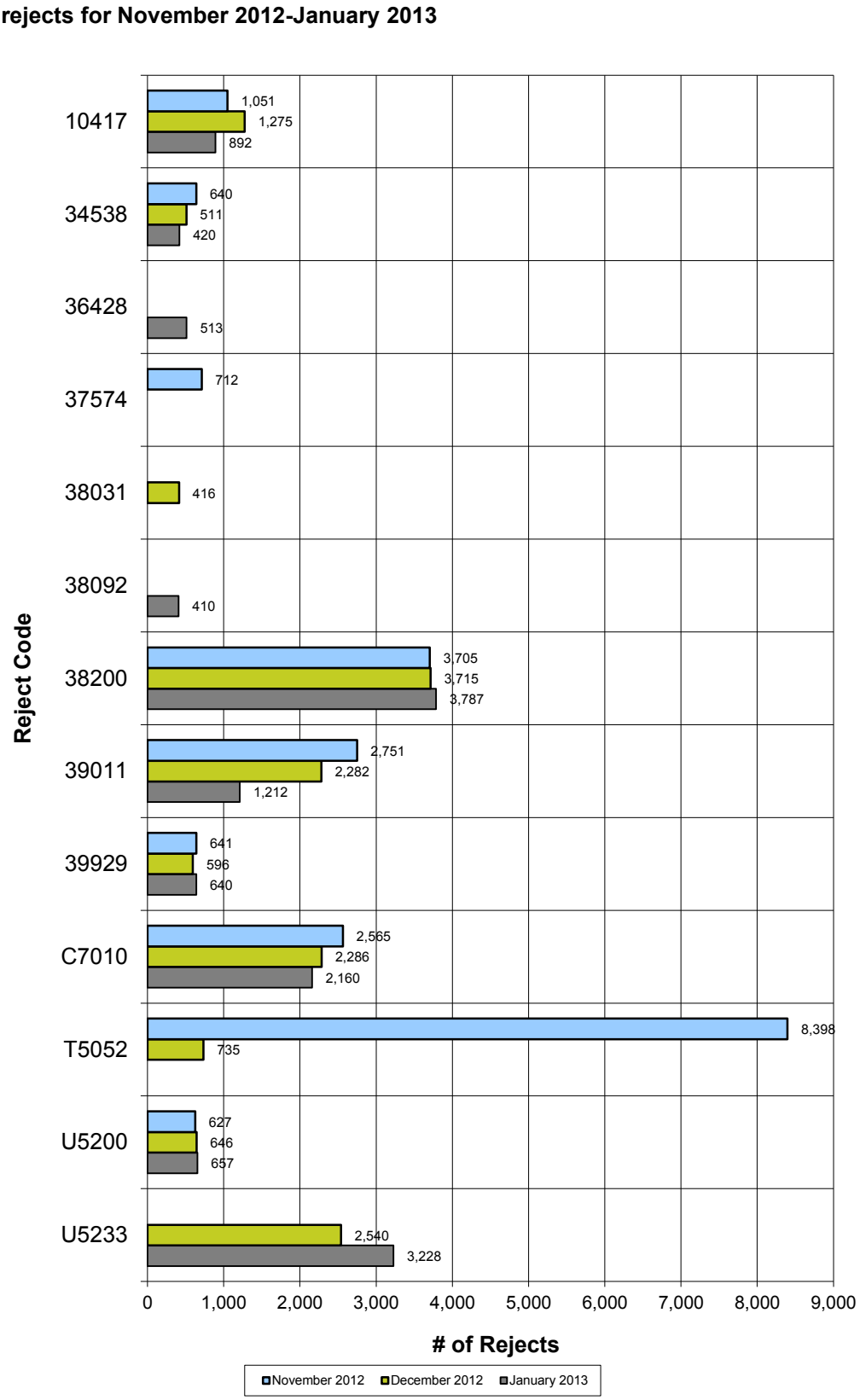
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during November 2012 through January 2013.

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*.

Top inquiries for November 2012-January 2013

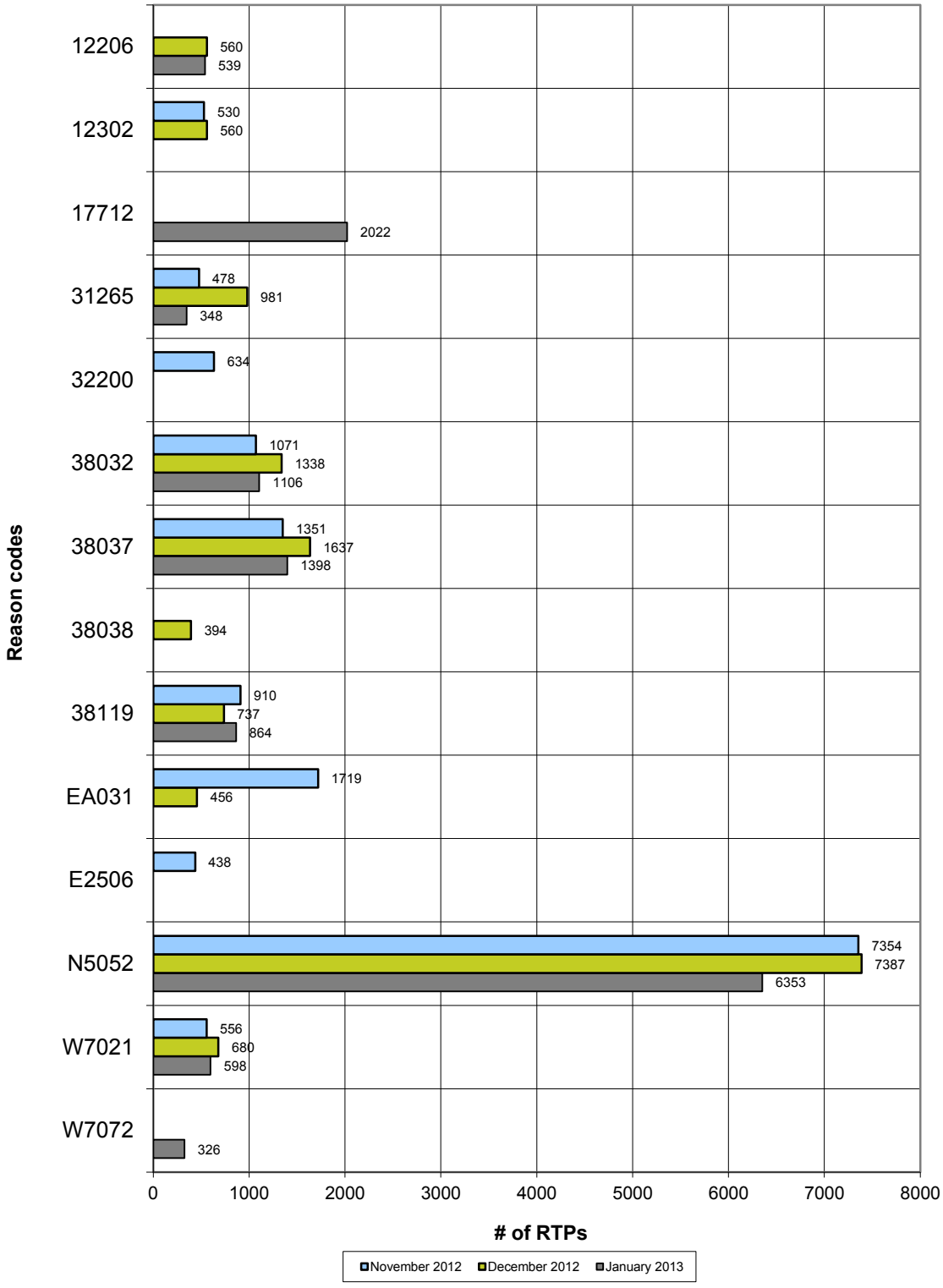


Part A top rejects for November 2012-January 2013



Part A top return to providers (RTPs) for November 2012-January 2013

Top RTPs for November 2012-January 2013



CMS adds data reporting requirements on home health claims

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) that bill regional home health intermediaries (RHHIs) or Medicare administrative contractors (A/B MACs) for home health services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8136 which adds new data reporting requirements for home health prospective payment system (HHPPS) claims. home health agencies (HHAs) must report new codes indicating the location of where services were provided and indicating whether services were added to the HH plan of care by a physician who did not certify the plan of care. Make sure that your billing staffs are aware of these changes.

Background

Generally, original Medicare makes payment under the HHPPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate pays for the delivery of home health services, which includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Claims must report all home health services provided to the beneficiary within the episode.

Healthcare common procedure coding system (HCPCS) codes Q5001 through Q5009 currently describe where hospice services were provided (in the patient's home, assisted living facility, etc). These codes have been reported on hospice claims since 2007. Medicare is planning to capture data to show:

1. Where home health services were provided by requiring HHAs to report the location on the claim; and
2. When a physician (other than the certifying physician) changes/adds to the plan of care. This will enable the program to see how often additional orders are added to the plan of care.

Effective for HH episodes beginning on or after July 1, 2013, HHAs are to use the HCPCS codes Q5001, Q5002, and Q5009 on home health claims to report where home health services were provided. The following table lists the definitions of the Q codes Q5001, Q5002, and Q5009, which were revised effective April 1, 2013:

HCPCS Code	Definition
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5009	Hospice or home health care provided in place not otherwise specified (NO)

The location where services were provided should be reported along with the first billable visit in a HH PPS episode. In addition to reporting a service line according to current instructions, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit, and a nominal charge (e.g., a penny).

If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

HHAs must report when there are changes/additions to the plan of care by a physician other than the certifying physician using a modifier to indicate changes/additions to the plan of care by a physician other than the certifying physician. Modifier XX must be appended to the HCPCS G code describing any visits added to the plan of care by that physician.

Note: Revisions to the definitions of the Q codes above (Q5001, Q5002, and Q5009) will be published in the HCPCS update on March 31, 2013. Modifier XX is a placeholder value. The actual modifier and its final definition will also be published in the HCPCS update. CR 8136 and this article will be reissued with the final modifier information following the March 31, 2013 HCPCS update.

(continued on next page)

Home health *(continued)*

Billing information

Note the following billing requirements:

- HCPCS codes Q5001, Q5002, or Q5009 must be reported on HHPPS claims containing revenue code 042X, 043X, 044X, 055X, 056X, or 057X or the claim will be returned to the provider.
- The line item date of service of the line reporting Q5001, Q5002, or Q5009 must match the earliest dated HH visit line (revenue codes 042X, 043X, 044X, 055X, 056X, or 057X) on the claim or the claim will be returned to the provider.
- When more than one line on an HHPPS claim reports Q5001, Q5002, or Q5009, then the same HCPCS code must not be reported on consecutive dates or the claim will be returned to the provider.
- Claim lines reporting Q5001, Q5002, or Q5009 are not included in the visit counts passed to the HH pricer, nor are they counted in medical policy parameters that count number of visits.

Additional information

The official instruction, CR 8136 issued to your A/B MACs and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2650CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your 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* on the CMS website.

MLN Matters® Number: MM8136
Related Change Request (CR) #: CR 8136
Related CR Release Date: February 1, 2013
Effective Date: Home health episodes beginning on or after July 1, 2013
Related CR Transmittal #: R2650CP
Implementation Date: July 1, 2013

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CMS announces DMEPOS competitive bidding payment amounts for the round two and national mail-order competitions

The Centers for Medicare & Medicaid Services (CMS) announced the single payment amounts for the round two and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program.

The CMS Office of the Actuary estimates that the program will save the Medicare Part B trust fund $25.7 billion and beneficiaries $17.1 billion between 2013 and 2022. Scheduled to begin July 1, 2013, the pricing program will save Medicare beneficiaries in 91 major metropolitan areas an average of 45 percent for certain DMEPOS items.

For additional information:

Press release

CMS website

Fact sheet

Source: PERL 201301-06

CMS clarifies process for denying multiple hospice claims in same month

Provider types affected

This *MLN Matters*® article is intended for hospices submitting claims to Medicare contractors (regional home health intermediaries (RHHI) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8142, which implements system edits to return hospice claims to the provider when the hospice has submitted more than one claim per month per beneficiary or when the hospice has submitted claims spanning more than one calendar month, effective for claims with dates of service on or after July 1, 2013. There is no change in policy with CR 8142. Make sure that your billing staff is aware of this clarification.

Background

Hospices are subject to the repetitive billing requirements as provided in the "*Medicare Claims Processing Manual*", Chapter 1, Section 50.2.2. This requirement was further clarified in Chapter 11, Section 90 of the same manual, requiring that hospice providers conform to calendar month billing.

CR 8142 instruction enforces the calendar month billing requirement and establishes standard system edits to return claims to hospice providers when more than one claim per beneficiary is received in a single month, beginning with dates of service on or after July 1, 2013. The only exception to this processing requirement is if the beneficiary was discharged from the hospice or revoked the hospice election and later re-elected the benefit during the same month.

Specifically, Medicare will return to the hospice provider (RTP) claims (bill types 81x or 82x) with dates of service on or after July 1, 2013 when;

- There is a patient status code of 30 and the thru date of the claim does not equal the last day of the billing period month: or
- The claim from and thru dates span multiple months.

Additional information

The official instruction, CR 8142, issued to your RHHI or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2642CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your RHHI 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* on the CMS website.

MLN Matters® Number: MM8142
Related Change Request (CR) #: CR 8142
Related CR Release Date: January 31, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2642CP
Implementation Date: July 1, 2013

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Emergency update to the physician fee schedule database (MPFSDB)

Provider types affected

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

Provider action needed

Payment files were originally issued to contractors based upon the CY 2013 Medicare physician fee schedule (MPFS) final rule, issued on November 1, 2012, and published in the *Federal Register* on November 28, 2012.

This article is based on change request (CR) 8143 which informs Medicare contractors about the amendments to payment files to include corrections described in the CY 2013 MPFS final rule correction notice, as well as the statutory changes from the "American Taxpayer Relief Act of 2012", where the zero percent update to the 2013 conversion factor and the non-budget neutral geographic practice cost index (GPCI) work floor extenders will be effective January 1 for calendar year 2013. Make sure that your billing staffs are aware of these changes.

Background

Some physician work, practice expense, and malpractice relative value units (RVUs) published in the CY 2013 Medicare physician fee schedule (MPFS) final rule have been revised to align their values with the CY 2013 MPFS Final Rule policies.

These changes are discussed in the CY 2013 MPFS final rule correction notice and revised RVU values are found in Addendum B and Addendum C of the CY 2013 MPFS final rule correction notice. (These addenda are available as a download at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html* on the Centers for Medicare & Medicaid Services (CMS) website.)

In addition to RVU revisions, changes have been made to some healthcare common procedure coding system (HCPCS) code payment indicators in order to reflect the appropriate payment policy.

Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2013 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2013 MPFS final rule correction notice public use data files.

Also, per CR 8143, Medicare contractors shall update their systems to add code G0459, "Telehealth inpt pharm mgmt", with an effective date of January 1, 2013, and your contractor was to implement this change no later than January 25, 2013.

Additional information

The official instruction, CR 8143 issued to your FI, carrier, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2651CP.pdf* on the CMS website.

If you have any questions, please contact your FI, carrier, RHHI, 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* on the CMS website.

MLN Matters® Number: MM8143
Related Change Request (CR) #: CR 8143
Related CR Release Date: February 1, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2651CP
Implementation Date: No later than January 25, 2013

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April 2013 quarterly average sales price (ASP) Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

What You Need to Know

Medicare will use the April 2013 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2013, with dates of service from April 1, 2013, through June 30, 2013.

Change request (CR) 8161, from which this article is taken, instructs Medicare contractors to implement the April 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2013, October 2012, July 2012, and April 2012 files. Make sure that your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4, Part B Hospital (including inpatient hospital Part B and OPPS), Section 50 Outpatient PRICER, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf* on the CMS website.)

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

Files	Effective for Dates of Service
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012

Additional information

You can find the official instruction, CR 8161, issued to your FI, carrier, A/B MAC, DME MAC, and RHHI by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2624CP.pdf* on the CMS website.

If you have any questions, please contact your FI, carrier, A/B MAC, DME MAC, or RHHI 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* on the CMS website.

MLN Matters® Number: MM8161
Related Change Request (CR) #: CR 8161
Related CR Release Date: December 28, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2624CP
Implementation Date: April 1, 2013

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Guidance on hospital inpatient admission decisions

Note: This article was updated on July 31, 2012, to reflect current Web addresses. All other information remains the same. This article was previously published in the February 2011 *Medicare A Connection* on pages 40-41.

Provider types affected

Inpatient acute care hospitals that bill Medicare contractors (fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries are affected.

What you need to know

It is important that any staff involved with the clinical decision to admit the patient stay abreast of all CMS (Centers for Medicare & Medicaid Services) national inpatient hospital policy and national and local coverage determinations. Additionally, make sure medical documentation submitted demonstrates evidence of the clinical need for the patient to be admitted to the facility and fully and accurately identifies any subsequent care that was provided during the inpatient stay.

Background

Some hospitals have recently expressed concern about how recovery audit contractors (RACs), MACs, FIs, and the comprehensive error rate testing contractor (CERT) are utilizing screening criteria to analyze medical documentation and make a medical necessity determination on inpatient hospital claims. There are several commercially available screening tools that Medicare contractors in specific jurisdictions may use to assist in the review of medical documentation to determine if a hospital admission is medically necessary. These include Interqual, Milliman, and other proprietary systems.

CMS Policy Guidance

To assist hospitals regarding inpatient admission decisions, CMS would refer hospitals to the following:

Chapter 6, Section 6.5.1, of the *Medicare Program Integrity Manual* requires that contractor review staff use a screening tool as part of their medical review process for inpatient claims.

CMS does not require the contractor to use specific criteria nor endorse any particular brand of screening guidelines. CMS contractors are not required to pay a claim even if screening criteria indicate inpatient admission is appropriate.

Conversely, CMS contractors are not required to automatically deny a claim that does not meet the admission guidelines of a screening tool. In all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record. For each case, the review staff will utilize the following when making a medical necessity determination

- Admission criteria;
- Invasive procedure criteria;
- CMS coverage guidelines;
- Published CMS criteria; and
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community).

Note: CMS considers the use of screening criteria as only one tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination.

Chapter 6, Section 6.5.2, of the *Medicare Program Integrity Manual* states that the review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay.

The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The reviewer will consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.

Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.

Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if

(continued on next page)

Inpatient *(continued)*

care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

Chapter 6 of the *Medicare Program Integrity Manual*, Section 6.5 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf*.

The *Medicare Benefit Policy Manual*, Chapter 1, Section 10 also contains relevant information regarding what constitutes an appropriate inpatient admission. According to that manual section, an inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark (i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis).

However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services
- (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital. Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf*.

Additional information

Chapter six of the *Medicare Program Integrity Manual*, Section 6.5 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf* and Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf* on the CMS website.

If you have any questions, please contact your carrier, 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* on the CMS website.

MLN Matters® Number: SE1037
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal N/A
Implementation Date: N/A

Educational Events

Provider outreach and educational events – March 2013

Medifest 2013 - Fort Lauderdale

When: March 12-13
Location: Renaisssance Fort Lauderdale-Plantation Hotel
Time: All Day **Delivery language:** English
Type of Event: Educational Seminar **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Medicare Part A: changes and regulations

When: Tuesday, March 19
Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time user?** Set up an account by completing "Request a New Account" online. Providers who do not have a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the 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 *www.fcsouniversity.com*.

Other 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 then disseminates 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 conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- 'CMS Medicare FFS Provider e-News': January 31, 2013, 2012 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-31-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': February 7, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-07-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': February 14, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-14-eNews.pdf*

Source: CMS PERL 201301-06, 201302-01, 201302-02

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

CGS Administrators, LLC
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

Puerto Rico Contact Information

Addresses

Claims

Additional documentation
General mailing
Congressmen mailing
First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

Redeterminations on overpayments
First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

Credit balance
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Audit and reimbursement department

Reporte de costo, auditoría, apelación de reporte de costo, porcentaje tentativo, rama de PS &R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone Numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

For the hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov

CMS clarifies instructions for implementation of Section 5506 of the Affordable Care Act

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7746, which provides guidance for Medicare contractors to amend cost reports for hospitals receiving reassigned graduate medical education (GME) or indirect medical education (IME) slots.

Section 5506 of the Affordable Care Act directed CMS to develop a process to preserve resident caps from teaching hospitals that close. CMS finalized its policy for implementing section 5506, which included establishment of an application process and procedures for redistributing the resident cap slots associated with the closed hospital's direct GME and IME caps

CMS completed the initial two rounds of awarding these slots to eligible hospitals in February 2012 and November 2012 respectively. The agency is not requiring hospitals to file amended cost reports to incorporate Section 5506 cap increases that are effective retroactively and affect cost reports that have already been filed. Change request 7746 provides the instructions for Medicare contractors to perform these adjustments on behalf of the applicable hospitals.

A full copy of the change request is published in the following appendix of this edition of *Medicare A Connection*. The full change request document may also be found by *clicking here*.

(continued on next page)

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1171	**Date: January 31, 2013**
	Change Request 7746

SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA)-Preservation of Resident Cap Positions from Closed Teaching Hospitals - Round 1 and Round 2 Only

I. SUMMARY OF CHANGES: This Change Request (CR) provides contractors with instructions for incorporating section 5506 resident cap increases that are effective retroactively on applicable hospitals" cost reports that have already been filed, and for recalculating the hospital"s direct GME and IME payments accordingly on those filed cost reports. This CR applies to Round 1 and Round 2 of section 5506.

EFFECTIVE DATE: March 4, 2013
IMPLEMENTATION DATE: March 4, 2013, as part of the normal settlement process.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1171	Date: January 31, 2013	Change Request: 7746

SUBJECT: Instructions to Contractors for Implementing Section 5506 of the Affordable Care Act (ACA) - Preservation of Resident Cap Positions from Closed Teaching Hospitals – Round 1 and Round 2 Only

Effective Date: **March 4, 2013**

Implementation Date: **March 4, 2013, as part of the normal settlement process.**

I. GENERAL INFORMATION

A. Background: Section 5506 of the ACA directed CMS to develop a process to preserve the FTE (full-time equivalent) resident caps from teaching hospitals that close. CMS finalized its policy for implementing section 5506, which included establishment of an application process and procedures for redistributing the FTE resident cap slots associated with the closed hospital's direct GME and IME caps, in the November 24, 2010 Federal Register (75 FR 72212). Hospitals that wished to apply for the FTE resident cap slots of the 14 teaching hospitals that closed between March 23, 2008 and August 3, 2010 submitted their applications to CMS by April 1, 2011. For ease of reference, we are referring to this first round of section 5506 applications as Round 1. Hospitals that applied for the FTE resident cap slots of the 1 New York City teaching hospital that closed on October 31, 2010 (St. Vincent's Medical Center, SVMC), submitted their applications to CMS by December 1, 2011. For ease of reference, we are referring to this second round of section 5506 application as Round 2.

On February 28, 2012, CMS mailed award letters to hospitals and posted on the CMS website the awards for hospitals that received slots from hospitals closed under Round 1. To see the awardees, the awards, and the effective dates, go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html, and in the Downloads section of the page, click on Section 5506 Cap Increases Related to Applications Due April 1, 2011.

On November 30, 2012, CMS posted on our website the awards from Round 2 for hospitals that received slots due to the closure of SVMC. On December 6, 2012, CMS mailed award letters to hospitals. To see the awardees, the awards, and the effective dates, go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html, and click on the "Section 5506 Cap Increases Round 2 – Applications due Dec 1, 2011" link in the Downloads section of the page.

Based on the policy established in the November 24, 2010 Federal Register (75 FR 72225-6), and further clarified in the August 31, 2012 Federal Register (77 FR 53437-53443), the additional cap slots that a hospital receives under section 5506 may have different effective dates. That is, of the total cap slots that a qualifying hospital receives, some slots may increase the FTE resident cap retroactively, while other slots may increase the hospital's FTE resident cap prospectively. CMS is not requiring hospitals to file amended cost reports to incorporate section 5506 cap increases that are effective retroactively and affect cost reports that have already been filed. Instead, the contractors will revise the applicable hospitals' cost reports. The purpose of this CR is to provide instructions to the contractors for incorporating the section 5506 cap increases *that are effective retroactively* on applicable hospitals' cost reports *that have already been filed,* and for recalculating the hospital's direct GME and IME payments accordingly on those already filed cost reports. This CR also provides hospitals with instructions for incorporating Round 1 and Round 2 section 5506 cap increases into cost reports that have not yet been filed. *This CR does NOT apply to future rounds of section 5506 after Round 1 and Round 2.*

B. Policy: In the November 24, 2010 Federal Register, CMS established seven Ranking Criteria under which hospitals' applications for slots from closed hospitals are ranked. CMS clarified the effective dates of the Ranking Criteria applicable to Round 1 and Round 2 in the August 31, 2012 IPPS Federal Register [77

FR 53437-53443 August 31, 2012]. Slots are redistributed to applying hospitals based, in part, on these seven Ranking Criteria, with a higher-ranked application receiving slots before a lower-ranked application. For hospitals receiving slots under Ranking Criteria 1 or 3, the permanent cap increase would be effective beginning with the cost reporting period *following* the one in which the hospital closure occurred (see 75 FR 72225 November 24, 2010). For hospitals receiving slots under Ranking Criterion 2, the permanent cap increase is effective on the day of the particular hospital's closure (77 FR 53437-8 August 31, 2012). Since the first section 5506 hospital closure occurred on May 31, 2008, these cost reporting periods are all in the past, dating as far back as calendar year 2008. For hospitals receiving slots under Ranking Criteria 4, 5, 6, or 7, the permanent cap increases are effective as of a July 1, either in the past or in the future, or on January 30, 2012, the date of the award announcement under Round 1, and November 30, 2012, the date of the award announcement under Round 2. Following are instructions for contractors on how to amend hospitals' applicable submitted cost reports to reflect the change in direct GME and IME payment due to the FTE resident cap increases received under section 5506, and instructions for providers on how to report the FTE counts of cost reports that have not yet been submitted.

Note that contractors may be amending several cost reports for each applicable hospital; that is, the hospital's FYs 2008, 2009, 2010 2011, and possibly 2012 cost report, depending on the hospital's fiscal year end.

Also note that separate instructions are provided below for amending cost reports filed on the CMS Form 2552-96 and on the CMS Form 2552-10. This is because worksheet E, Part A and worksheet E-3, Part IV on the CMS Form 2552-96 were not revised, and will not be revised, to incorporate lines to report the section 5506 FTE resident cap increases. However, worksheet E, Part A and worksheet E-4 of the CMS Form 2552-10 were amended to accommodate the section 5506 FTE resident cap increases. Therefore, the instructions for amending a cost report and reporting the section 5506 FTE resident cap increase will differ depending on whether the applicable cost report is filed on the CMS Form 2552-96 or the CMS Form 2552-10.

Contractors and hospitals shall use the excel spreadsheet called CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase. The 3rd and 4th tabs of that spreadsheet may be used to record and track all of a hospital's section 5506 cap adjustments and their effective dates (even for subsequent section 5506 rounds).

I. Steps to Recalculate the IME and Direct GME Payment Due to a Section 5506 FTE Resident Cap Increase

1. Refer to the CMS website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html) or the hospital's section 5506 award letter to identify any cap increases that are effective during cost reports that have already been filed. Contractors shall complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx. (Instructions for completing these tabs are on the tabs, and in the EXAMPLE provided below).

2. Determine if the cost report was filed on CMS Form 2552-96 or CMS Form 2552-10. If it was filed on CMS Form 2552-96, then proceed to step 3. If it was filed on CMS Form 2552-10, then skip to step 4.

3. If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 3.a.

   If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 3.a. and incorporate the applicable steps in this CR into the desk review.

If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 3.a. and complete the applicable steps in this CR before settling the cost report.

For Form 2552-96 Cost Reports:

a. Report the amount of the section 5506 cap increase for IME and/or direct GME respectively that *is effective during the cost report that you are amending* on worksheet S-3, Part I, line 17. Use column 7 for the IME cap increase and column 8 for the direct GME cap increase. (Normally line 17 is for "Other Long Term Care Facilities," but we are adopting this line and its columns for special reporting of the section 5506 cap increases on the Form 2552-96 cost reports, and it will serve as an indicator as to whether the hospital received a section 5506 cap increase in this cost reporting period). If you complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, then the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amounts to be entered on worksheet S-3, Part I, line 17. Proceed to step 3.b.

b. IME: On worksheet E, Part A, line 3.06, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.06 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital's allowable FTE count and IME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.06, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E, Part A, line 3.06. (Note that this calculated amount for line 3.06 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital's IME payment on that cost report. For providers that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards, complete Tab1 and Tab2 of the CR 7746 Section 5506 Temp Adj Cal.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E, Part A. Refer to section II. below for detailed instructions on completing CR 7746 Section 5506 Temp Adj Calc.xlsx and worksheet E, Part A.

c. Direct GME: On worksheet E-3, Part IV, line 3.03, enter the amount of the section 5506 cap increase applicable to this cost reporting period. (Normally line 3.03 is used to report an adjustment to the cap due to Medicare GME affiliation agreements, but we are adopting it for purposes of recalculating the hospital's allowable FTE count and direct GME payment under section 5506. However, if a hospital is also a member of a Medicare GME affiliation group during this cost reporting period, the positive or negative adjustment due to that Medicare GME affiliation agreement would still be reported on line 3.03, as usual, so that the section 5506 cap and the affiliations adjustment would be added together). If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.) Complete Tab3 and Tab4 of the CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab4 will automatically calculate the amount to be entered on worksheet E-3, Part IV, line 3.03. (Note that this calculated amount for line 3.03 does *not* include any adjustments for affiliation agreements).

Proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital's direct GME payment on that cost report. For providers that have received temporary adjustments under 42 CFR 413.79(h) for displaced residents *and* that received section 5506 cap awards, complete Tab1 and Tab2 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the chart called Cost Report Entries at the bottom of Tab1 will automatically calculate the amounts to be entered on worksheet E-3, Part IV. Refer to section II. below for detailed instructions on completing on completing CR 7746 Section 5506 Temp Adj Calc.xlsx and worksheet E-3, Part IV on the CMS Form 2552-96 and the worksheet E-4 on the CMS Form 2552-10.

4. If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount. Proceed to step 4.a.

   If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to step 4.a. and incorporate the applicable steps in this CR into the desk review.

   If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to step 4.a. and complete the applicable steps in this CR before settling the cost report.

   For Form 2552-10 Cost Reports:

a. IME: Report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E, Part A, making revisions as necessary.

   The instructions for IME on worksheet E, Part A, line 8.02 state, "Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. *Further subscript this line (lines 8.03 through 8.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase . . .*" The phrase "if the hospital receives FTE cap slot awards on more than one occasion under section 5506" means that a hospital could receive slots from more than one round of section 5506 applications; that is, from Round 1 or Round 2 and/or from future teaching hospital closures. Upon the completion of each round of section 5506 application processes, CMS will post the awards on its website and issue an award letter to each hospital receiving section 5506 slots under that round. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective over multiple cost reporting periods, line 8.02 will reflect the *total* IME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 8.03 will reflect the *total* IME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2, then line 8.02 would reflect the awards from Round 2, and so forth. Each subscript of line 8.02 will eventually reflect the total IME section 5506 cap increase received for each respective round).

   Refer to section II. below for detailed instructions on completing worksheet E, Part A.

b. Direct GME: Report the amount of the section 5506 cap increase for direct GME on worksheet E-4, line 4.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E-4, making revisions as necessary.

The instructions for direct GME on worksheet E-4, line 4.02 state, "Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. *Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase . . .*" The phrase "if the hospital receives FTE cap slot awards on more than one occasion under section 5506" means that a hospital could receive slots from more than one round of section 5506 applications; that is, from future teaching hospital closures. Upon the completion of each round of section 5506 application processes, CMS will post the awards on its website and issue an award letter to each hospital receiving section 5506 slots under that round. The number of times line 4.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 4.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes. Eventually, as the multiple effective dates become effective, line 4.02 will reflect the *total* direct GME section 5506 cap increase the hospital received the first time that it received section 5506 slots, but not necessarily from Round 1. Similarly, line 4.03 will reflect the *total* direct GME section 5506 cap increase the hospital received under a subsequent round of section 5506. (In other words, if a hospital did not receive slots under Round 1, but did receive slots under Round 2, then line 4.02 would reflect the awards from Round 2, and so forth. Each subscript of line 4.02 will eventually reflect the total direct GME section 5506 cap increase received for each respective round).

Refer to section II. below for detailed instructions on completing worksheet E-4.

II. Interaction of the 3-Year Rolling Average and Slots Awarded Under Section 5506 (Applicable to CMS Form 2552-96 and CMS Form 2552-10):

As a hospital's FTE resident cap increases as a result of section 5506 awarded slots, the hospital is able to count more FTE residents for IME and direct GME payment purposes on a cost report. The higher allowable current year FTE count also means that a larger FTE count would be incorporated into the rolling average calculation and into the IME intern and resident-to-bed (IRB) ratio cap. If a hospital received a section 5506 award, but did not also receive a temporary cap adjustment for displaced residents under section 413.79(h), then the additional FTEs counted are immediately subject to the rolling average and the IRB ratio cap. For a hospital that did receive a temporary FTE cap adjustment and an attending exemption from the rolling average under section 413.79(h) for training residents displaced from a closed hospital, the following describes when and how section 5506 slots would replace the temporary cap adjustments of displaced FTE residents, resulting in the inclusion of the displaced FTEs in the rolling average and subjection to the IME IRB ratio cap:

Separation of Awards from Round 1 and Round 2:

Slots awarded under Round 1 may only replace temporary FTE cap adjustments associated with residents displaced from Round 1. If in a cost reporting period, a hospital is awarded slots from Round 1 and is training FTEs displaced both by the closed hospitals associated with Round 1 and with the closed hospital associated with Round 2, the slots awarded under Round 1 would not remove Round 2 SVMC displaced FTEs from exemption from the rolling average. Only slots awarded from Round 2 may remove SVMC FTEs from being reported after the rolling average. Similarly, slots awarded under Round 2 would not remove Round 1 displaced FTEs from exemption from the rolling average. Furthermore, no slots awarded under Round 1 or Round 2 may replace residents displaced by the closure of other programs or hospitals that were not part of Round 1 or Round 2 (such as the closure in New York of Brookdale University Hospital Medical Center's anesthesiology program or the closure of Peninsula Hospital Center). If a hospital received a temporary cap adjustment under section 413.79(h) for residents displaced from another closed

program or hospital not associated with Round 1 or Round 2, those displaced FTEs would continue to be exempt from the rolling average and the IRB ratio cap, so long as the hospital qualifies for a temporary cap adjustment (i.e., the hospital's total allopathic and osteopathic FTE count including FTEs from all program or hospital closures is greater than the hospital's FTE resident cap *with* the usual adjustments (including section 5503 or section 5506 adjustments)).

Use the attached spreadsheet CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the amount of temporary cap adjustment, if any, a hospital qualifies for in a cost reporting period, and how to report the section 5506 cap adjustments and FTE counts on the cost report. Complete Tab1 for a hospital if the hospital was training displaced residents from closed hospitals in the particular cost reporting period you are working on, AND also received a section 5506 award(s) applicable in that cost reporting period. (Note that Tab1 may also be completed for the purpose of determining if a hospital is eligible for a temporary cap adjustment under 42 CFR 413.79(h) for displaced FTEs, even in the absence of section 5506 awards). Complete Tab2 if the hospital was training displaced residents from closed hospitals in this cost reporting period, AND a portion of the displaced residents were from closed hospitals that had caps slots redistributed under Round 1 or Round 2 of section 5506, AND the hospital received a section 5506 award(s) under Round 1 or Round 2 applicable during this cost reporting period. Complete Tabs3 and 4 for all hospitals that received a section 5506 cap award(s), even if the hospital did not train displaced residents in this cost reporting period. Be sure to enter into Tab3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. When completing Tab1 and/or Tab2, be sure to enter into cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. Contractors shall ask a hospital to provide any FTE information for IME and for direct GME respectively (including unweighted, weighted, and displaced FTE information) that the contractor requires in order to implement this CR.

A. IME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L21.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L25).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell I19, and then it will automatically input into Tab 2, cell L27. Note: Tab 2, cell L27 and Tab 1, cell I19 must equal each other.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26).

3. Determination of FTE Caps and Counts

a. Determine the IME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E, Part A, line 3.07 of Form CMS 2552-96 and on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs,* no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, than all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.)

from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT the absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L31).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. -1.b.) (NOT the absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L32).

d. Add 4.a., 4.b., and 4.c. This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59).

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1. See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

B. DIRECT GME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 7746 Section 5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 (that is, the cost report for the current year should reflect the section 5506 adjustments in effect from the prior cost reports, if applicable, and the current cost report cumulatively). If the portion of the cap increase that is effective during this cost reporting period is effective on a date other than the fiscal year begin date, then prorate that portion of the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period). Complete Tabs 3 and 4 of CR 7746 Section

5506 Temp Adj Calc.xlsx, and the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L37.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period from Round 1 and Round 2 and also from program or hospital closures *not* associated with Round 1 or Round 2 (first you have to manually enter the amount into Tab 1, cell D19, and then it will automatically input into Tab 2, cell L42. Note: Tab 2, cell L42 and Tab 1, cell D19 must equal each other.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41).

3. Determination of FTE Caps and Counts

a. Determine the direct GME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E-3, Part IV, line 3.04 of Form CMS 2552-96 and on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. is greater than the adjusted cap from 3.a., then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap. If this amount is greater than zero, then that is the portion of displaced FTEs that is covered by the FTE cap and *for this portion of displaced FTEs,* no temporary cap adjustment to or exemption from the rolling average is necessary. If this amount is less than or equal to zero, than all of the hospital's FTEs, including displaced FTEs, are in excess of the cap, and a temporary adjustment is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. or the displaced FTE count of closures not associated with either Round 1 or Round 2 from 2.d. This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. This step offsets the number of displaced FTEs associated with Round 1 (2.a.) from the Round 1 section 5506 award effective in this cost reporting period (1.a.). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (3.e. – 4.a.) or (2.a. – 1.a.) (NOT absolute value). The result is the amount of temporary cap adjustment, if any, that will be provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L46).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b.) from the Round 2 section 5506 award effective in this cost reporting period (1.b.). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (3.e. - 4.a. - 4.b.) or (2.b. -1.b.) (NOT absolute value). The result is the amount of temporary adjustment, if any, that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L47).

d. Add 4.a., 4.b., and 4.c. This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54).

5. Weighted FTE Count Calculation

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after non-primary care rolling average:

a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30).

b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32).

c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34).

d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b.) (automatic input into Tab 1, cell D36)

e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c.) (Tab 1, cell D38).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and non-primary care FTE counts. Complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted primary care/OB/GYN and nonprimary care FTEs, respectively, including displaced FTEs. See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. (Choosing either 2552-96 or 2552-10 will also change references to cost report lines in Tab 1, cells C15, H15, J34, and J40).

C. EXAMPLE

Following is an example illustrating how the amount of FTEs to be reported after the rolling average should be determined and reported on the cost report:

Hospital X has a 12/31 FYE and the Medicare contractor is working on amending the 12/31/11 cost report.

Hospital X has the following relevant FTE counts (you will need this information to complete the example):

a. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 1 of section 5506 = 7.00
b. IME and direct GME unweighted allopathic and osteopathic displaced FTE resident count for residents relating to closed hospitals in Round 2 of section 5506 = 6.00
c. Remaining unweighted allopathic and osteopathic displaced FTE resident count (not associated with Round 1 or Round 2) = 2.00
d. IME and direct GME total unweighted displaced FTE count = 7.00 + 6.00 + 2.00 = 15.00.
e. IME and direct GME adjusted cap, including the section 5506 add-on in FYE 12/31/11 = 100.00.
f. IME and direct GME unweighted allopathic and osteopathic FTE count *without* displaced FTE residents = 98.00.
g. Direct GME weighted displaced FTEs in primary care and OB/GYN = 8.00.
h. Direct GME weighted displaced FTEs in non-primary care = 2.00.
i. Direct GME weighted primary care and OB/GYN audited FTE residents including displaced FTEs = 45.00.
j. Direct GME weighted non-primary care audited FTE residents including displaced FTEs (excluding dental and podiatry) = 38.00.
k. Prior year allowable IME FTEs = 100.00
l. Prior year available beds = 300.00.

Hospital X received the following slots and effective dates under Round 1:

IME
Effective 7/1/08: 1.75
Effective date for cost reports beginning after 6/16/08: 1.07
Effective 7/1/09: 1.70
Effective 7/1/10: 21.12
Effective 7/10/10: 3.00
Effective date for cost reports beginning after 7/10/10: 0.43

Effective 7/1/11: 7.02

DGME
Effective 6/16/08: 7.00
Effective 7/1/08: 1.75
Effective date for cost reports beginning after 6/16/08: 2.60
Effective 7/1/09: 1.55
Effective 7/1/10: 17.02
Effective 7/10/10: 3.00
Effective date for cost reports beginning after 7/10/10: 1.14
Effective 7/1/11: 5.43

Hospital X received the following slots and effective dates under Round 2:

IME
Effective date for cost reports beginning after 10/31/10: 1.00
Effective 7/1/11: 1.99

DGME
Effective date for cost reports beginning after 10/31/10: 1.00
Effective 7/1/11: 1.99

Enter into Tab 3, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/11 and FYE is 12/31/11.

Enter into Tab 3, columns B through L, the effective dates and the corresponding amount of slots awarded. Round 1 effective dates and slots begin on row 22, and Round 2 effective dates and slots begin on row 63. For DGME, enter into Tab3, column B, the effective dates that say, "Effective date for cost reports beginning after m/dd/yy", and enter the corresponding slots into column C. If the effective date is just "Effective m/d/yy," then enter into Tab3, column E the effective date, and the corresponding slots in column F. For IME, enter into Tab3, column H, the effective dates that say, "Effective date for cost reports beginning after m/dd/yy," and enter the corresponding slots into column I. If the effective date is just, "Effective m/d/yy," then enter into Tab3, column K the effective date, and the corresponding slots into column L. For example, for IME Round 1, enter into Tab3 cell K22 "7/1/08," and enter into cell L22 "1.75." Then enter into cell H22 "6/16/08," and enter into cell I22 "1.07." Continue to enter the rest of the Round 1 and the Round 2 effective dates and slots in this manner.

Note that in columns N through R, the actual amount of each cap award that is effective during FYE 12/31/11 is automatically calculated, and prorating for slots effective 7/1/11 also occurs automatically. Also note that the total cumulative slots effective during FYE 12/31/11 are automatically calculated for DGME, Round 1, in cell O54 (should say 36.80), and Round 2, in cell O95 (should say 2.00), and for IME, Round 1, cell R55 (should say 32.61), and Round 2, in cell R96 (should say 2.00).

The detailed effective date and award information from Tab 3 must be manually transferred to Tab 4 in summary form. Tab 4 lists in chronological order the applicable round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Cells G14 and G31 on Tab4 should say "2" – the number of award rounds applicable to this cost reporting period. Follow the instructions on Tab 4.

For DGME, enter 1 into cell B19, and enter 36.80 into cell C19 (note that 36.80 comes from Tab 3, cell O54). Enter 2 into cell B20, and enter 2.00 into cell C20 (note that 2.00 comes from Tab 3, cell O95).

For IME, enter 1 into cell B36, and enter 32.61 into cell C36 (note that 32.61 comes from Tab 3, cell R55). Enter 2 into cell B37, and enter 2.00 into cell C37 (note that 2.00 comes from Tab 3, cell R96).

Cell H29 should say 38.80, the combined Round 1 and Round 2 DGME cap increase, and cell H46 should say 34.61, the combined Round 1 and Round 2 IME cap increase. At the bottom of Tab 4, there is a chart listing the lines on the cost report where the section 5506 cap awards are reported, and the amount reported on each line. Click on cell D49 to access the down arrow to toggle between cost report Form 2552-96 and Form 2552-10. Since the current cost report in this example is FYE 12/31/11, choose Form 2552-10.

Proceed to complete Tabs 1 and 2.

Enter into Tab 1, cells B1, B2, B3, and B4, the provider's name, provider number, fiscal year begin (FYB) date, and fiscal year end (FYE) date, respectively. FYB is 01/01/11 and FYE is 12/31/11.

IME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L21 = 32.61.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22 =2.00.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L24=7.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L25 = 6.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (First manual input into Tab 1, cell I19 = 15.00, and then automatic input into Tab 2, cell L27 = 15.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L26=2.00).

3. Determination of FTE Caps and Counts

a. Determine the IME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on on worksheet E, Part A, line 9 of Form CMS 2552-10 (manual input into Tab 1, cell I14 = 100.00).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell I17 = 98.00).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell I21= 113.00)

d. Of the total unweighted displaced FTEs from 2.c., determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (113.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a

temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell I24, should say 13.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell I26 (automatic input, should say 2.00) is the amount of displaced FTEs that are not over the cap. This means that of the 15 total displaced FTEs, 13.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap and *for this portion of FTEs,* no temporary cap adjustment to the rolling average is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell I28 and automatic input into Tab 2, cell L28; should say 13.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 13.00.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (13.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (2.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L30; should say 2.00).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1 (13.00 – 2.00 = 11.00 remaining). This step offsets the number of displaced FTEs associated with Round 1 (2.a., 7.00 FTEs, Tab 2, cell L24) from the Round 1 section 5506 award effective in this cost reporting period (1.a., 32.61, Tab 2, cell L21). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (13.00 – 2.00) or (7.00 – 32.61) (not absolute value). While there are 11 slots potentially available from which to provide a temporary cap adjustment under Round 1, since the Round 1 section 5506 award of 32.61 effective in this cost reporting period exceeds the 7.00 Round 1 displaced FTEs, the section 5506 award "cancels" any temporary cap adjustment for Round 1 displaced FTEs. Mathematically, since 7.00 – 32.61 equals a negative number, this means that there is no temporary cap adjustment provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L31 = 0).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. Since none of 11 available slots were assigned to Round 1, there are still 11 slots potentially available to be added after the rolling average for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b., 6.00 FTEs, Tab 2, cell L25) from the Round 2 section 5506 award effective in this cost reporting period (1.b., 2.00, Tab 2, cell L22). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (13.00 – 2.00 – 0.00) or (6.00 – 2.00) (not absolute value). 4.00 is less than 11.00, and the result of 4.00 means that the

Round 2 section 5506 award of 2.00 "cancels" the temporary cap adjustment of 2 out of the 6 displaced FTEs associated with Round 2. Therefore, 4.00 FTEs is the amount of temporary adjustment that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L32 = 4.00).

d. Add 4.a., 4.b., and 4.c. (2.00 + 0 + 4.00 = 6.00). This sum is the portion of the displaced FTEs that is added after the rolling average to the numerator of the current year IRB ratio (automatic input into Tab 2, cell L33, and Tab 1, cell I29 = 6.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E59 = 107.00). Note that 6.00 + 107.00 = 113.00, the current year total unweighted allopathic and osteopathic FTEs in Tab 1, cell I21. All of the hospital's 113 FTEs are accounted for.

To compute the prior year IRB ratio, complete cells I34 through I41 on Tab 1. Using the FTE information provided about Hospital X at the beginning of this example, manually input 100.00 into cell I34, 0 into cell I35, and 0 into cell I37. Cell I38 should automatically calculate 6.00 FTEs as the displaced FTEs to add to the numerator of the prior year IRB ratio, and cell I39 should automatically calculate 106.00 as the prior year numerator. Next, manually input 300 beds into cell I40, and the revised IRB ratio of 0.353333 should automatically calculate in cell I41.

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/11, and choose Form 2552-96 as the prior year cost report because Form 2552-96 is the form to use for FYE 12/31/10.

DIRECT GME

1. Section 5506 Cap Calculation

a. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 1. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 1 will automatically populate Tab2, cell L36 = 36.80.

b. Determine the cumulative section 5506 cap amount effective in this cost reporting period for Round 2. Since Tabs 3 and 4 are completed, the cumulative section 5506 cap amount effective in this cost reporting period for Round 2 will automatically populate Tab2, cell L22 Tab2, cell L37 = 2.00.

2. Identification of the Displaced FTE Residents

a. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital(s) that closed under Round 1 (manual input into Tab 2, cell L39 = 7.00).

b. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period associated with the hospital that closed under Round 2 (manual input Tab 2, cell L40 = 6.00).

c. Determine the total unweighted allopathic and osteopathic displaced FTEs training in this cost reporting period (first manually input into Tab 1, cell D19 = 15.00, and then automatic input into Tab 2, cell L42 = 15.00.)

d. Determine the unweighted number of allopathic and osteopathic displaced FTEs training in this cost reporting period from program or hospital closures not associated with Round 1 or Round 2 (automatic input into Tab 2, cell L41 = 2.00).

3. Determination of FTE Caps and Counts

a. Determine the direct GME adjusted FTE cap, including the section 5506 cap increase(s). This amount is reported on worksheet E-4, line 5 of Form CMS 2552-10 (manual input into Tab 1, cell D14 = 100.00).

b. Determine the current year unweighted allopathic and osteopathic FTE count *without* displaced FTE residents (manual input into Tab 1, cell D17 = 98.00).

c. Determine the current year unweighted allopathic and osteopathic FTE count, *including* the unweighted displaced FTE residents (automatic input into Tab 1, cell D21 = 113.00)

d. Of the total unweighted displaced FTEs from 2.c. (15.00), determine the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average. If the total count from 3.c. (113.00) is greater than the adjusted cap from 3.a. (100.00), then the hospital might be eligible for a temporary cap adjustment because the hospital is in excess of its cap (automatic input into Tab 1, cell D24 = 13.00). It may be that all of the displaced FTEs are in excess of the adjusted cap from 3.a., or only a portion of the displaced FTEs cause the hospital to exceed the adjusted cap from 3.a. Tab 1, cell D26 (automatic input) is the amount of displaced FTEs that are not over the cap (should say 2.00). This means that of the 15 total displaced FTEs, 13.00 are over the cap, and potentially may be exempt from the rolling average. However, 2.00 displaced FTEs are covered by the FTE cap and *for this portion of FTEs,* no temporary cap adjustment to the rolling average is necessary.

e. The portion of displaced FTEs in excess of the FTE cap is the potential amount for which the hospital might qualify for a temporary cap adjustment/exemption from the rolling average (automatic input into Tab 1, cell D28 and automatic input into Tab 2, cell L43 should say 13.00). However, the actual amount of temporary cap adjustment may ultimately be less than this potential amount of 13.00.

4. Temporary Adjustment Calculation

If the hospital is training any displaced FTEs not associated with Round 1 or Round 2, first ensure that a temporary cap adjustment is provided for these displaced FTEs.

a. Take the lesser of the potential for a temporary cap adjustment from 3.e. (13.00) or the displaced FTE count of closures not associated with either Round 1 or Round 1 from 2.d. (2.00). This is the temporary cap add-on for displaced FTEs not associated with either Round 1 or Round 2 for this cost reporting period (automatic input into Tab 2, cell L45, should say 2.00).

b. If, after assigning the temporary cap adjustment for displaced FTEs not associated with Round 1 or Round 2 under 4.a., there is anything remaining from the potential available for a temporary cap add-on from 3.e., then determine if the hospital may also receive a temporary cap add-on for displaced FTEs associated with Round 1. (13.00 – 2.00 = 11.00 remaining). This step offsets the number of displaced FTEs associated with Round 1 (2.a., 7.00 FTEs, Tab 2, cell L39) from the Round 1 section 5506 award effective in this cost reporting period (1.a., 36.80, Tab 2, cell L36). If a hospital's cumulative section 5506 Round 1 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 1, then the Round 1 section 5506 award will "cancel" any temporary cap adjustment associated with Round 1 displaced FTEs. Only if the amount of Round 1 displaced FTEs exceeds the Round 1 section 5506 award will some amount of temporary cap adjustment be provided for the Round 1 displaced FTEs. Specifically, take the lower of (13.00 – 2.00) or (7.00 – 36.80) (not absolute value). While there are 11 slots potentially available from which to provide a temporary cap adjustment under Round 1, since the Round 1 section 5506 award of 36.80 effective in this cost reporting period exceeds the 7.00 Round 1 displaced FTEs, the section 5506 award "cancels" any temporary cap adjustment for Round 1 displaced FTEs. Mathematically, since 7.00 – 36.80 equals a negative number, this means that there is no temporary cap adjustment provided in this cost reporting period for Round 1 displaced FTEs (automatic input into Tab 2, cell L46 = 0).

c. Next, determine if some temporary cap adjustment will be provided for displaced FTEs associated with Round 2. If, after assigning a temporary cap adjustment to displaced FTEs not associated with Round 1 or Round 2, and assigning a temporary cap adjustment to Round 1 displaced FTEs, determine if there is anything remaining from the potential available (3.e.) to provide a temporary cap adjustment for Round 2 displaced FTEs. Since none of 11 available slots were assigned to Round 1, there are still 11 slots potentially available to be added after the rolling average for Round 2 displaced FTEs. This step offsets the number of displaced FTEs associated with Round 2 (2.b., 6.00 FTEs, Tab 2, cell L40) from the Round 2 section 5506 award effective in this cost reporting period (1.b., 2.00, Tab 2, cell L37). If a hospital's cumulative section 5506 Round 2 award effective in this cost reporting period is greater than or equal to the number of displaced FTE residents associated with Round 2, then the Round 2 section 5506 award will "cancel" any temporary cap adjustment associated with Round 2 displaced FTEs. Only if the amount of Round 2 displaced FTEs exceeds the Round 2 section 5506 award will some amount of temporary cap adjustment be provided for the Round 2 displaced FTEs. Specifically, take the lower of (13.00 – 2.00 – 0.00) or (6.00 – 2.00) (not absolute value). 4.00 is less than 11.00, and the result of 4.00 means that the Round 2 section 5506 award of 2.00 "cancels" the temporary cap adjustment of 2 out of the 6 displaced FTEs associated with Round 2. Therefore, 4.00 FTEs is the amount of temporary adjustment that will be provided in this cost reporting period for Round 2 displaced FTEs (automatic input into Tab 2, cell L47 = 4.00).

d. Add 4.a., 4.b., and 4.c. (2.00 +0.00 + 4.00 = 6.00). This sum is the *unweighted direct GME* portion of the displaced FTEs that is exempt from the rolling average (automatic input into Tab 2, cell L48, and Tab 1, cell D29 should say 6.00). The remaining portion of the displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count (automatic input into Tab 1, cell E54 should say 107.00). Note that 6.00 + 107.00 = 113.00, the current year total unweighted allopathic and osteopathic FTEs in Tab 1, cell D21. All of the hospital's 113 FTEs are accounted for.

5. Calculation of Weighted FTE Counts

Convert unweighted FTE counts to weighted FTE counts and determine a weighted portion to be added after the primary care & OB/GYN rolling average and the weighted portion to be added after nonprimary care rolling average:

a. Determine the ratio of the unweighted temporary cap adjustment to the total displaced FTEs (automatic input into Tab 1, cell D30 should say 0.40).

b. Determine the current year weighted primary care and OB/GYN displaced FTEs (manual input into Tab 1, cell D32 = 8.00).

c. Determine the current year weighted non-primary care displaced FTEs (manual input into Tab 1, cell D34 = 2.00).

d. Determine the weighted temporary cap adjustment/amount to be added to the primary care & OB/GYN rolling average (multiply the ratio in 5.a. by the weighted primary care & OB/GYN displaced FTEs in 5.b. = 0.40 x 8.00, automatic input into Tab 1, cell D36 = 3.20)

e. Determine the weighted temporary cap adjustment/amount to be added to nonprimary care rolling average (multiply the ratio in 5.a. by the weighted non-primary care displaced FTEs in 5.c., 0.40 x 2.00, automatic input into Tab 1, cell D38 = 0.80).

The remaining portion of the weighted displaced FTEs is reported prior to the rolling average in the current year total allopathic and osteopathic unweighted FTE count, and in the weighted primary care & OB/GYN and nonprimary care FTE counts. Using the information about Hospital X provided at the beginning of this example, complete Tab 1, cells D41 and D44, entering the current year allopathic and osteopathic weighted

primary care/OB/GYN and nonprimary care FTEs, respectively, including displaced FTEs. (D41 = 45.00 and D44 = 38.00).

See the chart at the bottom of Tab 1 to obtain the FTE counts to report on the appropriate cost report lines, either before the rolling average or after the rolling average. Click on cells C47 and C49 of Tab 1, and then click on the drop-down arrow to the right to switch the chart between Form 2552-96 and Form 2552-10. Choose Form 2552-10 for the current cost report because the FYE is 12/31/11, and choose Form 2552-96 as the prior year cost report because Form 2552-96 is the form to use for FYE 12/31/10.

III. Timeframe for Implementation

Contractors shall complete the business requirements in this CR as part of the normal settlement and reopening processes. If the SSI ratios for a fiscal year are not available (e.g., FY 2010), those cost reports that are impacted by CR 7746 shall not be settled.

Once a hospital's CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).

At this point, we are not instructing contractors to issue revised tentative settlements on any open cost reports for any cost report revisions made pursuant to this CR resulting in additional monies due to the hospitals. However, if an extended period of time occurs between proposing the adjustments to incorporate the DGME and/or IME cap increases and the final settlement of the cost report, contractors may consider issuing a subsequent tentative settlement.

Contractors shall use the provider's IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7746.1	Contractors shall refer to the hospital's section 5506 award letter or CMS website (go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html, and for Round 1, click on Section 5506 Cap Increases Related to Applications Due April 1, 2011 in the Downloads section, and for Round 2, click on the "Section 5506 Cap Increases Round 2 – Applications due Dec 1, 2011" link in the Downloads section of the page) to identify any cap increases that are effective during cost reports that have	x		x							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CF	
	already been filed.										
7746.2	Contractors and hospitals shall use the excel spreadsheet called CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the proper FTE counts and section 5506 adjustments to be reported on each applicable cost report in which there were displaced residents and/or a section 5506 cap increase.	x		x							
7746.3	Contractors shall determine if the hospital's cost report was filed on CMS Form 2552-96 or CMS Form 2552-10. If it was filed on CMS Form 2552-96, then proceed to BR 7746.4. If it was filed on CMS Form 2552-10, then skip to BR 7746.10.	x		x							
7746.4	If the Form 2552-96 cost report has been settled as of the implementation date of this CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	x		x							
7746.5	If the Form 2552-96 cost report has NOT been settled, and the desk review/audit has not been completed as of the date of this CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to BR 7746.7 and incorporate the applicable steps in this CR into the desk review.	x		x							
7746.6	If the Form 2552-96 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to BR 7746.7 and complete the applicable steps in this CR before settling the cost report.	x		x							
7746.7	For Form 2552-96 Cost Reports: Contractors shall report the amount of the section 5506 cap increase for IME and/or direct GME respectively that *is effective during the cost report that the contractors are amending* on worksheet S-3, Part I, line 17. Contractors shall use column 7 for the IME cap increase and column 8 for the direct GME cap increase. Proceed to BR 7746.8.	x		x							
7746.8	IME: On worksheet E, Part A, line 3.06, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly.	x		x							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CF	
	Contractors shall proceed through lines 3.07 through 3.24 on worksheet E, Part A, to recalculate the hospital's IME payment on that cost report.										
7746.9	Direct GME: On worksheet E-3, Part IV, line 3.03, contractors shall enter the amount of the section 5506 cap increase applicable to this cost reporting period. If the effective date of the cap increase is not the same as the fiscal year begin date, then prorate the cap increase accordingly. Contractors shall proceed through lines 3.04 through 6.08 on worksheet E-3, Part IV, to recalculate the hospital's direct GME payment on that cost report.	x		x							
7746.10	For Form 2552-10 Cost Reports: If the Form 2552-10 cost report has been settled as of the date of the CR, the contractor shall reopen the cost report for purposes of including the section 5506 direct GME and/or IME cap increase(s) applicable to this cost reporting period. Contractors shall process the reopening regardless of their reopening threshold amount.	x		x							
7746.11	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has NOT been completed as of the date of the CR, when the contractor performs the desk review/audit for this cost report, the contractor shall proceed to BR 7746.13 and incorporate the applicable steps in this CR into the desk review.	x		x							
7746.12	If the Form 2552-10 cost report has NOT been settled and the desk review/audit has been completed as of the date of the CR, the contractor shall proceed to BR 7746.13 and complete the applicable steps in this CR before settling the cost report.	x		x							
7746.13	IME: Contractors shall report the amount of the section 5506 cap increase for IME on worksheet E, Part A, line 8.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E, Part A, making revisions as necessary. The number of times line 8.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 8.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes.	x		x							
7746.14	Direct GME: Contractors shall report the amount of the section 5506 cap increase for direct GME on worksheet	x		x							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CF	
	E-4, line 4.02 *applicable to this cost reporting period*, and proceed through the rest of Worksheet E-4, making revisions as necessary. The number of times line 4.02 and its subscripts are filled out shall equal the number of times the hospital receives awards on the web file and the number of award letters the hospital receives for each respective round. Line 4.02 shall only be subscripted to report slots awarded from *different* rounds of section 5506; that is, from different CMS application processes.										
7746.15	Contractors shall refer to section II of the CR 7746 for detailed instructions on completing worksheets E, Part A, E-3, Part IV, and E-4.	x		x							
7746.16	Contractors shall use the spreadsheet CR 7746 Section 5506 Temp Adj Calc.xlsx that is provided with this CR to determine the amount of temporary cap adjustment, if any, a hospital qualifies for in a cost reporting period, and how to report the section 5506 cap adjustments and FTE counts on the cost report. Complete Tab1 for a hospital if the hospital was training displaced residents from closed hospitals in the particular cost reporting period you are working on, AND also received a section 5506 award(s) applicable in that cost reporting period. Complete Tab2 if the hospital was training displaced residents from closed hospitals in this cost reporting period, AND a portion of the displaced residents were from closed hospitals that had caps slots redistributed under Round 1 or Round 2 of section 5506, AND the hospital received a section 5506 award(s) under Round 1 or Round 2 applicable during this cost reporting period. Complete Tabs3 and 4 for all hospitals that received a section 5506 cap award(s), even if the hospital did not train displaced residents in this cost reporting period.	x		x							
7746.17	Contractors shall follow and implement the instructions in section II.A. for IME and section II.B. for direct GME of this CR 7746. Contractors shall ask a hospital to provide any FTE information for IME and for direct GME respectively (including unweighted, weighted, and displaced FTE information) that the contractor requires in order to implement this CR 7746.	x		x							
7746.18	Contractors shall complete the business requirements in this CR as part of the normal settlement and reopening processes. If the SSI ratios for a fiscal year are not										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CF	
	available (e.g., FY 2010), those cost reports that are impacted by CR 7746 shall not be settled. Once a hospital's CMS Form 2552-96 or Form 2552-10 cost report has been adjusted and is ready to be settled, contractors shall issue a Notice of Program Reimbursement (NPR) for open cost reports and a revised NPR for those cost reports reopened for purposes of including the section 5506 direct GME and/or IME cap increase(s).										
7746.19	Contractors shall use the provider's IME and direct GME FTE resident caps as adjusted by section 5506 when completing the next scheduled interim rate review for these hospitals.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CF	
7746.20	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	x		x							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Miechal Lefkowitz (212) 616-2517, Renate Dombrowski (410) 786-4645

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

Provider Name
Provider No.
FYB
FYE

Displaced Resident Cost Report Calculation

PURPOSE: To report IME and DGME displaced resident FTEs due to the closure of another teaching hospital and/or program on the Medicare cost report
Complete Tab1 if the provider has displaced residents but no section 5506 cap awards, OR complete Tab1 if the provider has displaced residents *and* section 5506 award(s)

= Input cell

DGME

DGME adjusted cap, including ACA 5506 add-on *(E-4 line 5)*	
CY unwtd A&O FTEs w/o displaced residents	
CY unwtd A&O displaced resident FTEs	
CY total unwtd A&O FTEs *(including displaced residents)*	0.00
FTEs over the CAP	0.00
Portion of unwtd displaced FTEs not over the cap *(if negative or zero, all displaced FTEs are in excess of cap)*	0.00
Potential unwtd temp. cap adjustment for displaced residents	0.00
Unwtd temp cap adj for displaced residents	0.00
Ratio of unwtd temp cap adj to total displaced FTEs	0.00
CY weighted displaced FTEs Prim. Care&OBGYN	
CY weighted displaced FTEs Non Primary Care	
Final temp. cap adj. wghtd displ. FTEs Prim. Care&OBGYN	0.00
Final temp. cap adj. wghtd displ. FTEs Non-Primary Care	0.00
	0.00
CY wghtd primary care and OBGYN FTEs *(including displaced residents)*	
CY wghtd NonPrim.Care FTEs (excl. dent. & podiatry) *(including displaced residents)*	

IME

IME adjusted cap, including ACA 5506 add-on *(E Part A line 9)*	
CY unwtd A&O FTEs w/o displaced residents	
CY unwtd A&O displaced resident FTEs	
CY total unwtd A&O FTEs *(including displaced residents)*	0.00
FTEs over the CAP	0.00
Portion of unwtd displaced FTEs not over the cap *(if negative or zero, all displaced FTEs are in excess of cap)*	0.00
Potential Temp. cap adjustment for displaced residents	0.00
Total temp. cap adjustment for displaced residents	0.00

Prior Year Resident-to-Bed Ratio:

Prior Year allowable IME FTEs		*(PY E part A line 12)*
Add on for increase in affiliation FTEs		
Add on for new programs in initial yrs		
Add on for CY displaced residents	0.00	
Prior Year numerator	0.00	
Prior Year available beds		*(PY E Part A line 4)*
Revised IRB Ratio	0.000000	

formula = (PY FTE+affiliation increase+new programs in initials years + CY add on for displaced residents)/PY Beds

CY Cost Reporting Form: 2552-10
(2552-96 or 2552-10) Click on cell C47 to access the down arrow to toggle between 2552-96 and 2552-10.

Prior Year Cost Reporting Form 2552-10
(2552-96 or 2552-10) Click on cell C49 to access the down arrow to toggle between 2552-96 and 2552-10.

COST REPORT ENTRIES:

W/S	Line	Column	Adjustment
E-4	6	1	0.00
E-4	8	1	0.00
E-4	16	1	0.00
E-4	8	2	0.00
E-4	16	2	0.00
E, part A	10	1	0.00
E, part A	17	1	0.00
E, part A	20	1	0.000000

Regulation 42 CFR Sec. 412.105(f)(1)(v), 413.79(h) & (i) & (m)
Reference CMS Pub 15-2 Sec. 4030.1, 4034

Provider Name
Provider No.
FYB
FYE

Displaced Resident Cost Report Calculation

PURPOSE: To calculate the net temporary cap adjustment for displaced residents when there is also a round 1 or round 2 ACA 5506 cap award

Complete this worksheet only IF:
The provider was training displaced residents from closed hospitals in this cost reporting period
AND
A portion of the displaced residents were from closed hospitals that had caps slots redistributed under round 1 or round 2 of ACA 5506
AND
The provider received cap awards from round 1 or 2 of ACA 5506 for this cost reporting period
OTHERWISE
Leave this schedule blank

1)	IME Calculation	
a.	Section 5506 cap awards applicable to this cost report from round 1	0.00
b.	Section 5506 cap awards applicable to this cost report from round 2	0.00
c.	unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506	
d.	unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506	
e.	Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)	0.00
f.	Total displaced FTE resident count	0.00
g.	Portion of displaced FTE residents potentially eligible for temporary cap adjustment	0.00
h.	Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards	0.00
i.	Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)	0.00
j.	Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)	0.00
k.	Total allowable temporary cap adjustment for displaced residents	0.00
2)	DGME Calculation	
a.	Section 5506 cap awards applicable to this cost report from round 1	0.00
b.	Section 5506 cap awards applicable to this cost report from round 2	0.00
c.	unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 1 of section 5506	
d.	unweighted A&O displaced FTE resident count for residents relating to closed hospitals in round 2 of section 5506	
e.	Remaining unweighted A&O displaced FTE resident count (not associated with round 1 or round 2)	0.00
f.	Total displaced FTE resident count	0.00
g.	Portion of displaced FTE residents potentially eligible for temporary cap adjustment	0.00
h.	Priority 1 - Temporary adj. for displaced residents not associated with round 1 or 2 awards	0.00
i.	Priority 2 - Temporary adj. for round 1 displaced residents (portion in excess of cap less round 1 section 5506 award)	0.00
j.	Priority 3 - Temporary adj. for round 2 displaced residents (portion in excess of cap less round 2 section 5506 award)	0.00
k.	Unwtd temp cap adj for displaced residents	0.00
l.	Determine what portion of step k. should be added to the primary care rolling avg and/or to the non-primary care rolling avg	
m.	Weighted portion to be added to the primary care/OB/GYN rolling avg on 2552-96 E-3 Pt IV line 3.22 or 2552-10 E-4 line 16	0.00
n.	Weighted portion to be added to the non-primary care rolling avg on 2552-96 E-3 Pt IV line 3.16 or 2552-10 E-4 line 16	0.00
o.	Total adjustment to DGME rolling average	0.00

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 1											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 2											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 3

DGME				IME				Detail of Award Applicable to this Cost Reporting Period: DGME		Detail of Award Applicable to this Cost Reporting Period: IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F)	**0.00**
Total IME slots per this round (sum of Col. I + L)	**0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)	**N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)	**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 4											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 5											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 6											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 7

DGME				IME				Detail of Award Applicable to this Cost Reporting Period			
								DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet. Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 8											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 9											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 10

DGME				IME				Detail of Award Applicable to this Cost Reporting Period			
								DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F) **0.00**
Total IME slots per this round (sum of Col. I + L) **0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O) **N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R) **N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 11

DGME				IME				Detail of Award Applicable to this Cost Reporting Period			
								DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 12

DGME				IME				Detail of Award Applicable to this Cost Reporting Period			
								DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

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Round 13											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			**0.00**								
Total IME slots per this round (sum of Col. I + L)							**0.00**				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									**N/A**		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 14											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 15

DGME				IME				Detail of Award Applicable to this Cost Reporting Period			
								DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F)	**0.00**
Total IME slots per this round (sum of Col. I + L)	**0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)	**N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)	**N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 16

DGME				IME				Detail of Award Applicable to this Cost Reporting Period: DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F) **0.00**
Total IME slots per this round (sum of Col. I + L) **0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O) **N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R) **N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 17

DGME				IME				Detail of Award Applicable to this Cost Reporting Period: DGME		Detail of Award Applicable to this Cost Reporting Period: IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F) **0.00**
Total IME slots per this round (sum of Col. I + L) **0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O) **N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R) **N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 18											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date
Total DGME slots per this round (sum of Col. C + F)			0.00								
Total IME slots per this round (sum of Col. I + L)							0.00				
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O)									N/A		
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R)											N/A

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To list the IME and DGME FTE cap awards and effective dates to transfer to "Tab4 ACA 5506 Cap Award Summary" worksheet.
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents

Note: List the cap awards by each round awarded by CMS. Be sure to capture the cap awards in the correct round. If the hospital did not receive cap increases in a particular round or that round has not yet occurred, leave that section blank.

= Input cell

Round 19											
								Detail of Award Applicable to this Cost Reporting Period			
DGME				IME				DGME		IME	
Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Effective date for Cost Reports Beginning After:	Slots	Slots Effective:	Slots	Slots Per CR Begin Date	Slots Per Effective Date	Slots Per CR Begin Date	Slots Per Effective Date

Total DGME slots per this round (sum of Col. C + F) **0.00**
Total IME slots per this round (sum of Col. I + L) **0.00**
Total DGME slots per this round applicable to this cost reporting period (sum of Col. N + O) **N/A**
Total IME slots per this round applicable to this cost reporting period (sum of Col. Q + R) **N/A**

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

PURPOSE: To report IME and DGME FTE cap awards per ACA Section 5506 on the Medicare cost report
Tabs 3 and 4 are completed by all providers that received section 5506 cap awards, even if the providers did not train displaced residents.

= Input cell

DGME

1) Number of award rounds applicable to this cost reporting period: 0

2)

Enter in chronological order the Applicable Round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Obtain the amounts from Tab3 ACA 5506 Cap Award Detail, col. O. For example, if the hospital received slots under Round 1, enter 1 into cell B19. Obtain the Round 1 Increase Per Round to enter into cell C19 from Tab 3, cell O54. If the hospital did not receive slots under Round 1 but did receive slots under Round 2, enter 2 into cell B19. Obtain the Round 2 Increase Per Round to enter into cell C19 from Tab 3, cell O95. If the hospital received slots under Round 1 and Round 2, enter 1 into cell B19, and obtain the Round 1 Increase Per Round to enter into cell C19 from Tab 3, cell O54; enter 2 into cell B20, and obtain the Round 2 Increase Per Round to enter into cell C20 from Tab 3, cell O95. If the hospital did not receive slots in a particular Round, do not enter any information for that Round.

Applicable Round #	Increase Per Round

Applicable Round #	Increase Per Round

Total 0.00

IME

3) Number of award rounds applicable to this cost reporting period: 0

4)

Enter in chronological order the Applicable Round and the cumulative section 5506 cap award effective during prior and current cost reporting periods. Obtain the amounts from Tab3 ACA 5506 Cap Award Detail, col. R. For example, if the hospital received slots under Round 1, enter 1 into cell B36. Obtain the Round 1 Increase Per Round to enter into cell C36 from Tab 3, cell R55. If the hospital did not receive slots under Round 1 but did receive slots under Round 2, enter 2 into cell B36. Obtain the Round 2 Increase Per Round to enter into cell C36 from Tab 3, cell R96. If the hospital received slots under Round 1 and Round 2, enter 1 into cell B36, and obtain the Round 1 Increase Per Round to enter into cell C36 from Tab 3, cell R55; enter 2 into cell B37, and obtain the Round 2 Increase Per Round to enter into cell C37 from Tab 3, cell R96. If the hospital did not receive slots in a particular Round, do not enter any information for that Round.

Applicable Round #	Increase Per Round

Applicable Round #	Increase Per Round

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

Total 0.00

Provider Name
Provider No.
FYB
FYE

ACA 5506 IME and DGME FTE Cap Awards

CY Cost Reporting Form: 2552-96
(2552-96 or 2552-10) Click on cell D49 to access the down arrow to toggle between 2552-96 and 2552-10.

COST REPORT ENTRIES:

W/S	Line	Column	Adjustment
S-3, Part I	17	7	0.00
S-3, Part I	17	8	0.00
E-3 Part IV	3.03	1	0.00
E, Part A	3.06	1	0.00

Regulation 42 CFR Sec. 412.105(f)(1)(v), 413.79(h) & (i) & (m)
Reference CMS Pub 15-2 Sec. 3600, 3633.4