Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers April 2011

Features

'Partnership for Patients' to improve care and lower costs for Americans

New partnership between the administration, private sector, hospitals, and doctors will make patient care safer and potentially save up to $50 billion

Health and Human Services Secretary Kathleen Sebelius, joined by leaders of major hospitals, employers, health plans, physicians, nurses, and patient advocates, announced the creation of the "Partnership for Patients," a new national partnership that will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next three years. The Partnership for Patients also has the potential to save up to $35 billion in health care costs, including up to $10 billion for Medicare. Over the next 10 years, the Partnership for Patients could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings. Already, more than 500 hospitals, as well as physicians and nurses groups, consumer groups, and employers have pledged their commitment to the new initiative.

"Americans go the hospital to get well, but millions of patients are injured because of preventable complications and accidents," said Secretary Sebelius. "Working closely with hospitals, doctors, nurses, patients, families and employers, we will support efforts to help keep patients safe, improve care, and reduce costs. Working together, we can help eliminate preventable harm to patients."

Leaders from across the nation pledged their commitment to this new initiative. To launch this initiative, the Department of Health and Human Services (HHS) announced it would invest up to $1 billion in federal funding, made available under the Affordable Care Act. On Tuesday, April12, $500 million of that funding was made available through the Community-based Care Transitions Program. Up to $500 million more will be dedicated from the Centers for Medicare & Medicaid Services (CMS) Innovation Center to support new demonstrations related to reducing hospital-acquired conditions. The funding will be invested in reforms that help achieve two shared goals:

- Keep hospital patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40-percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.
- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20-percent compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

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

Publication staff:
Cindi Fox
Terri Drury
Mark Willett
Robert Petty

Fax questions and comments about this publication to:

Medicare Publications
904-361-0723

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

The Medicare B Connection

About the *Medicare B Connection*

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Part B providers in Florida, Puerto Rico, and U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to FCSO Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the Connection be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The Connection is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- . **Educational Resources**, and
- **Addresses, and Phone Numbers, and Websites** for Florida and the U.S. Virgin Islands.

The Medicare B Connection represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

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

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.
Providers may access the Quarterly Provider Update by going to the CMS website at *http://www.cms.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131 form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms – the General Use form (CMS-R-131G) and the Laboratory Tests form (CMSR-131L). Both are standard forms that may not be modified; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/BNI/01_overview.asp#TopOfPage*.

Note: Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6136.pdf*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (wavier of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the Contact Information section of this publication for the address in which to send written appeals requests.

Ambulatory Surgical Center

April 2011 update of the ambulatory surgical center payment system

Provider types affected

This article is for ambulatory surgical centers (ASCs) that submit claims to Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider action needed

This article is based on change request (CR) 7343 which describes changes to and billing instructions for payment policies implemented in the April 2011 ASC payment system update. CR 7343 also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Background

Policy under the revised ASC payment system requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly.

In addition, the other key ASC updates effective on April 1, 2011, are as follows:

New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective April 1, 2011

Four new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after April 1, 2011. The new HCPCS codes, the short descriptors, the long descriptors, and payment indicators are identified in Table 1.

The new separately payable drug and biological codes and their payment rates are included in the April 2011 ASC DRUG file.

Table 1 New drugs and biologicals separately payable under the ASC payment system, effective April 1, 2011

HCPCS code	Long descriptor	Short descriptor	Payment indicator
C9280	Injection, eribulin mesylate, 1 mg	Injection, eribulin mesylate	K2
C9281	Injection, pegloticase, 1 mg	Injection, pegloticase	K2
C9282	Injection, ceftaroline fosamil, 10 mg	Inj, ceftaroline fosamil	K2
Q2040*	Injection, incobotulinumtoxin A, 1 unit	Incobotulinumtoxin A	K2

Note: HCPCS code Q2040 is replacing HCPCS code C9278 beginning on April 1, 2011.

Updated payment rates for certain HCPCS codes, effective October 1-December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 and have been included in the revised October 2010 ASC DRUG file effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Suppliers who have received an incorrect payment for services provided on or between October 1, 2010, and December 31, 2010, may request their Medicare contractor to adjust the previously processed claims.

Table 2 Updated payment rates for certain HCPCS codes, effective October 1-December 31, 2010

HCPCS code	Short descriptor	ASC payment rate	Payment indicator
J0833	Cosyntropin injection NOS	$51.32	K2
J1451	Fomepizole, 15 mg	$7.14	K2
J3030	Sumatriptan succinate / 6 MG	$45.71	K2
J7502	Cyclosporine oral 100 mg	$3.04	K2
J7507	Tacrolimus oral per 1 MG	$3.18	K2
J9185	Fludarabine phosphate inj	$162.67	K2
J9206	Irinotecan injection	$7.45	K2
J9218	Leuprolide acetate injection	$4.50	K2
J9263	Oxaliplatin	$4.52	K2

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Updated payment rate for HCPCS code Q4118 effective January 1, 2011, through March 31, 2011
The payment rate for HCPCS code Q4118 was incorrect in the January 2011 ASC DRUG file. The corrected payment rate is listed in Table 3 and has been included in the revised January 2011 ASC drug file, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Suppliers who think they may have received an incorrect payment between January 1, 2011, and the implementation of the April 2011 update, may request contractor adjustment of the previously processed claims.

Table 3 Updated payment rate for HCPCS code Q4118, effective January 1-March 31, 2011

HCPCS code	Short descriptor	ASC payment rate	Payment indicator
Q4118	Matristem micromatrix	$3.19	K2

Corrected payment indicator for HCPCS code Q4119 effective January 1, 2011, through March 31, 2011
In the January 2011 update, HCPCS code Q4119 was assigned to payment indicator "Y5." This payment indicator will be updated for the April 2011 update. Specifically, the payment indicator for Q4119 will be updated from "Y5" to "K2" retroactive to January 1, 2011. The corrected payment indicator and payment rate is listed in Table 4 and has been included in the revised January 2011 ASC drug file, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Suppliers who think they may have received an incorrect payment between January 1, 2011, and March 31, 2011, inclusive, may request contractor adjustment of the previously processed claims.

Table 4 Updated payment rate for HCPCS code Q4119, effective January 1-March 31, 2011

HCPCS code	Short descriptor	ASC payment rate	Payment indicator
Q4119	Matristem wound matrix	$5.62	K2

HCPCS code Q1003 deleted, effective April 1, 2011
Effective April 1, 2011, HCPCS code Q1003 (New technology intraocular lens category 3 (reduced spherical aberration)) will no longer be reportable under the ASC payment system. ASCs were instructed to report HCPCS code Q1003 to bill for a Category 3 NTIOL associated with reduced spherical aberration from February 27, 2006, through February 26, 2011. As stated in the January 2011 ASC update (Transmittal 2128, change request 7275, dated December 29, 2010), because this NTIOL category expired February 26, 2011, CMS assigned HCPCS code Q1003 to a packaged code indicator (PI= N1) for dates of service beginning February 27, 2011. Since HCPCS code Q1003 will be deleted, HCPCS code Q1003 will be reassigned from a packaged code indicator (PI=N1) to a deleted payment indicator (PI=D5) effective April 1, 2011.

Additional information

The official instruction, CR 7343 issued to your carrier and MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2185CP.pdf*. If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7343
Related Change Request (CR) #: 7343
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Related CR Transmittal #: R2185CP
Implementation Date: April 4, 2011

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.

Consolidated Billing

July 2011 update to skilled nursing facility consolidated billing provision

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7345 which provides the July quarterly update to the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) codes used for SNF CB enforcement.

Caution – what you need to know

Changes to *Current Procedural Terminology* (*CPT*)/HCPCS codes and Medicare physician fee schedule designations will be used to revise Medicare systems to allow your Medicare contractor(s) to make appropriate payments in accordance with policy for SNF consolidated billing in the *Medicare Claims Processing Manual* (Chapter 6, Section 20.6).

Go – what you need to do

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

Background

The Social Security Act (Section 1888; see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*) codifies skilled nursing facility (SNF) prospective payment system (PPS) and consolidated billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are excluded from the consolidated billing (CB) provision of the SNF PPS.

The new coding identified in each update describes the same services that are subject to SNF PPS payment by law, and no additional services are added by these routine updates. The new updates are required because of changes to the coding system, not because the services subject to SNF CB are being redefined.

Services excluded from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when the beneficiary is in a SNF stay.

Services not appearing on the exclusion lists submitted on claims to Medicare contractors (FIs, carriers, A/B MACs including durable medical equipment [DME] MACS) will not be paid by Medicare to any providers other than a SNF.

For non-therapy services:

- SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay.
- However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

Note: Codes added or terminated with this update are available at *http://www.cms.gov/SNFConsolidatedBilling/71_2011Update.asp*. A general explanation of the major categories for SNF CB can be found at *http://www.cms.gov/SNFConsolidatedBilling/Downloads/2011MajorCatExpl.pdf*.

CR 7345 instructs Medicare systems to **add**:

- *CPT* codes *74176, 74177,* and *74178* to Major Category I.A. (Exclusion of Services Beyond the Scope of an SNF (Computerized Axial Tomography (CT) Scans)) effective January 1, 2011
- HCPCS codes Q2035, Q2036, Q2037, Q2038, and Q2039 to Major Category IV.B. (U((Additional Excluded Preventive and Screening Services (Vaccines (Pneumococcal, Flu or Hepatitis B)) effective January 1, 2011
- HCPCS code G0105 to Major Category IV.E. (U((Additional Excluded Preventive and Screening Services (Colorectal Screening Services)) effective January 1, 2011
- *CPT* codes *93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93563, 93564, 93565, 93566, 93567*, and *93568* to Major Category I.B. (Exclusion of Services Beyond

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the Scope of an SNF (Cardiac Catheterization)) effective January 1, 2011, and

- *CPT* code *96466* to Major Category III.B (Additional Exclusion of Services Rendered by Certified Providers (Chemotherapy Administration)) effective January 1, 2011.

CR 7345 instructs Medicare systems to **terminate**:

- *CPT* code *90658* from Major Category IV.B. (U((Additional Excluded Preventive and Screening Services (Vaccines (Pneumococcal, Flu or Hepatitis B))) effective December 31, 2010, and
- *CPT* codes *93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544*, and *93545* from Major Category I.B. (Exclusion of Services Beyond the Scope of an SNF (Cardiac Catheterization)) effective December 31, 2010.

Note: Your Medicare contractor(s) will reprocess claims affected by this instruction when you bring those claims to their attention.

Additional Information

The official instruction, CR 7345, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2184CP.pdf*.

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

MLN Matters® Number: MM7345
Related Change Request (CR) #: 7345
Related CR Release Date: March 25, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2184CP
Implementation Date: July 5, 2011

Drugs and Biologicals

CMS issues proposed decision memorandum for PROVENGE®

The Centers for Medicare & Medicaid Services (CMS) issued a proposed decision memorandum to cover on-label use of Sipuleucel-T (PROVENGE®) under a national coverage determination on March 30. PROVENGE® is the only FDA-approved autologous cellular immunotherapy treatment for metastatic prostate cancer. It is labeled for use in men with asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Coverage of off-label use would be determined by Medicare's local contractors.

CMS will accept public comments on this proposed decision for 30 days. A final decision will be announced within 90 days.

For more details or to submit a public comment, please see the proposed decision memorandum at *http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=247&ver=8&NcaName=Autologous+Cellular+Immunotherapy+Treatment+of+Metastatic+Prostate+Cancer&bc=BEAAAAAAEAAA&*.

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

Source: CMS PERL 201104-09

July 2011 quarterly average sales price update and revision to prior files

Provider types affected

This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs], or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7357, which instructs Medicare contractors to download and implement the July 2011 average sales price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2011, January 2011, October 2010, and July 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2011, with dates of service July 1, 2011, through September 30, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies 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.

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

Files	Effective for dates of service
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010

Additional information

If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction (CR 7357) issued to your Medicare MAC, carrier, and FI may be found at *http://www.cms.gov/transmittals/downloads/R2182CP.pdf*.

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Updated October 2010 and January 2011 average sales price files now available

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 average sale price (ASP) pricing files, which are available for download at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

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

Source: CMS PERL 201104-02

Hospice

Home health and hospice face-to-face encounter requirement

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects that home health agencies and hospices will have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she or a non-physician practitioner working with the physician, has seen the patient. The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care. Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3131(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification and with each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance with the requirements, beginning with the second quarter of calendar year (CY) 2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a *MLN Matters* article, questions and answers documents, training slides, and manual instructions which are available via CMS' home health agency center and hospice Web pages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements and will update information on its website at *http://www.cms.gov/center/hha.asp* and *http://www.cms.gov/center/hospice.asp*.

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

Source: CMS PERL 201104-43, 201104-31, 201103-63

Laboratory/Pathology

Clinical laboratory fee schedule – removal of test code G0431QW and addition of test code G0434QW

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the clinical laboratory fee schedule (CLFS):

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a modifier QW; the modifier QW indicates a Clinical Laboratory Improvement Amendments (CLIA) waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the modifier QW to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

Source: CMS PERL 201104-18

Signature on requisition for clinical diagnostic laboratory tests

In the Monday, November 29, 2010, Medicare physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from the community, CMS has decided to focus the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Source: CMS PERL 201103-64

General Coverage

New information to improve patient safety at America's hospitals

Hospital compare website offers new data about hospital acquired conditions at more than 4,700 hospitals across the nation

For the first time, Medicare patients can see how often hospitals report serious conditions that develop during an inpatient hospital stay and possibly harm patients. Important new data about the safety of care available in America's hospitals has been added to the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare website.

The Hospital Compare website can be accessed at *http://www.HealthCare.gov/compare*.

"Any potentially preventable complication of care is unacceptable," said CMS Administrator Donald Berwick, M.D. "We at CMS are working together with the hospital and consumer community to bring hospital acquired conditions into the forefront and do all we can to eliminate harm from the very healthcare system intended to heal us."

These serious conditions, also known as hospital acquired conditions (or HACs), often result from improper procedures followed during inpatient care. The data release shows the number of times a HAC occurred for Medicare fee-for-service patients between October 2008 and June 2010. The numbers are reported as number of HACs per 1,000 discharges, and are not adjusted for hospitals' patient populations or case-mix.

Independent data from the Institute of Medicine estimates that as many as 98,000 people die in hospitals each year from medical errors that could have been prevented through proper care. Although not every HAC represents a medical error, the HAC rates provide important clues about the state of patient safety in America's hospitals. In particular, HACs show how often the following potentially life-threatening events take place:

- Blood infections from a catheter placed in the hospital
- Urinary tract infections from a catheter placed in the hospital
- Falls, burns, electric shock, broken bones, and other injuries during a hospital stay
- Blood transfusions with incompatible blood
- Pressure ulcers (also known as bed sores) that develop after a patient enters the hospital
- Injuries and complications from air or gas bubbles entering a blood vessel
- Objects left in patients after surgery (such as sponges or surgical instruments)
- Poor control of blood sugar for patients with diabetes

In total, CMS reports HAC rates for eight measures, which were selected because they incur high costs to the Medicare program or because they occur frequently during inpatient stays for Medicare patients. Furthermore, HACs usually result in higher reimbursement rates for hospitals when they occur as complications for an

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New....(continued)

inpatient stay because they require more resources to care for the patient with the complication. Lastly, CMS considers HACs to be conditions that could have reasonably been prevented through the use of evidence-based guidelines for appropriate hospital inpatient care.

CMS has gathered HAC rates from hospitals since 2007. Since 2008, Medicare has not provided additional reimbursement for cases in which one of the HACs was reported as having developed through the course of a patient's hospital stay.

Rates for the eight HAC rates reported on Hospital Compare vary among hospitals. The most common HAC reported was injury from a fall or some other type of trauma, which occurred just once for every 2,000 discharges. Over 70 percent of hospitals reported at least one fall or trauma during the reporting period.

"Any potentially preventable complication of care is unacceptable"

Donald Berwick, M.D.
CMS Administrator

Rates for infection were also relatively common, with about 45 percent of hospitals reporting at least one blood or urinary tract infection developed during the hospital stay. Nationwide, a blood or urinary tract infection was reported once for every 3,300 discharges. Rates were lowest for instances of blood incompatibility, which was reported by less than 1 percent of hospitals and occurred once for every 1,000,000 discharges.

CMS is working with the members of the Hospital Quality Alliance – a national private-public partnership of hospital, consumer, provider, employer, payer, and government agencies – to make HAC data accessible to the public in meaningful, relevant, and easily understood ways that encourage health care quality improvement. Later this year, CMS will work with the Alliance and directly with consumers about how to fold HAC data directly into the Hospital Compare framework. For now, HAC data is available through a downloadable file linked to the Hospital Compare website.

CMS is also working with its Quality Improvement Organization (QIO) contractors and to give hospitals the resources they need to eliminate HACs as much as possible. For instance, QIOs have been working since 2008 with providers across the country to reduce rates of hospital-associated infections, slow rates of pressure ulcers in nursing homes and hospitals, and improve safety and reduce infection for surgery patients. More information about QIOs' efforts is online at *http://www.cms.gov/qualityimprovementorgs*.

In addition to information about HACs, Hospital Compare reports 25 inpatient and five outpatient process of care measures, readmission and mortality rates for certain conditions, three children's asthma care measures, and 10 measures that capture patient satisfaction with hospital care. The site also features information about the volume of certain hospital procedures performed and conditions treated for Medicare patients and what Medicare pays for those services.

The information contained on Hospital Compare is available for consumers to use in making health care decisions. However, consumers should gather information from multiple sources when choosing a hospital. For example, patients and caregivers could use the website to help them discuss plans of care with their trusted health care providers. In an emergency situation, patients should always go to the nearest, most easily accessible facility.

Consumers have relied on Hospital Compare since 2005 to provide information about the quality of care provided in over 4,700 of America's acute-care, critical access and children's hospitals. Hospital Compare is one of CMS' most popular websites, receiving about 1 million page views each month.

To review the HAC data CMS released today, please visit the "Hospital Spotlight" section of Hospital Compare online at *http://www.HealthCare.gov/compare*.

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

Source: CMS PERL 201104-15

Find fees faster: Try FCSO's fee schedule lookup

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

Implementation of the PWK (paperwork) segment for X12N version 5010

Note: This article was revised on April 21, 2011, to reflect a revised change request (CR) 7041 issued on April 20, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7041 have been revised. Also, a reference to *MLN Matters*® article SE1106 was added in the *Additional information* section to give important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service (FFS) implementation schedule and readiness assessments. This information was previously published in the November 2010 *Medicare B Update!* pages 24-25.

Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors [MACs], durable medical equipment [DME] MACs, and fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs]).

Provider action needed

This article is based on change request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 professional and institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at *http://www.cms.gov/Transmittals/downloads/R874OTN.pdf*.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

Additional information

If you have questions, please contact your MAC and/or FI/carrier at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at *http://www.cms.gov/Transmittals/downloads/R874OTN.pdf*.

You may also want to review *MLN Matters*® article MM7306 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7306.pdf*.

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Implementation....(continued)

You may also want to review *MLN Matters*® article SE1106 available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1106.pdf* for important reminders about the implementation of HIPAA 5010 and D.O., including FFS implementation schedule and readiness assessments.

MLN Matters® Number: MM7041 *Revised*
Related Change Request (CR) #: 7041
Related CR Release Date: April 20, 2011
Effective Date for Providers: July 1, 2011
Related CR Transmittal #: R874OTN
Implementation Date: July 5, 2011

Implementation of errata for version 5010 – priority (type) of admission or visit code and reason code 11701

The Centers for Medicare & Medicaid Services (CMS) does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The priority (type) of admission or visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (information not available). Additional priority (type) of admission or visit code values and descriptions are available from the National Uniform Billing Committee (*www.NUBC.org*) or from your servicing Medicare administrative contractor (MAC). The priority (type) of admission or visit code is not required on 4010A1 institutional claims submitted or corrected via an 837.

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

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

Source: CMS PERL 201104-22

Version 5010 transaction standards deadline is approaching

There are less than 10 months until all HIPAA-covered entities need to transition from version 4010/4010A1 to version 5010 electronic transaction standards. With the January 1, 2012, deadline quickly approaching; you need to have taken the necessary steps to get ready.

Unlike the current version 4010/4010A1, version 5010 accommodates the ICD-10 codes and must be in place before the change over to ICD-10 on October 1, 2013. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code.

A key step in preparing your office for this upgrade is testing transactions in the new version 5010 format. **If you have not already done so, you should begin external version 5010 testing now**.

Testing transactions using version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will also allow you to identify any potential issues and address them in advance of the January 1, 2012, compliance date.

Keep up-to-date on version 5010 and ICD-10

CMS has resources to help you prepare. Visit *http://www.cms.gov/ICD10* and click on “Version 5010.”

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

Source: CMS PERL 201103-57

General Information

'Partnership....(continued from page 1)

The Partnership will target all forms of harm to patients but will start by asking hospitals to focus on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country. Examples include preventing adverse drug reactions, pressure ulcers, childbirth complications, and surgical site infections. The CMS Innovation Center will help hospitals adapt effective, evidence-based care improvements to target preventable patient injuries on a local level, developing innovative approaches to spreading and sharing strategies among public and private partners in all states. Members of the partnership will identify specific steps they will take to reduce preventable injuries and complications in patient care.

"With new tools provided by the Affordable Care Act, we can aggressively implement programs that will help hospitals reduce preventable errors," said CMS Administrator Donald Berwick, M.D. "We will provide hospitals with incentives to improve the quality of health care, and provide real assistance to medical professionals and hospitals to support their efforts to reduce harm."

"we are supporting the hospital community to significantly reduce harm to patients."

Donald Berwick, M.D.
CMS Administrator

HHS has committed $500 million to community-based organizations partnering with eligible hospitals to help patients safely transition between settings of care. Today, community-based organizations and acute care hospitals that partner with community-based organizations can begin submitting applications for this funding. Applications are being accepted on a rolling basis. Awards will be made on an ongoing basis as funding permits.

In coordination with stakeholders from across the health care system, the CMS Innovation Center is planning to use up to $500 million in additional funding to test different models of improving patient care and patient engagement and collaboration in order to reduce hospital-acquired conditions and improve care transitions nationwide. These collaborative models will help hospitals adopt effective interventions for improving patient safety in their facilities.
The programs are just two of the many ways the Affordable Care Act is helping improve the health care system. Last month, HHS announced the first-ever National Quality Strategy, which will serve as a tool to help coordinate quality initiatives between public and private partners as well as to leverage and coordinate existing efforts by federal agencies and departments to improve patient care. HHS also announced new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). By 2015, a portion of Medicare payments to the majority of hospitals will be linked to whether hospitals are delivering safer care, using information technology effectively and meeting patient needs. Payment incentives and supports to improve quality and lower costs will also be available to state Medicaid programs.

"No single entity can improve care for millions of hospital patients alone," said Berwick. "Through strong partnerships at national, regional, state and local levels – including the public sector and some of the nation's largest companies – we are supporting the hospital community to significantly reduce harm to patients."

For more information about the Partnership for Patients, visit *www.HealthCare.gov/center/programs/partnership*. For a fact sheet on the announcement, visit *www.HealthCare.gov/news/factsheets/partnership04122011a.html*. For more information about the Community-based Care Transitions Program funding opportunity, visit *www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313*.

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

Source: CMS PERL 201104-30

New proposed rules regarding the Medicare Shared Savings Program

The U.S. Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

The Centers for Medicare & Medicaid Services (CMS) has worked closely with other federal agencies, including the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC), and Internal Revenue Service (IRS) to ensure that providers and suppliers have the clear and practical guidance they need to form ACOs without running afoul of the fraud and abuse, antitrust, and tax laws. Concurrently with the publication of this proposed rule, the following documents have been issued: a joint CMS and OIG notice and solicitation of public comments on potential waivers of certain fraud and abuse laws in connection with the Medicare Shared Savings Program; a joint FTC and DOJ proposed antitrust policy statement; and an IRS notice requesting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, participating in the Medicare Shared Savings Program.

The proposed rule and joint CMS/OIG notice are posted at: *www.ofr.gov/inspection.aspx*.

For more information, read the fact sheet at *www.HealthCare.gov/news/factsheets/accountablecare03312011a.html*.

Comments on the proposed rule will be accepted until June 6, 2011, at *www.regulations.gov*.

CMS will respond to all comments in a final rule to be issued later this year.

The CMS dedicated website for providers of services and suppliers is *www.cms.gov/sharedsavingsprogram*.

The Proposed Antitrust Policy Statement is posted at: *www.ftc.gov/opp/aco/*.

The IRS Guidance and Solicitation of Comments will be posted at: *http://www.irs.gov/pub/irs-drop/n-11-20.pdf*.

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

Source: CMS PERL 201103-65

Sign-up for the ICD-10 industry update messages

Did you know that the Centers for Medicare & Medicaid Services (CMS) has an email update specific to ICD-10 that you can sign-up for?

The CMS ICD-10 industry e-mail update provides subscribers with timely information about the upcoming version 5010 and ICD-10 transitions. Each message is delivered directly to your email inbox, supplying helpful reminders, information on new resources, and other ICD-10 and version 5010 news. Recent messages have covered important topics, such as:

- The partial code freeze prior to ICD-10 implementation
- External testing of version 5010 transaction standards, and
- The general equivalence mappings (GEMs).

To sign up for the ICD-10 industry e-mail updates, or to view previous email updates, visit *http://www.CMS.gov/ICD10/02d_CMS_ICD-10_Industry_Email_Updates.asp*. To keep up to date on version 5010 and ICD-10, and for the latest news and resources, be sure to keep current with *http://www.CMS.gov/ICD10*.

Version 5010 and ICD-10 are coming. Will you be ready?

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

Source: CMS PERL 201103-54

Effective date of certified provider or supplier agreement or approval

Provider types affected

This article is for providers and suppliers subject to survey and certification requirements.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7232 which clarifies instructions regarding the determination of the effective date of certified provider agreement or supplier approval.

Caution – what you need to know

The *Code of Federal Regulations* (42 CFR 489.13) has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by the Centers for Medicare & Medicaid Services (CMS) legacy fiscal intermediary (FI), legacy carrier, or Medicare administrative contractor (MAC).

Go – what you need to do

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

Background

The fiscal year (FY) 2011 inpatient prospective payment system (IPPS) final rule was published on August 16, 2010 (75 FR50042) and was effective October 1, 2010 (see the FY 2011 IPPS final rule at *http://edocket.access.gpo.gov/2010/2010-19092.htm*). Several provisions in the FY 2011 IPPS final rule amend Section 489.13 of the *Code of Federal Regulations* (42 CFR 489.13) which governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. The revised Section 489.13 makes it clearer that:

- The date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and
- Such requirements include review and verification of an application to enroll in the Medicare program by the CMS legacy fiscal intermediary (FI), legacy carrier, regional home health intermediary (RHHI), or MAC.

You may review the revised 489.13 of the CFR at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=cbe4615ac0d1730fe7871c78553897f9;rgn=div2;view=text;node=20100816%3A1.77;idno=42;cc=ecfr;start=1;size=25*.

These clarifications were necessary because a September 28, 2009, decision of the Appellate Division of the Departmental Appeals Board (DAB) interpreted Section 489.13 as not including enrollment application processing among federal requirements that must be met. You may review the DAB Decision No. 2271 at *http://www.hhs.gov/dab/decisions/dabdecisions/dab2271.pdf*.

In that case a state agency had:

- Conducted a survey of an applicant on July 6, 2007, and
- Received the FI's notice on November 21, 2007, recommending the applicant's enrollment approval.

The CMS regional office (RO) issued a provider approval effective November 21, 2007 (the date the FI recommended the applicant's enrollment approval), consistent with our traditional interpretation of Section 489.13. However, the DAB ruled that the effective date must be July 6, 2007 (the date the survey was conducted).

The DAB agreed with the applicant in this case that the requirement for the Medicare contractor to verify and determine whether an application should be approved is:

- Not a requirement for the provider to meet (under Section 489.13), but rather
- A requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

In accordance with Section 2003B of the *State Operations Manual* (SOM), state agencies and accreditation organizations are aware that they should perform a survey of a new facility after the MAC/legacy FI/legacy carrier has provided notice that:

- The information on the enrollment application has been verified, and
- Enrollment is being recommended.

However, circumstances do occur when the sequence is reversed, i.e. the survey occurs prior to enrollment verification activities. Accreditation organizations, in particular, often find it challenging to confirm whether the MAC, FI, RHHI, or carrier has completed its review and made a recommendation, since they are dependent upon the applicant providing copies of the pertinent notices.

When the survey occurs prior to the enrollment verification activities, CMS believes it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application was verified and recommends approval.

There are other federal requirements not related to a facility's survey, such as the provision of required Office for Civil Rights documentation. Accordingly, the revised rule explicitly states in Section 489.13(b) that:

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Effective....(continued)

"Federal requirements include, but are not limited to –

1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;
2) The requirements identified in (Sections) 489.10 and 489.12; and
3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

Additional information

The official instruction, CR 7232, issued to your carriers, FIs, MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R372PI.pdf*. If you have any questions, please contact your carriers, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7232
Related Change Request (CR) #: 7232
Related CR Release Date: March 25, 2011
Effective Date: October 1, 2010
Related CR Transmittal #: R372PI
Implementation Date: April 25, 2011

Specialty code for advanced diagnostic imaging services

Note: This article was revised on April 12, 2011, to reflect a revised change request (CR) 7175 issued on April 12, 2011. In this article, the CR release date, transmittal number, the effective and implementation dates, and the Web address for accessing CR 7175 have changed. All other information is the same. This information was previously published in the November 2010 *Medicare B Update!* page 28.

Provider types affected

This article is for physicians, providers, and suppliers who submit claims to Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for providing diagnostic imaging services to Medicare beneficiaries.

What you need to know

CR 7175, from which this article is taken announces that (effective July 1, 2011) the Centers for Medicare & Medicaid Services (CMS) will establish a new specialty code (specialty code 95) for advanced diagnostic imaging (ADI) accreditation. (**Note**: Previously, CMS had designated this specialty code for the Competitive Acquisition Program for drugs project, the code will now be used for ADI accreditation.)

You should ensure that your billing staffs are aware of this new specialty code for ADI accreditation.

Additional information

The official instruction, CR 7175, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2192CP.pdf*. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7175 *Revised*
Related Change Request (CR) #: 7175
Related CR Release Date: April 12, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2192CP
Implementation Date: July 5, 2011

HCPCS public meeting agendas for drugs, biologicals, and radiopharmaceuticals

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of the May 17-18, 2011, Healthcare Common Procedure Coding System (HCPCS) public meeting agendas for drugs, biologicals, and radiopharmaceuticals. These documents and the link for the corresponding public meeting registrations are located on the HCPCS website at *http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp*.

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

Source: CMS PERL 201104-30

Healthcare Common Procedure Coding System code set update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web page at *http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp*. Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201104-01

Medicare enrollment application fees and new screening categories

Find out how the provider enrollment provisions, effective March 25, affect you. Learn more about the following:

1. Submission of provider application fees
2. Establishment of provider enrollment screening categories
3. Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type in a geographic area

MLN Matters® article MM7350 – titled "Implementation of Provider Enrollment Provisions in CMS-6028-FC" – explains how Medicare will implement the above provisions cited in the recent regulation (CMS-6028-FC). Available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*.

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

Source: CMS PERL 201104-05, 201103-60

CMS to release podiatry services comparative billing report

The Centers for Medicare & Medicaid Services (CMS) will release its fifth national provider comparative billing report (CBR) in April. The purpose of this CBR is to inform podiatric providers of billing information for selected services billed to Medicare and to help prevent improper payments. The data in this report illustrates peer comparisons of debridement codes billed, evaluation and management high level code use, and the number of patients billed per day in both the office and skilled nursing facility settings. The CBRs will be released to approximately 5,000 podiatry providers nationwide.

The CBRs, produced by SafeGuard Services, under contract with CMS, provide comparative data on how an individual healthcare provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers. These reports are not available to anyone but the provider who receives them. To ensure privacy, CMS presents only summary billing information. No patient- or case-specific data is included. These reports are an example of a tool that helps providers comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients.

For more information and to review a sample of the podiatry CBR, please visit the CBR Services website at *www.CBRServices.com* or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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

Source: CMS PERL 201104-08

Incentive Programs

Announcement regarding the Physician Quality Reporting System

The Centers for Medicare & Medicaid Services (CMS) has announced that the Physician Quality Reporting System URL has changed.

In the calendar year 2011 Medicare physician fee schedule final rule that was published in the *Federal Register* on November 29, 2010, CMS announced the renaming of the Physician Quality Reporting Initiative (PQRI) to the Physician Quality Reporting System. As a result of the name change, the Physician Quality Reporting System's Web page URL address has also changed.

The new URL address is *http://www.cms.gov/pqrs*. The previous URL address (*http://www.cms.gov/pqri*) will automatically redirect to the new URL address.

Please note that educational materials and content that currently refer to PQRI will be changed over time to reflect the new name.

The Physician Quality Reporting System Web page will be updated regularly, so check it often for timely and reliable information from CMS.

In order to receive important information on the Physician Quality Reporting System and the electronic prescribing (eRx) incentive program, subscribe to Medicare fee-for-service physician listserv at *https://list.nih.gov/cgi-bin/wa.exe?A0=physicians-l*.

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

Source: CMS PERL 201104-27

Your Feedback Matters

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

Program reminder: 2011 electronic prescribing incentive – avoiding the adjustment

In November, the Centers for Medicare & Medicaid Services (CMS) announced that beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between January 1, 2011-June 30, 2011, may be subject to a payment adjustment on their Medicare Part B physician fee schedule (PFS) covered professional services. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx incentive program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99 percent of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5 percent of their Medicare Part B PFS covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2 percent, resulting in an eligible professional or group practice receiving 98 percent of their Medicare Part B PFS covered professional services.

The payment adjustment does not apply if less than 10 percent of an eligible professional's (or group practice's) allowed charges for the January 1, 2011, through June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx measure.

Please note that earning an eRx incentive for 2011 will not necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to avoid the 2012 eRx payment adjustment

Eligible professionals – an eligible professional can avoid the 2012 eRx payment if he/she:

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in National Plan & Provider Enumeration System (NPPES);
- Does not have prescribing privileges. **Note**: He/she must report (G8644) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber by reporting the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure. For successful reporting under the 2011 eRx incentive program, a single quality-data code (G8553) should be reported for denominator eligible visits.

Group practices – for group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice must become a successful e-prescriber.

- Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the "Getting Started" page at *http://www.cms.gov/erxincentive* on the CMS website for more information; or download the Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program under "Educational Resources."

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

Source: CMS PERL 201104-57

Data show gains in the Physician Quality Reporting System and eRx incentive programs

2009 data show increases in how many eligible professionals successfully participate as well as how many instances professionals report delivering evidence-based care that can lead to better patient outcomes

Recently, the Centers for Medicare & Medicaid Services (CMS) issued a report that highlights significant trends in the growth of two important "pay-for-reporting" programs. The report also articulates key areas in which physician-level quality measures appear to show positive results in quality of care delivered to Medicare beneficiaries.

CMS' 2009 Physician Quality Reporting System and ePrescribing Experience Report states that 119,804 physicians and other eligible professionals in 12,647 practices who satisfactorily reported data on quality measures to Medicare received incentive payments under the Physician Quality Reporting System totaling more than $234 million – well above the $36 million paid in 2007, the first year of the program. Under the ePrescribing (eRx) incentive program, CMS paid $148 million to 48,354 physicians and other eligible professionals in 2009, the first payment year for the program. Results show that participation in the Physician Quality Reporting System has grown at about 50 percent every year, on average, since the program began.

Although the two pay-for-reporting programs are open to a wide range of health care professionals, much of the reported data relate to care provided in ambulatory settings, such as physician offices. CMS Administrator Donald Berwick, M.D., explained, "Most beneficiaries get their care in the physician office; however, this is the care setting for which we have the least amount of data about quality of that care. The Physician Quality Reporting System and the eRx incentive program help bridge the knowledge gap so we can better understand the care millions of patients receive from physicians and other care providers every day. The significant growth in the Physician Quality Reporting System shows us that the health care community shares CMS's commitment to improving the quality and safety of care our beneficiaries receive."

On average, 2009 bonus payments for satisfactory reporters in the Physician Quality Reporting System were $1,956 per eligible professional and $18,525 per practice. Eligible professionals who were successful electronic prescribers received even more from the eRx incentive program in 2009: the average bonus payment was just over $3,000 per eligible professional and $14,501 per practice. Physicians and other eligible professionals who satisfactorily reported Physician Quality Reporting System quality measures data and thus qualified for an incentive payment for the 2009 Physician Quality Reporting System received their payments in the fall of 2010.

"Our patients deserve nothing less."
Donald Berwick, M.D.
CMS Administrator

Along with increases in participation rates and incentive payment amounts, CMS is encouraged by data from the Physician Quality Reporting System that shows growing rates in how often a health care professional will report that they are complying more often with evidence-based care practices. These increased reporting rates could signal a positive trend in the quality of healthcare Medicare beneficiaries receive from professionals who report data through the Physician Quality Reporting System. One of the Physician Quality Reporting System's main goals is to collect information about care practices that can ultimately help improve the quality and efficiency of care for all Americans, especially Medicare beneficiaries. Accordingly, the system's measures capture evidence-based practices that are shown to improve patient outcomes, such as providing preventive services, taking steps to reduce health care disparities, planning care for patients with chronic conditions to keep them healthy for as long as possible, and integrating health information technology solutions into how providers deliver care. These measures are created by nationally recognized experts from groups such as the American Medical Association, and are endorsed by national quality consensus organizations.

Based on reported data on the 55 measures that have been a part of the system since it began in 2007, providers have improved the frequency for which they deliver recommended care by about 3.1 percent on average. Similarly, of the 99 measures that were part of the system in 2008 and 2009, performance improved at about 10.6 percent on average. In some cases, gains have been even more dramatic.

The measures chosen for the Physician Quality Reporting System also provide increased opportunities for eligible care giving professionals from all segments of the health delivery system to participate. Since the program began, CMS expanded the system from 74 measures (with an eligible professional participation pool of roughly 600,000) to 194 measures (with an eligible professional participation pool over 1,000,000). Currently, about one in five health care professionals who can participate do so.

"Although participation in our pay-for-reporting programs is optional now, it should be regarded as imperative in terms every health care provider who has not yet participated to begin today. We will not improve the quality

continued on next page

Data....(continued)

of health care in this country without knowing where we stand in delivering care and using that knowledge to continually improve our practices. Our patients deserve nothing less."

Dr. Berwick noted that participation in the Physician Quality Reporting System and the eRx incentive program also makes good business sense for health care providers. Both programs currently reward eligible professionals with a percentage of their estimated Part B Medicare physician fee schedule (PFS) allowed charges for covered professional services furnished by the eligible professional during the reporting period.

Both programs also serve as part of a broader strategy to encourage health care providers to adopt practices that can improve patient care. In early 2011, CMS launched incentive programs for both Medicare and Medicaid that reward providers financially for becoming meaningful users of certain health information technology solutions this year.

Physicians will also see data on how well they perform against their peers on quality measures as CMS' Physician Compare website expands to include quality information by 2013. Also, providers who are able to participate in the eRx incentive program and the Physician Quality Reporting System program, but who choose not to, will receive payment reductions from Medicare beginning in 2012 and 2015, respectively for each program.

To learn more about the Physician Quality Reporting System, including instructions on how to get started, visit the CMS website at *http://www.cms.gov/PQRS*. Information on the eRx incentive program is available at *http://www.cms.gov/ERxIncentive/*.

The full Physician Quality Reporting System and ePrescribing Experience Report is also available on CMS' website at *http://www.cms.gov/PQRS*.

Additional 2009 program results may be found in a CMS fact sheet at *http://www.cms.gov/apps/media/fact_sheets.asp*.

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

Source: CMS PERL 201104-35

Alabama and Missouri have launched their Medicaid electronic health record programs

Recently, Alabama and Missouri began participating in the Medicaid electronic health record (EHR) incentive program. This means that eligible professionals (EPs) and eligible hospitals in Alabama and Missouri will be able to receive incentive payments through the Medicaid EHR incentive program. More information about the Medicaid EHR incentive program may be found on the Medicare and Medicaid EHR Incentive Program Basics page at *http://www.cms.gov/EHRIncentivePrograms/*.

If you are a resident of Alabama or Missouri and are eligible to participate in the Medicaid EHR incentive program, visit your state's Medicaid agency website for more information on your state's participation in the Medicaid EHR incentive program:

Alabama – *http://www.onehealthrecord.alabama.gov/*
Missouri – *http://www.dss.mo.gov/mhd/ehr/*

As of April 4, 13 states have launched their Medicaid EHR incentive programs, and six states have issued incentive payments to Medicaid EPs who have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the state Medicaid information document at *http://www.cms.gov/apps/files/statecontacts.pdf*.

Want more information about the EHR incentive programs?

Make sure to visit the EHR Incentive Programs website at *http://www.cms.gov/EHRIncentivePrograms,* for the latest news and updates on the EHR incentive programs.

Reminder: Attestation for the Medicare EHR incentive program is only a few weeks away. On April 18, Medicare EPs and eligible hospitals will be able to use the CMS Web-based attestation system to attest to meeting meaningful use criteria. Prepare now for this important milestone.

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

Source: CMS PERL 201104-19

Medicare electronic health record incentive payment process

Provider types affected

This article is intended for Medicare eligible professionals (EPs), eligible hospitals, including Medicare Advantage affiliated hospitals, and critical access hospitals (CAHs) that are meaningful users of certified electronic health record (EHR) technology.

What you need to know

This article describes the payment process for the Medicare EHR Incentive Program.

Background

The American Recovery and Reinvestment Act (Recovery Act) of 2009 provides for incentive payments beginning in 2011 for Medicare EPs, eligible hospitals, including Medicare Advantage affiliated hospitals, and CAHs that are meaningful users of certified EHR technology.

Note: For information about the Medicaid EHR Incentive Program, please see *http://www.cms.gov/EhrIncentivePrograms*. For questions about how Medicaid incentive payments will be made, contact your state agency. Contact information may be found at *http://www.cms.gov/apps/files/statecontacts.pdf*.

Key points

Who is eligible for the Medicare EHR Incentive Program and how will payments be calculated?
Refer to the following products to determine which providers are eligible and how incentive payments are calculated. Sample payment calculations are provided.

- The *Medicare Electronic Health Record Incentive Program for Eligible Professionals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf*.
- The *EHR Incentive Program for Medicare Hospitals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf*.
- The *EHR Incentive Program for Critical Access Hospitals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf*.

What must I do to get a Medicare EHR incentive payment?

- **Make sure you're eligible for the Medicare EHR Incentive Program**. View eligibility guidelines at *http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp*.
- Get registered. Registration is now open. Visit *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp* for more details.
- **Use certified EHR technology**. To receive incentive payments, make sure the EHR technology you are using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit the Certified EHR Technology Page at *http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp* for more details.
- **Be a meaningful user**. You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent year) to receive EHR incentive payments. Visit the "Meaningful Use" page at *http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp* to learn about meaningful use objectives and measures.
- **Attest for incentive payments**. To get your EHR incentive payment, you must attest (legally state) through Medicare's secure Web site that you've demonstrated "meaningful use" with certified EHR technology. You can get to the secure attestation website through the new attestation page available at *http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage*.

For more information on registration, attestation and meaningful use, go to *http://www.cms.gov/EHRIncentivePrograms*.

When will I receive a payment?

Payments will be made approximately 4-8 weeks after the provider successfully attests to meaningful use, assuming the provider has met the allowed charges threshold. For more information, read the FAQ on payment at *http://questions.cms.gov/app/answers/detail/a_id/10160/kw/payment/session/L3NpZC84ZW9CZk9yaw%3D%3D*.

How will I receive the incentive payment?

- If you are eligible for an incentive payment, the payment will be made to the taxpayer identification number you selected during registration. The payment will be deposited in the first bank account on file with CMS and will be noted as "EHR Incentive Payment" by the bank.

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Medicare....(continued)

- If you receive payments for Medicare services via electronic funds transfer, you will receive your Medicare EHR incentive payment the same way. If you currently receive Medicare payments by paper check, you will also receive your first Medicare EHR incentive payment by paper check.

Important note: Medicare administration contractors (MACs), carriers, and fiscal intermediaries (FIs) will not be making these payments. CMS has contracted with a payment file development contractor to make these payments.

- **DON'T**: Call your MAC/carrier/FI with questions about your EHR incentive payment.
- **INSTEAD**: Call the EHR Information Center. Contact information and hours of operation are contained in the *Additional information* section of this article.

Why is the amount less than I thought?

- The Medicare & Medicaid EHR Incentive Program Registration and Attestation System contains a status tab at the top will contain the amount of the incentive payment, the amount of tax or nontax offsets applied, and the adjustment reason code for any reduction. Providers will not receive a remittance advice (835) for this payment; however, an electronic remit (820) will be sent to the bank along with the payment. (See the *Additional information* section for contact information related to the offsets.)
- For those receiving paper checks, there will be a tear off pay stub which identifies offsets made to the incentive payment.

Additional information

For more information about offsets:

- Call the Internal Revenue Service (IRS) toll-free at 800-829-3903 for tax offsets.
- Call the Department of the Treasury, Financial Management Service (FMS) toll free at 800-304-3107 for nontax offsets.

For other frequently asked questions (FAQs) about the EHR Incentive Program, visit *http://www.cms.gov/EhrIncentivePrograms/*.

The Electronic Health Record (EHR) Information Center is open to assist the EHR provider community with inquiries. EHR Information Center hours of operation are 7:30 a.m.-6:30 p.m. (Central Time) Monday through Friday, except federal holidays. The Center's toll free number is 1-888-734-6433 (primary number) or 888-734-6563 (TTY number).

To submit an inquiry to the EHR Information Center, visit *http://questions.cms.gov/app/ask/p/21,26,1139*.

MLN Matters® Number: SE1111
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: N/A
Related CR Transmittal #: NA
Implementation Date: N/A

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Medicare electronic health record incentive program attestation began April 18

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program began on April 18. To receive your Medicare EHR incentive payment, you must attest through the Centers for Medicare & Medicaid Services' (CMS') Web-based Medicare and Medicaid EHR incentive programs registration and attestation system.

You can preview selected screenshots of the attestation system to help you understand what the process will involve at *http://www.cms.gov/EHRIncentivePrograms/Downloads/AttestationSneakPeek.pdf*. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes.

CMS will release additional information about the Medicare attestation process soon, including user guides that provide step-by-step instructions for completing attestation, and educational webinars that describe the attestation process in depth.

Here is more information to help you prepare for Medicare attestation:

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the

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Medicare....(continued)

Medicare EHR incentive program are different:

EP meaningful use criteria – must report on 15 core measures, five of 10 menu measures, and six clinical quality measures, consisting of three required core measures and three additional measures.

- Go to the *Stage 1 EHR Meaningful Use Specification Sheets for EPs* at *https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf*, for information on core and menu measures for EPs.
- Go to the "Clinical Quality Measures" page at *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp*, for information on the required clinical quality measures for EPs.

Eligible Hospital and CAH Meaningful Use Criteria – Must report on 14 core measures, five of 10 menu measures, and 15 clinical quality measures.

- Go to the *Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs* at *https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf*, for information on core and menu measures for eligible hospitals and CAHs.
- Go to the "Clinical Quality Measures" page at *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp*, for information on the required clinical quality measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last day to begin your 90-day reporting period for 2011 incentive payments is:

- July 3, 2011, for eligible hospitals and CAHs
- October 1, 2011, for EPs

Under the Medicaid EHR Incentive Programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Go to the "Medicaid State EHR Incentive Program Web tool" at *https://www.cms.gov/apps/files/medicaid-HIT-sites/*, for more information about your state's participation in the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs?

Make sure to visit the CMS EHR Incentive Programs Web page at *http://www.cms.gov/EHRIncentivePrograms/*, for the latest news and updates on the EHR Incentive Programs.

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

Source: CMS PERL 201104-31, 201104-07, 201103-58

Additional EHR incentive program FAQs are now available on CMS' website

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with the latest information on the Medicare and Medicaid electronic health record (EHR) incentive programs. Last week, CMS sent you a message highlighting some of the new FAQs that have been posted to its website. Take a minute and review the remaining new FAQs on eligibility, certified EHR technology, meaningful use, and attestation.

New FAQs on eligibility

1. If I am receiving payments under the CMS Electronic Prescribing (eRx) Incentive Program, can I also receive Medicare and Medicaid EHR incentive payments? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10088/kw/10088/session/L3NpZC9BWUVtNXFvaw%3D%3D*.
2. Can EPs participate in the 2011 Physician Quality Reporting System (formerly called PQRI), 2011 Electronic Prescribing (eRx) Incentive Program, and the EHR Incentive Program (aka Meaningful Use) at the same time and earn incentives for each? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10474*.

New FAQs on certified EHR technology

1. If a provider feeds data from certified EHR technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10153/kw/10153*.
2. For the Medicare and Medicaid EHR Incentive Programs, is an EP or eligible hospital limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified?

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Additional....(continued)

For example, if a Complete EHR has been tested and certified using a specific workflow, is an EP or eligible hospital required to use that specific workflow when it demonstrates meaningful use? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10473*.

3. If data is captured using certified EHR technology, can an EP or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10465/kw/10465*.

New FAQs on meaningful use

1. If my certified EHR technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10467/kw/10467*.
2. If a State utilizes the option to include patient panels when looking at patient volume for the Medicaid EHR Incentive Program, what does it mean to have "unduplicated encounters"? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10476/kw/10476*.
3. Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10469/kw/10469*.
4. For the Medicare and Medicaid EHR Incentive Programs, does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10468/kw/10468*.
5. For the Medicare and Medicaid EHR Incentive Programs, should patient encounters in an ambulatory surgical center (place of service 24) be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10466/kw/10466*.
6. To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid EHR Incentive Programs, should EPs include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10462/kw/10462*.
7. If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10475*.
8. Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10067/kw/10067*.

New FAQ on attestation

1. How will I attest for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10463/kw/10463*.

Additional information

Want more information about the EHR incentive programs? CMS will keep you informed of future updates to its FAQs throughout the duration of the CMS EHR incentive programs. Make sure to visit the CMS EHR Incentive Program website for the latest news and updates on the EHR incentive programs. Available at *http://www.cms.gov/EHRIncentivePrograms/*.

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

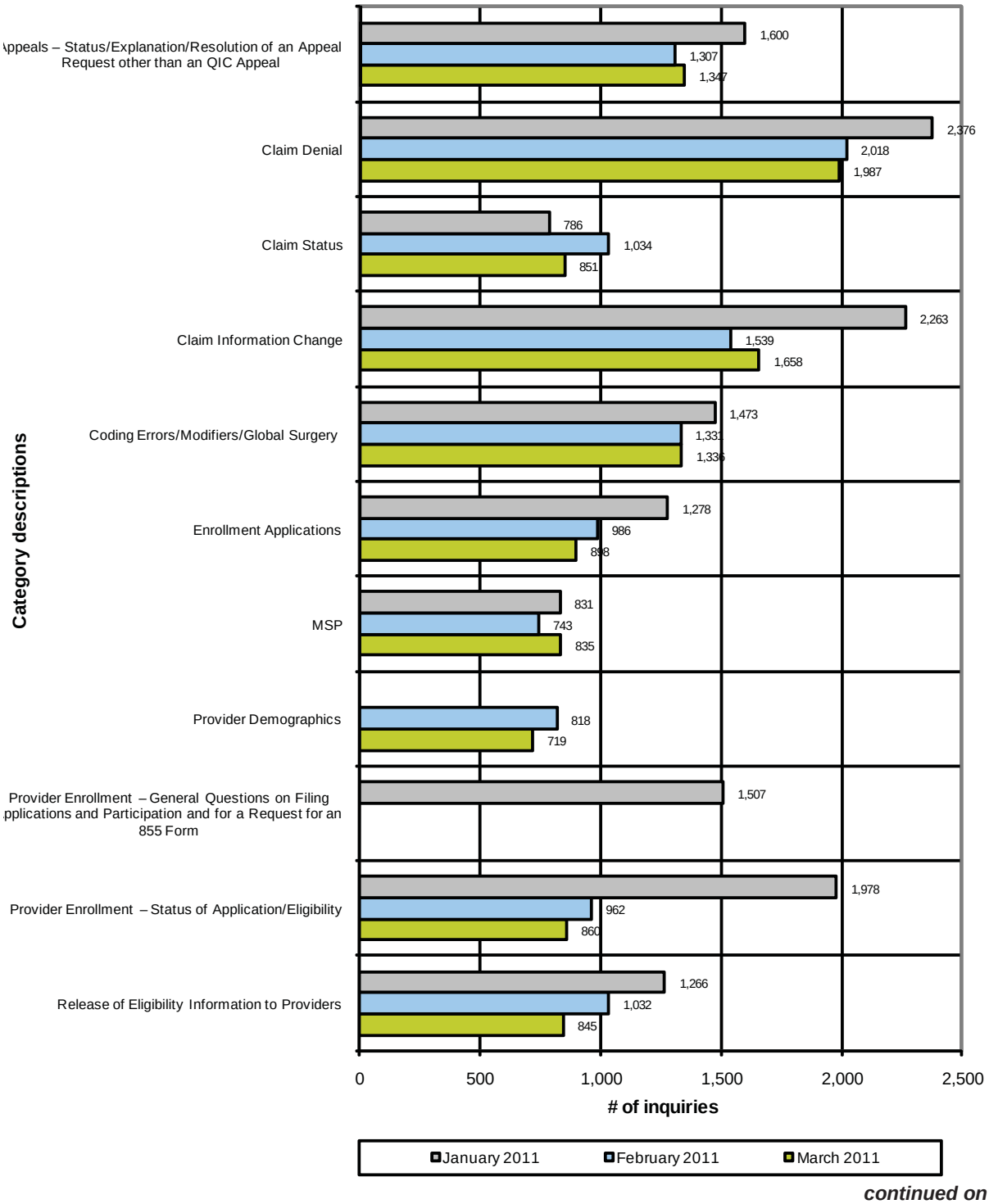
Source: CMS PERL 201103-62

Top inquiries, denials, and return unprocessable claims

Top inquiries, denials, and return unprocessable claims

The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during January-March 2011. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part B top inquiries for January-March 2011



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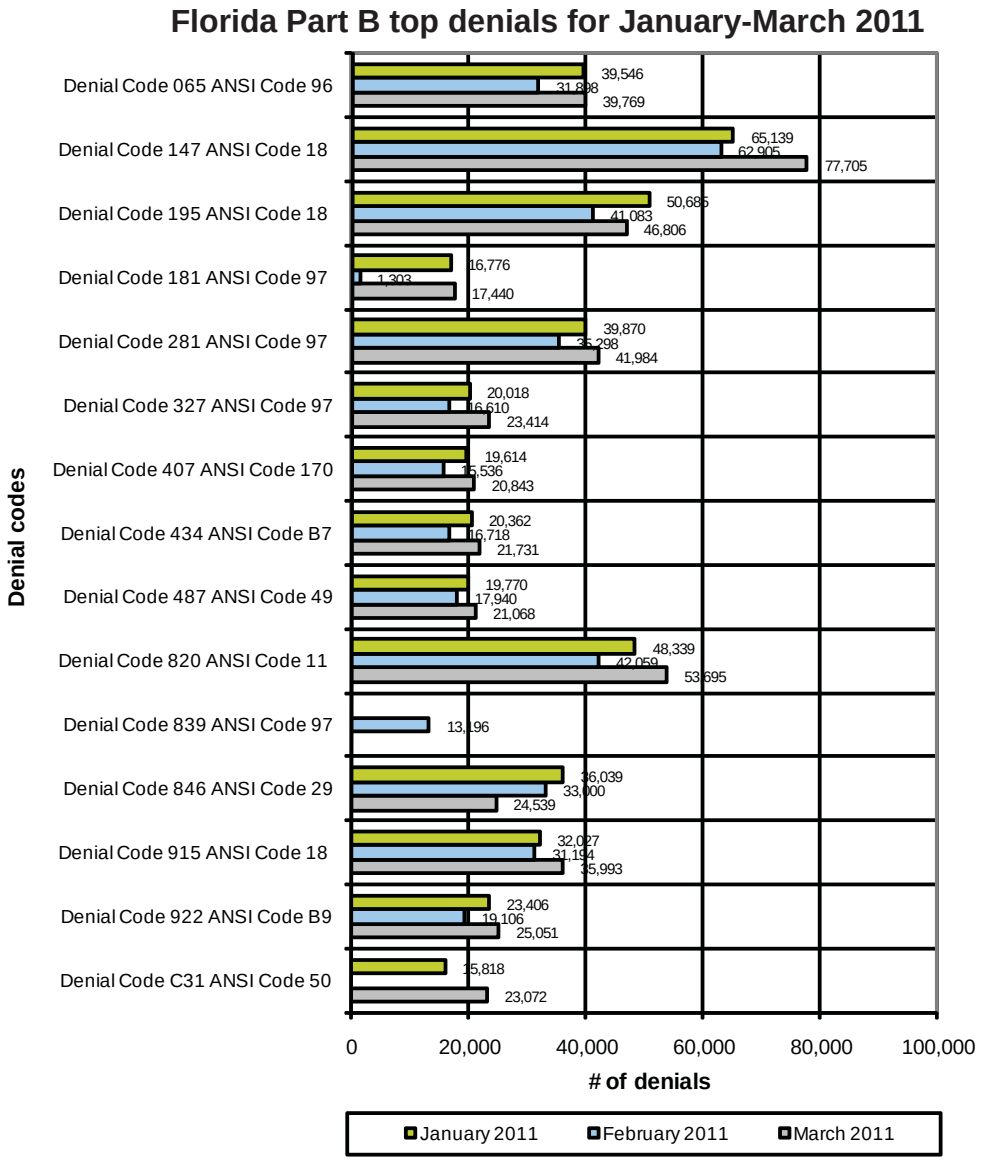

Steps to reduce the number of claim submission errors

Errors in your claim submissions can significantly delay processing and payment.

Did you review your batch detail control listing?

Claims submission errors may be obtained in a timely fashion through your electronic data interchange (EDI) gateway mailbox on a report titled batch detail control listing. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. This report will also inform you of any major problems with your claims, so they can be corrected before creating an interruption in your cash flow.

Did you know you can now create an account and receive your personalized Provider Data Summary report?

The Provider Data Summary (PDS) is a comprehensive billing report designed to be utilized along with Medicare Remittance Notices (MRNs) and other provider-accessible billing resources to help identify potential Medicare billing issues through a detailed analysis of your personal billing patterns in comparison with those of similar providers. To request this useful report and enhance the accuracy and efficiency of your Medicare billing process, use the PDS portal, available at *http://medicare.fcso.com/Reporting/*.

Obtain your personalized PDS report by visiting our Provider Data Summary page at *http://medicare.fcso.com/PDS/*. It is here you will find all PDS resources, including a guide, helpful frequently-asked questions (FAQs), and the PDS Portal. Select the link titled “PDS Portal.” From there, you will be given the option to log in, get help with a misplaced password, or create an account.

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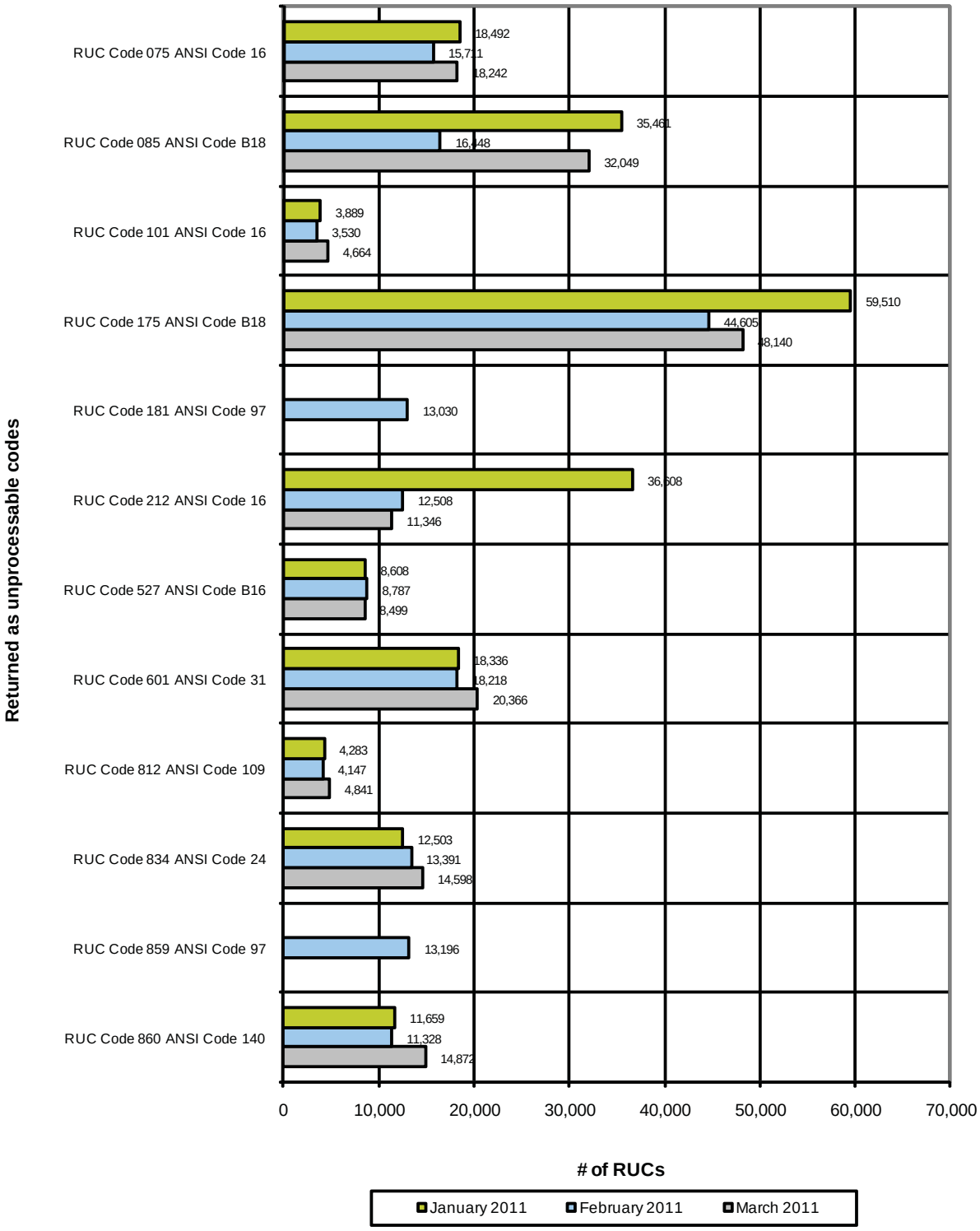
Florida Part B top return as unprocessable claims for January-March 2011



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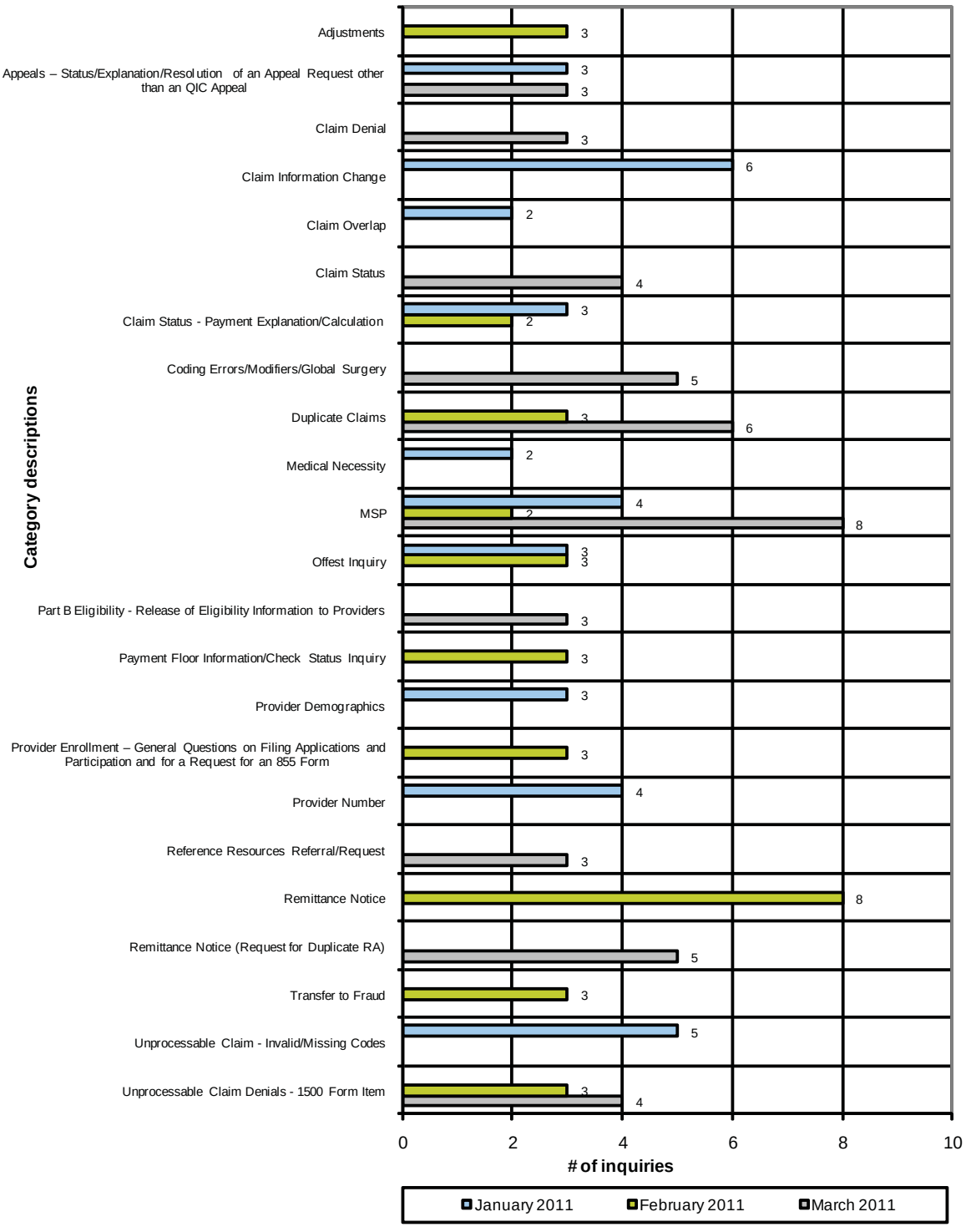
U.S. Virgin Islands Part B top inquiries for January-March 2011



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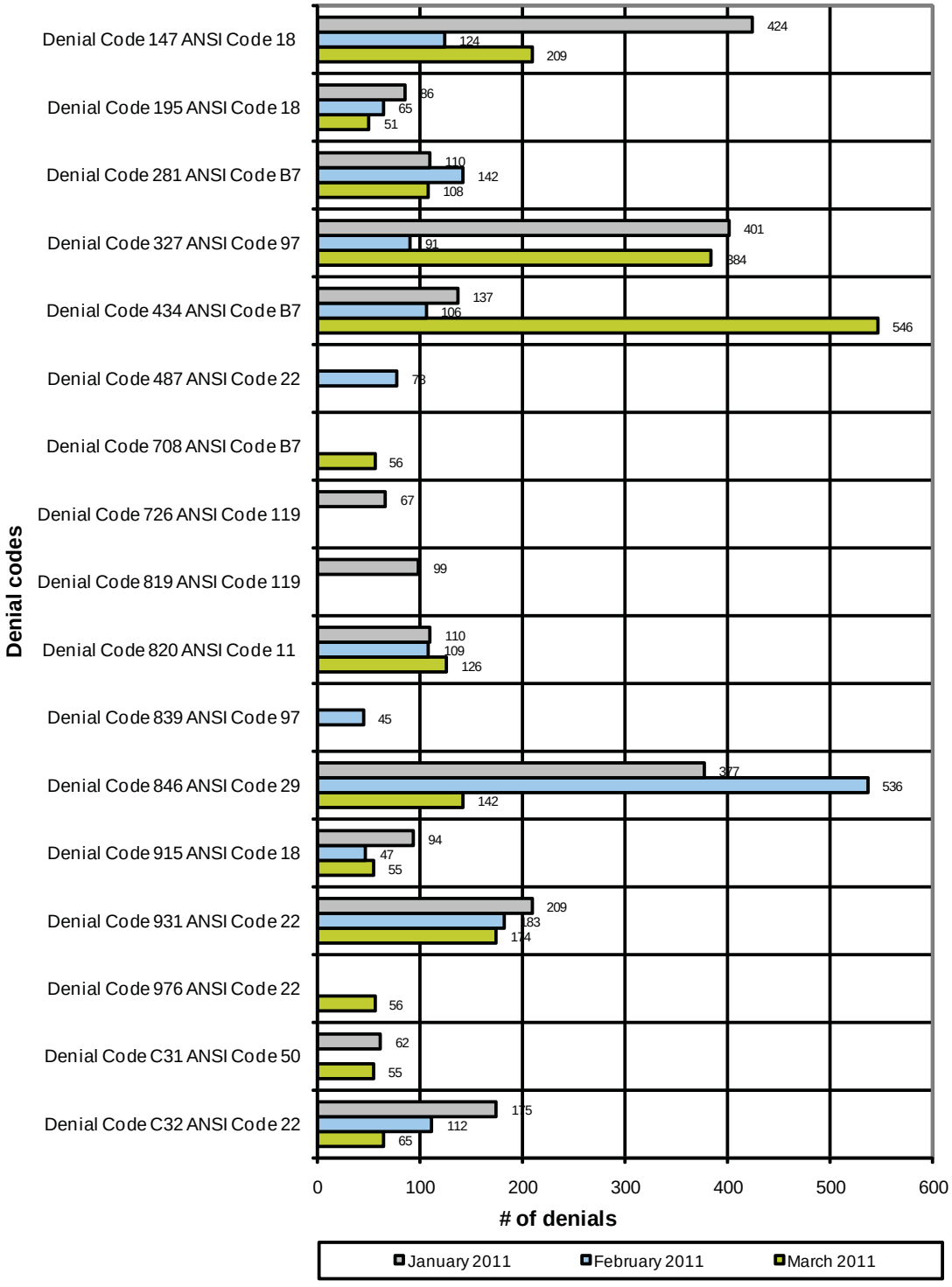
U.S. Virgin Islands Part B top denials for January-March 2011



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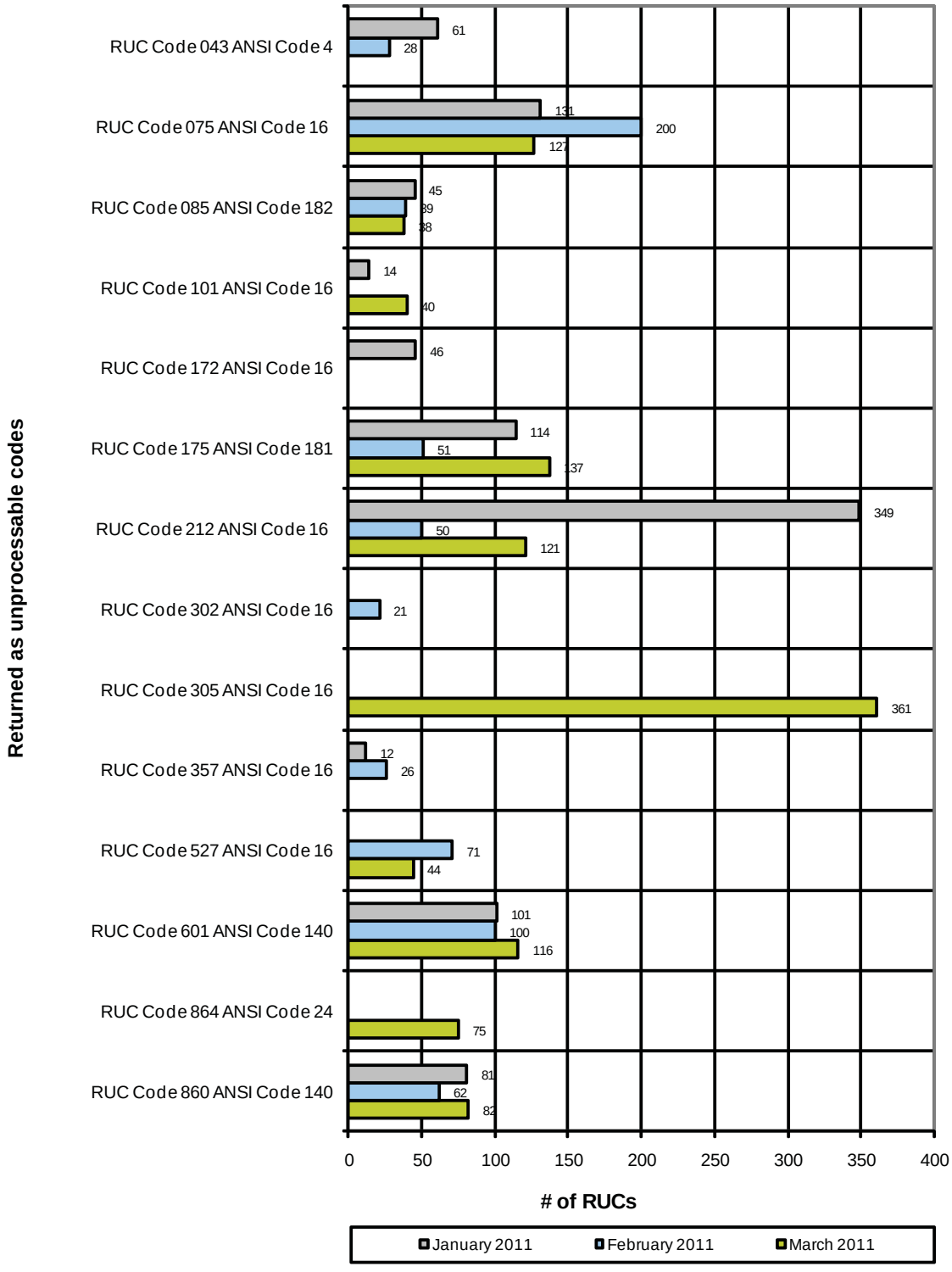
U.S. Virgin Islands Part B top return as unprocessable claims for January-March 2011



This section of *Medicare B 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.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Contents

Advance beneficiary notice

Modifier GZ must be used when 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.

Modifier GA must be used when 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 must append the billed service with modifier GA or GZ.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at *http://www.cms.gov/medicare-coverage-database/*, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Additions to the LCDs

J7308: Topical photosensitizers used with PDT for actinic keratoses and certain skin cancers – new LCD

LCD ID number: L31805 (Florida/Puerto Rico/U.S. Virgin Islands)

Photodynamic therapy (PDT) involves the use of photochemical reactions mediated through the interaction of photosensitizing agents, light, and oxygen for the treatment of malignant or benign diseases. The most commonly used photosensitizers in PDT are aminolevulinic acid HCL (ALA) and methyl aminolevulinate (MAL). Currently, the only Food and Drug Administration (FDA) approved indication for ALA PDT and MAL PDT in dermatology is the treatment of actinic keratoses (AKs) on the face or scalp. Common off-label uses include the treatment of basal cell carcinoma (BCC), photoaging, acne, vulgaris, and Bowen's disease.

A local coverage determination (LCD) has been developed to provide coverage for two drugs, Levulan® Kerastick® (ALA) and Metvixia (MAL) Cream, used with PDT for the treatment of AKs on the face and scalp, as well as the off-label use of BCC and squamous cell carcinoma (Bowen's disease). This LCD gives indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes and coding guidelines for the following HCPCS codes/descriptors for photosensitizing drugs:

- J7308 Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg) [Levulan® Kerastick®]
- J7309 Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram [Metvixia Cream]

Effective date

This new LCD is effective for services rendered **on or after June 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Revisions to the LCDs

BOTULINUM TOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L29088 (Florida)
LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised on March 3, 2011. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2150, change request 7319, dated February 4, 2011; CMS transmittal 2147, change request 7299, dated February 4, 2011; and CMS transmittal 2185, change request 7343, dated March 25, 2011. In this regard, the "*CPT*/HCPCS Codes" section of the LCD has been revised to delete HCPCS codes J3590 and C9278 and add HCPCS code Q2040 (Injection, incobotulinumtoxin a, 1 unit). The "ICD-9 Codes that Support Medical Necessity" section of the LCD has also been revised to add HCPCS code Q2040 (Injection, incobotulinumtoxin a, 1 unit).

The LCD "Coding Guidelines" attachment has also been revised to update the coding and billing information for incobotulinumtoxina (Xeomin®).

Effective date

This LCD revision is effective for claims processed **on or after April 4, 2011**, for services rendered **on or after April 1, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Computed tomography (CT) scans – revisions to LCDs

LCD ID number: L29118, L29119, L29120, L29121 (Florida)
LCD ID number: L29136, L29137, L29138, L29139 (Puerto Rico/U.S. Virgin Islands)

First Coast Service Options Inc. the Medicare J9 MAC, has reviewed the local coverage determinations (LCDs) for computed tomography (CT) scans and determined that language located under the "Documentation Requirements" section of the LCD should be revised to make the language consistent among all CT LCDs and to ensure the language is in line with the literature that supports these requirements. In some instances the references were also updated. These revisions serve to further expand on existing language found in the LCD. The following LCDs have been revised: 70450 computed tomography scans of the head or brain, 71250 computed tomography of the thorax, 72192 computed tomography of the abdomen and pelvis, and 74261 computed tomographic colonography.

Effective date

These LCD revisions are effective for services rendered **on or after April 5, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

G0431: Qualitative drug screening – revision to the LCD coding guidelines

LCD ID number: L30574 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) "coding guidelines" attachment for qualitative drug screening was most recently revised on March 3, 2011. Since that time, the "coding guidelines" attachment was revised to include the latest Centers for Medicare & Medicaid Services (CMS) information regarding HCPCS codes G0431QW and G0434QW based on Joint Signature Memorandum/Technical Direction Letter (JSM/TDL) 11259. This JSM/TDL supersedes information previously issued concerning HCPCS codes G0431QW and G0434QW that was included in JSM 11194 and change request 7266. The following verbiage replaced previous language that had been added:

Effective April 1, 2011, code G0431QW is deleted from the clinical laboratory fee schedule (CLFS). Code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a Clinical Laboratory Improvement Amendments (CLIA) waived test.

Also

Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the modifier QW to indicate a CLIA waived test is necessary for accurate claim processing.

Effective date

This revision to the LCD "coding guidelines" attachment is effective for services rendered **on or after April 1, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

J9310: Rituximab (Rituxan®) – revision to the LCD

LCD ID number: L29271 (Florida)
LCD ID number: L29472 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab(Rituxan®) was most recently revised on February 18, 2010. Since that time, a revision was made under the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD to update the approved Food and Drug Administration (FDA) indications dated January 28, 2011, for follicular CD20-positive, B-cell NHL in combination with first line chemotherapy and in patients achieving a complete or partial response to Rituxan® in combination with chemotherapy, as single-agent maintenance therapy In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated to add an additional FDA label reference considered for this revision.

Effective date

This LCD revision is effective for claims processed **on or after March 31, 2011**, for services rendered **on or after January 28, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Magnetic resonance imaging (MRI) – revisions to LCDs

LCD ID number: L29219, L29220, L29221, L29222, L29223 (Florida)
LCD ID number: L29362, L29363, L29448, L29449, L29450 (Puerto Rico/U.S. Virgin Islands)

Revision 1

First Coast Services Options Inc. the Medicare J9 Medicare administrative contractor (MAC), has reviewed the local coverage determinations (LCDs) for magnetic resonance imaging (MRI) and determined that the language located under the "Documentation Requirements" section of the LCD should be revised to make the language consistent among all MRI LCDs and to ensure the language is in line with the literature that supports these requirements. In some instances the references were also updated. These revisions serve to further expand on existing language found in the LCD. The following LCDs have been revised: 70540 magnetic resonance imaging of the orbit, face and/or neck, 70551 magnetic resonance imaging of the brain, 72141 magnetic resonance imaging of the spine, 73218 magnetic resonance imaging of upper extremity, and 73721 magnetic resonance imaging of any joint of the lower extremities.

Effective date

These LCD revisions are effective for services rendered **on or after April 5, 2011**. FCSO 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*.

Revision 2

In addition to the above noted revisions, the J9 MAC has revised the MRI LCDs based on instructions issued in change request 7296, dated March 4, 2011. Language has been added and/or deleted from the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCDs based on the revised language issued in change request 7296 for the national coverage determination (NCD) magnetic resonance imaging, section 220.2. The following LCDs have been revised: 70540 magnetic resonance imaging of the orbit, face and/or neck, 70551 magnetic resonance imaging of the brain, 72141 magnetic resonance imaging of the spine, 73218 magnetic resonance imaging of upper extremity, and 73721 magnetic resonance imaging of any joint of the lower extremities.

Effective date

These LCD revisions are effective for claims processed **on or after April 4, 2011**, for services rendered **on or after February 24, 2011**. *FCSO LCDs are available through the CMS Medicare coverage database at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.*

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

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NCSVCS: Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised on April 12, 2011. Since that time, revisions were made to the LCD. Five Category III *CPT* codes from the Centers for Medicare & Medicaid Services (CMS) Annual 2011 HCPCS Update, change request (CR) 7121 were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III *CPT* codes *0239T*, *0242T*, *0243T, 0244T, and 0253T* were added to the noncovered services LCD.

Under the "CPT/HCPCS Codes – Local Noncoverage Decisions -- Procedures" section of the LCD, the following Category III CPT codes were added:

0239T Bioimpedance spectroscopy (BIS), measuring 100 frequencies or greater, direct measurement of extracellular fluid differences between the limbs

- *0242T Gastrointestinal tract transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report*
- *0243T Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report*
- *0244T Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation 3 to 24 hours, with interpretation and report*
- *0253T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space*

Also, *CPT* code *22899* (XClose® Tissue Repair System) was evaluated and was determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, *CPT* code *22899* [XClose® Tissue Repair System] was added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD.

In addition, BRCA1 & BRCA 2 (*CPT* code *88299*) was removed from the Noncovered Services LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Laboratory Procedures" section of the LCD per review of current evidence based literature. Removal of a service or specific code from the Noncovered Services LCD is not a positive coverage statement per say. Essentially, the contractor then has no coverage statement (LCD) when a service is removed from the Noncovered Services LCD and the service (as usual) must meet the reasonable and necessary threshold for coverage as outlined in the *Medicare Program Integrity Manual*, Pub.100.08, Chapter 13, Section 13.5.1. Many genetic tests can be coded in ways that payment of the service/procedure can occur, but the claim itself is not evaluated for coverage. Payment of a code does not equate to coverage. BRCA 1 and BRCA 2 testing could be reasonable and necessary very rarely in the Medicare population given the program's demographics. BRCA 1 and BRCA 2 was removed from the Noncovered Services LCD; however, medical necessity for testing would have to be met and clearly documented in the medical record. Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers tests for screening. It should be noted that currently there is no screening benefit for BRCA 1 and BRCA 2 testing; therefore, its use for screening is noncovered. The individual patient's medical record would have to clearly support the need for the testing.

Effective date

This LCD revision is effective for services rendered **on or after June 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Find fees faster: Try FCSO's fee schedule lookup

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

78451: Cardiovascular nuclear imaging studies – revision to the LCD

LCD ID number: L29093 (Florida)
LCD ID number: L29108 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for cardiovascular nuclear imaging studies was most recently revised on January 1, 2010. Since that time, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code 794.39 (Nonspecific abnormal results of function studies, cardiovascular, other) was added to the list of allowable ICD-9-CM diagnosis codes. This diagnosis is being added to support the indication in the LCD which states myocardial perfusion imaging is performed to determine if the patient has myocardial ischemia when there has been an abnormal or non-diagnostic standard exercise stress test.

Effective date

This LCD revision is effective for services rendered **on or after April 15, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Additional Information

Self-administered drug (SAD) list – Part B: J3490

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and, therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

- Effective for services rendered on or after June 4, 2011, the following drug has been added to the Medicare administrative contractor (MAC) Jurisdiction 9 (J9), Part B SAD list.
- J3490 Tesamorelin (Egrifta™)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (FCSO) SAD lists are available at *http://medicare.fcso.com/Self-administered_drugs/*.

Single and dual chamber cardiac pacemakers – draft LCD

LCD ID number: L29182 (Florida)
LCD ID number: L29432 (Puerto Rico/U.S. Virgin Islands)

The Jurisdiction 9 Medicare administrative contractor (J9 MAC) recently published a draft local coverage determination (LCD) for single and dual chamber cardiac pacemakers. Comments were received on this draft and were related to medical necessity criteria for single and dual chamber cardiac pacemakers, which are outlined in the *Medicare National Coverage Determinations (NCD) Manual* for cardiac pacemakers, Publication 100.03, Chapter 1, Section 20.8. It was the intention of the J9 MAC to address issues identified through CERT (Comprehensive Error Rate Testing, the Medicare national program to assess claims(s) payment error rates) medical review of claims for single and dual chamber cardiac pacemakers. CERT medical review of claims demonstrated that patients were not meeting the criteria for coverage for dual chamber cardiac pacemakers as outlined in the NCD. Given that the comments received were related to medical necessity criteria for single and dual chamber cardiac pacemakers established by the NCD and considering that the J9 MAC does not have discretion to alter language of the NCD, the J9 MAC has determined the best approach at this time will be to not finalize the draft LCD for single and dual chamber cardiac pacemakers. Instead the MAC J9 is publishing this article to discuss the coverage for cardiac pacemakers.

continued on next page

Single....(continued)

The NCD for cardiac pacemakers includes language for the indications for dual chamber cardiac pacemakers which requires providers to justify in the medical record the insertion of a dual chamber cardiac pacemaker over a single chamber cardiac pacemaker. The specific coverage criteria for dual chamber cardiac pacemakers is as follows:

1. Patients in whom single-chamber (ventricular pacing) at the time of pacemaker insertion elicits a definite drop in blood pressure, retrograde conduction, or discomfort.
2. Patients in whom the pacemaker syndrome (atrial ventricular asynchrony), with significant symptoms, has already been experienced with a pacemaker that is being replaced.
3. Patients whom even a relatively small increase in cardiac efficiency will importantly improve the quality of life, e.g., patients with congestive heart failure despite adequate other medical measures.
4. Patients in whom the pacemaker syndrome can be anticipated, e.g., in young and active people, etc.

Whenever the following conditions (which represent overriding contraindications) are present, dual chamber pacemakers are not covered:

1. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium).
2. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.
3. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged, e.g., the occasional patient with hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.
4. Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third-degree) and/or Type II second-degree AV block in association with bundle branch block.

All other indications for dual-chamber cardiac pacing for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated coverage remain nationally noncovered, except for Category B Investigational Device Exemptions (IDE) clinical trials, or as routine costs of dual-chamber cardiac pacing associated with clinical trials, in accordance with CMS Clinical Trial Policy contained in the *Medicare NCD Manual*, CMS Publication 100-03, Chapter 1, Section 310.1 at *http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf*.

Providers can access the CERT Cardiac Pacemaker Fact Sheet released in December 2010 by CMS at *http://www.hrsonline.org/Policy/CodingReimbursement/coverage/upload/CERT_Pmaker_FactSheet_ICN905144.pdf*.

The J9 MAC recommends that physician and allied health providers be familiar with the language in the NCD when determining the need for a single versus a dual chamber cardiac pacemaker and when documenting the medical justification for insertion of a dual chamber versus a single chamber cardiac pacemaker.

37205: Non-coronary vascular stents – draft LCD article clarification

LCD ID number: DL31824 (Florida/Puerto Rico/U.S. Virgin Islands)

Numerous comments were received in regard to the draft non-coronary vascular stents local coverage determination (LCD) from practicing physicians, specialty societies, and other interested stakeholders from within and outside the Part A/B Medicare administrative contractor (MAC) jurisdiction 9 (J9).

MAC J9 has elected not to finalize this draft at this time. Options include taking a new draft through the next LCD cycle (summer). Such a draft may focus on more limited areas (such as lower extremity, etc.), but that has not been decided upon.

There are several reasons for not finalizing the current draft LCD at this time and they include the following:

1. New coding for the lower extremity (endovascular revascularization) and unclear impact on utilization.
2. Concerns with the application of the diagnosis to procedure codes noted in the LCD. Some indications had evidence support in the peer reviewed literature; some indications with evidence support could possibly be excluded given the limitations of procedure code descriptors and ICD-9-CM diagnosis codes addressed in the draft; and some indications without evidence support could be argued as covered based on broad application in conjunction with the draft LCD language.

continued on next page

37205....(continued)

3. The implications of the statement on Food and Drug Administration (FDA) approved indications for a device (stents in this case). The Medical Policy department has researched language to address standards of care, but did not want the LCD used to justify investigational/experimental procedures or over-utilization of certain procedures. Not directly related, there was concern that a broad statement would be interpreted as a positive coverage statement for other devices that are used off-label with little evidence. For example, the movement of the peripheral atherectomy codes for supra-inguinal arteries from Level 1, Category I to Category III suggests that there are new, emerging device technologies and these devices may have more limited indications. There are clearly circumstances in which these devices should be non-covered or limited to their FDA clearance when documentation can support the reasonable and necessary (R&N) indication for a particular patient.

CDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – inappropriate denials

LCD ID number: L31510 (Florida/Puerto Rico/U.S. Virgin Islands)

First Coast Service Options Inc. (FCSO) recently implemented a new local coverage decision (LCD) addressing radiation therapy for T1 basal cell and squamous cell carcinomas of the skin. The LCD became effective February 13, 2011. Since implementation of the LCD, it has been brought to our attention that providers may be receiving inappropriate denials based on diagnosis codes related to the procedure codes listed in the LCD. FCSO has confirmed this and we are working diligently to correct this problem. Additionally, FCSO will identify all services that have been denied in error and make the appropriate adjustments. Providers will not need to resubmit denied claims or request an appeal for redetermination. FCSO apologizes for any inconvenience this may have caused our provider community.

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

90935-90937: Hemodialysis for treatment of schizophrenia – national coverage determination

The national coverage determination (NCD) for hemodialysis for treatment of schizophrenia (*Medicare National Coverage Determination Manual*, Pub. 100-03, Chapter 1, Section 130.8) indicates that *scientific evidence supporting use of hemodialysis as a safe and effective means of treatment of schizophrenia is inconclusive at this time. Accordingly, Medicare does not cover hemodialysis for treatment of schizophrenia*. First Coast Service Options Inc. has identified the following diagnoses to represent schizophrenia based on this NCD:

295.00-295.95 (Schizophrenic disorders)

Effective date

This article serves as a 45-day notice that hemodialysis for treatment of schizophrenia is not considered safe and effective when billed with diagnoses 295.00-295.95 effective for services rendered **on or after June 1, 2011**.

Educational Events

Upcoming provider outreach and educational events
May 2011

Overcoming 5010 testing barriers
When: Wednesday, May 11
Time: 10:00-11:30 a.m.

Bimonthly Medicare Part B ACT: Medicare changes and hot issues
When: Wednesday, May 11
Time: 11:30 a.m.-1:00 p.m.

Bimonthly Medicare's documentation and coding errors: What could it cost you?
When: Tuesday, May 17
Time: 11:30 a.m.-1:00 p.m.

Navigating your way through Medicare Part B
When: Wednesday, May 18
Time: 9:00 a.m.-noon
Type: Face-to-face
Focus: U.S. Virgin Islands

E/M coding and medical documentation: Errors and solutions
When: Wednesday, May 18
Time: 11:30 a.m.-1:00 p.m.

Bimonthly Medicare Part B ACT: Medicare data and CMS initiatives
When: Wednesday, May 18
Time: 2:00-3:30 p.m.

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training website at *www.fcsomedicaretraining.com*, log on 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 User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. 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: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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Upcoming....(continued)

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues 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 the FCSO Medicare training website, 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. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

Preventive Services

Three new Medicare-covered preventive services quick reference charts

- *The ABCs of Providing the Initial Preventive Physical Examination* quick reference chart provides Medicare fee-for-service providers a list of the elements of the initial preventive physical examination (IPPE), as well as coverage and coding information. To view the chart, please *visit http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.
- *The ABCs of Providing the Annual Wellness Visit* quick reference chart provides Medicare fee-for-service providers a list of the elements of the annual wellness visit (AWV), as well as coverage and coding information. To view the chart, please visit *http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*.
- *The Medicare Preventive Services* quick reference chart provides Medicare fee-for-service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. To view the chart, please visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

A hardcopy booklet containing all three charts, as well as the Quick Reference Information: Medicare Immunization Billing chart, will be available at a later date.

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

Source: CMS PERL 201104-11

April is National Minority Health Month

Please join with the Centers for Medicare & Medicaid Services (CMS) during National Minority Health Month to promote preventive benefits, which are often underutilized by minority populations. In general, low-income Americans and racial and ethnic minorities experience disproportionately higher rates of disease, fewer treatment options, and reduced access to care. Educating people about healthy behaviors and lifestyle modification can help to postpone and avoid illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs. Medicare pays for many preventive services to help keep seniors and others with Medicare healthy. These preventive services can detect health problems early, when treatment works best, and can keep our most vulnerable populations from getting certain diseases. Medicare-covered preventive services include exams, immunizations, lab tests, screenings, and programs for health monitoring, as well as counseling and education to help Medicare beneficiaries maintain optimum health.

The Affordable Care Act made improvements to the Medicare program. As a result, starting in 2011, beneficiaries with original Medicare are eligible to receive a yearly “wellness” exam in addition to many preventive services.

continued on next page

April....(continued)

Medicare-covered services

Medicare provides coverage of the following preventive services and screenings, subject to beneficiary eligibility:

- Abdominal aortic aneurysm screening
- Bone mass measurements
- Cancer screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical and vaginal (pap test and pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular disease screenings
- Diabetes screening, supplies, and self-management training
- EKG screening
- Glaucoma screening
- HIV screening
- Immunizations
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Medical nutrition therapy (beneficiaries with diabetes or renal disease)
- One-time "Welcome to Medicare" physical exam
- Tobacco use cessation counseling
- Annual wellness exam (new for 2011)

How can you help?

As a health care professional who provides services to seniors and other people with Medicare, CMS needs your help to ensure that all eligible Medicare beneficiaries take advantage of preventive services. We ask that you talk with your patients about their risk factors for various diseases and highlight the importance of prevention and early disease detection through the use of appropriate screenings (at the appropriate frequency).

Note: Many of these Medicare-covered services require provider referrals so we are counting on you to provide referrals when appropriate.

For more information

CMS Preventive Services website – *http://www.cms.gov/PrevntionGenInfo/*

Medicare Learning Network® (*MLN*) preventive services educational products – *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*

Quick Reference Information: Medicare Preventive Services – *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*

The Office of Minority Health – *http://minorityhealth.hhs.gov/*

Together we can help to eliminate health disparities and achieve optimal health for all racial and ethnic groups.

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

Source: CMS PERL 201104-13

Other Educational Resources

New dedicated Web page for the Medicare Shared Savings Program

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule, CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, in the *Federal Register*. The rule implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated Web page at *www.cms.gov/sharedsavingsprogram* for Medicare fee-for-service (FFS) providers and other providers of services and suppliers. Bookmark the Web page and check back often, as CMS continues to add information on the program.

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

Source: CMS PERL 201104-12

New information for compliance officers and billing and coding professionals

As part of ongoing efforts by the Centers for Medicare & Medicaid Services (CMS) to keep Medicare fee-for-service (FFS) providers aware of new and improved products, CMS encourages you to visit the Provider Compliance *Medicare Learning Network* (*MLN*) Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp#TopOfPage*, where you will find FFS provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. Be sure to pay particular attention to the listing of provider compliance national educational products, located at *http://www.cms.gov/MLNProducts/Downloads/ProvCmpl_Products.pdf*, from which you can quickly link to each available product. Also take a moment to review the first two issues of the Medicare Quarterly Provider Compliance Newsletter:

Volume 1, Issue 1 – *http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf*

Volume 1, Issue 2 – *http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf*

And like all *MLN* products, our downloadable compliance materials are available at no cost.

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

Source: CMS PERL 201103-55

New *Comprehensive Error Rate Testing Signature Requirements* fact sheet

A new publication titled *Comprehensive Error Rate Testing (CERT) Signature Requirements* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf*. This fact sheet is designed to provide education on signature requirements to healthcare providers and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

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

Source: CMS PERL 201104-34

New fact sheets for DMEPOS suppliers

DMEPOS Quality Standards fact sheet

The new publication titled *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf*. This fact sheet is designed to provide education on DMEPOS quality standards for Medicare deemed accreditation organizations (AOs) for DMEPOS suppliers. A hard copy version of this fact sheet will be available at a later date.

The Basics of DMEPOS Accreditation fact sheet

A new publication titled *The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf*. This fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. A hard copy version of this fact sheet will be available at a later date.

DMEPOS New Information for Pharmacies booklet

A new publication titled *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/DMEPOS_Pharm_FactSheet_ICN905711.pdf*. This booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by a CMS-approved independent national accreditation organization (AO) or must obtain an accreditation exemption. A hard copy version of this fact sheet will be available at a later date.

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

Source: CMS PERL 201104-34

Ambulance Fee Schedule fact sheet revised

The revised publication titled *Ambulance Fee Schedule* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*. This fact sheet is designed to provide education about the ambulance fee schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

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

Source: CMS PERL 201104-25

Evaluation and Management Services Guide is available in print

The publication titled *Evaluation and Management Services Guide* is now available in print format from the *Medicare Learning Network*®. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations; the "1995 Documentation Guidelines for Evaluation and Management Services" and the "1997 Documentation Guidelines for Evaluation and Management Services" are included in this publication. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to 'Related Links Inside CMS' and select "MLN Product Ordering Page."

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

Source: CMS PERL 201104-34

Health Professional Shortage Area fact sheet revised

The revised publication titled *Health Professional Shortage Area* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/HPSAfctsht.pdf*. This fact sheet is designed to provide education on the health professional shortage area (HPSA) payment system and includes an overview of the program and general requirements.

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

Source: CMS PERL 201104-25

Medical Privacy of Protected Health Information fact sheet revised

The revised publication titled *Medical Privacy of Protected Health Information* (revised January 2011) is now available from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNproducts/downloads/SE0726FactSheet.pdf*. This fact sheet contains resources and information regarding the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and how this applies to customary health care practices and other information on the Department of Health & Human Services (HHS) HIPAA Web page.

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

Source: CMS PERL 201103-55

New *Mental Health Services* booklet

A new publication titled *Mental Health Services* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf*. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

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

Source: CMS PERL 201104-25

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

E-mail address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare websites

Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

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

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

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

Local coverage determinations

First Coast Service Options Inc.
P. O. Box 2078
Jacksonville, FL 32231-0048

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

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

Medicare websites

Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011.	40300260	$33		
2011 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 11, 2011, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				

Please write legibly	Subtotal	$
	Tax (***add % for your area***)	$
	Total	$

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)

Medicare B Connection

First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048

Attention Billing Manager