Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers May 2011

Features

CMS proposes to expand access to seasonal influenza immunization

Proposed requirement would make flu shots available to patients at most commonly visited Medicare-certified health care facilities

The Centers for Medicare & Medicaid Services (CMS) proposed new requirements for Medicare-certified providers that are designed to expand access to seasonal influenza vaccination. The notice of proposed rulemaking would update the conditions of participation and conditions for coverage for a number of provider types, in an effort to increase access to the vaccine, increase the number of patients receiving annual vaccination against seasonal influenza, and to decrease flu-linked morbidity and mortality.

"Today's proposed rule will expand Medicare beneficiaries' options for where to receive a flu shot during flu season," said CMS Administrator, Donald M. Berwick, M.D. "The new requirements would make flu shots available in more of the health care facilities that Medicare beneficiaries are most likely to visit, including hospitals and rural health clinics."

This proposed rule would require many Medicare providers and suppliers to offer all patients an annual influenza vaccination during flu season, unless medically contraindicated. As always, any patient would retain the right to decline any vaccination. This proposed requirement would extend to Medicare-certified:

- Hospitals, including short-term acute care, psychiatric, rehabilitation, long-term care, children's, and cancer
- Critical access hospitals (CAHs)
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs), and
- End-stage renal disease (ESRD) facilities that offer dialysis services.

The proposed rule would update the conditions of participation and conditions for coverage for all of the provider types above. These rules apply to health care organizations that seek to begin and continue participating in the Medicare and Medicaid programs. The conditions are health and safety standards that are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS implements these standards through state departments of health and accrediting organizations recognized by CMS (through a process called "deeming"), which review provider practices to assure they meet or exceed the Medicare's condition standards.

In order to meet these proposed provisions, the providers and suppliers would need to develop and implement policies and procedures for offering and administering

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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.

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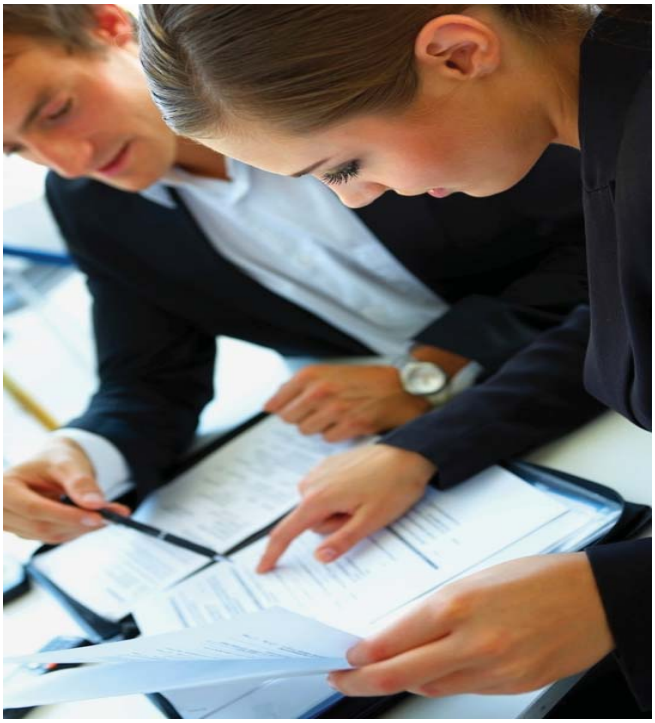
The *Medicare B Connection* represents formal notice of coverage policies. Articles included represent formal notice that specific coverage policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with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

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
- **Contact information** 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.

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.

Note: Effective July 1, 2011, line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

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.

July quarterly update to Correct Coding Initiative edits

Provider types affected

Physicians and providers submitting claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider action needed

This article is based on change request (CR) 7399, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in April 2011.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology* (*CPT*) *Manual*
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, version 17.2, is effective July 1, 2011, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

- Column 1/ Column 2 Correct Coding Edits
- Mutually Exclusive Code (MEC) Edits

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.gov/NationalCorrectCodInitEd*.

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at *http://www.cms.gov/manuals/downloads/clm104c23.pdf*. The official instruction, CR 7399, issued to your carrier or A/B MAC regarding this change can be found at *http://www.cms.gov/Transmittals/downloads/R2217CP.pdf*. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7399
Related Change Request (CR) #: 7399
Related CR Release Date: May 13, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2217CP
Implementation Date: July 5, 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.

Get Ready for 5010 – Test now

Visit our new HIPAA 5010 section of the provider website at *http://medicare.fcso.com/Landing/199612*.asp, where you'll learn the latest news about HIPAA 5010, find out how to prepare for 5010 testing, and discover the resources you need to make your the transition to 5010 as smooth as possible. Don't wait – call FCSO's EDI to test now -- 888-670-0940, option-5.

Consolidated Billing

Excluding certain HCPCS billing codes from SNF consolidated billing

Several new Healthcare Common Procedure Coding System (HCPCS) billing codes created for January 2011 were not excluded from the skilled nursing facility (SNF) consolidated billing bundled payment and allowed to be paid separately. Effective July 5, 2011, for dates of service on or after January 1, 2011, claim processing edits for institutional claims for computerized axial tomography (CT) scans codes (74176, 74177, and 74178) will be revised to allow separate payment for these codes outside of the SNF consolidated billing bundled payment. These codes were already included in the annual update for physician and practitioner claims and claims have processed correctly.

Institutional providers that submitted claims with dates of service on or after January 1, 2011, would have had claims denied for these services. These providers should contact their Medicare fiscal intermediary or Medicare administrative contractor to have the claims reopened and reprocessed.

In addition, a policy decision has been made by the Centers for Medicare & Medicaid Services that Dacogen (HCPCS code J0894) meets the clinical parameters for exclusion from SNF consolidated billing as a high-intensity chemotherapy drug. Therefore, effective October 3, 2011, for claims with dates of service on or after January 1, 2011, claim processing edits will be revised to allow for the separate payment of HCPCS code J0894 outside of the SNF consolidated billing bundled payment.

Institutional providers, physicians, and practitioners that submitted claims with dates of service on or after January 1, 2011, would have had claims denied for these services. These providers should contact their Medicare carrier, fiscal intermediary, or Medicare administrative contractor to have the claims reopened and reprocessed.

If you have any additional questions please contact your Medicare carrier, fiscal intermediary, or Medicare administrative contractor.

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

Source: CMS PERL 201105-31

Drugs and Biologicals

Medicare Part B average sales price – payments for Wilate and Flulaval

For the April 2011 average sales price quarterly update, the Centers for Medicare & Medicaid Services (CMS) is not publishing a payment limit for procedure code J7184 [Injection, Von Willebrand Factor Complex (Human), Wilate, Per 100 iu VWF:RCO] for claims with dates of service between April 1 and June 30. A price for Wilate may be found on the "April 2011 ASP Not Otherwise Classified (NOC)" pricing file available on the CMS website.

Additionally, as per updated change request 7234, CMS has updated the price for procedure code Q2036 (Flulaval vacc, 3 yrs & >, im) to $8.784 for the April 2011 ASP quarterly update. This updated price is effective for claims with dates of service on or after October 1, 2010. The revised price has been added to the October 2010 and January 2011 ASP pricing files.

These pricing files may be found on the CMS website at *http://www.CMS.gov/McrPartBDrugAvgSalesPrice*.

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

Source: CMS PERL 201105-10

CMS.... (continued from page 1)

seasonal influenza vaccine. The proposed rule does allow for situations in which vaccine supplies may be unavailable or in short supply, and recognizes that providers and suppliers could not be held accountable for providing vaccine for all patients in such circumstances.

Additionally, the proposed rule would require the included providers and suppliers to develop policies and procedures that would allow them to offer vaccinations for pandemic influenza, in case of a future pandemic influenza event for which a vaccine is developed.

"This proposal will remove barriers for Medicare beneficiaries who want to receive annual flu shots as part of their preventive health routine," said Dr. Berwick. "While CMS believes that flu vaccination is the best way to keep beneficiaries and their families safe and healthy during flu season, our proposal respects the rights of beneficiaries and their families to choose whether the flu shot is best for them. However, we hope that by expanding the breadth of places where flu shots are offered, beneficiaries will make the choice about whether to vaccinate based on health needs rather than convenience or availability."

CMS will accept public comments on the CMS proposed rule until July 5 and will respond to comments in a final rule to be published in the coming months. To submit comments, please visit *http://www.regulations.gov* and search for rule "CMS-3213-P."

The proposed rule is available online from the *Federal Register* at *http://edocket.access.gpo.gov/2011/pdf/2011-10646.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 201104-59

Coding rules for chemotherapy administration and nonchemotherapy injections and infusion services

First Coast Service Options, Inc has identified a Medicare claim coding issue for chemotherapy administration and nonchemotherapy injections and infusion services. This issue impacts the following *Current Procedural Terminology* (*CPT*) codes:

- *96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour*

Note: *CPT* code *96365* is effective January 1, 2009, replacing *CPT* code *90765*.

- *96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)*

Note: *CPT* code *96369* is effective January 1, 2009, replacing *CPT* code 90769.

- *96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*

When administering multiple infusions, injections, or combinations, the physician should report only one "initial" service code unless the protocol requires that two separate IV sites must be used. If more than one "initial' service code is billed per day, the second initial service code will be denied unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. **Note**: Use modifier 59 to note a separate identifiable service.

Source: Publication 100-04, Chapter 12, Section 30.5 (E)

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines

Note: This article was revised on April 25, 2011, to reflect a revised change request (CR) 7234 issued on April 22. The CR 7234 was revised to update the price of HCPCS code Q2036 to $8.784 retroactive to October 1, 2010. This article was revised accordingly. This information was previously published in the December 2010 *Medicare B Update!* pages 10-11.

Provider types affected

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

Provider action needed

The article is based on CR 7234 which establishes separate billing codes for each brand-name influenza vaccine product under *Current Procedural Terminology* (*CPT*) code *90658* and describes the process for updating the new specific Healthcare Common Procedure Coding System (HCPCS) codes and their payment allowances for Medicare during the 2010-2011 influenza season.

Background

CMS has created specific HCPCS codes and payment allowances to replace *CPT* code *90658* for Medicare billing purposes for the 2010-2011 influenza season.

Key points of CR 7234

The following describes the process for updating these specific HCPCS codes for Medicare payment effective for dates of service on or after October 1, 2010.

Effective for claims with dates of service on or after January 1, 2011, the following *CPT* code will no longer be payable for Medicare:

CPT code	Short description	Long description
90658	Flu vaccine, 3 yrs & >, im	*Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use*

Effective for claims with dates of service on or after October 1, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Note: *CPT 90658* describes the regular dose vaccine that is supplied in a multi-dose vial for use in patients over three years of age. For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) will replace the *CPT* code *90658* for Medicare payment purposes during the 2010-2011 influenza season. However, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when *CPT* code *90658* will no longer be recognized.

This instruction does not affect any other *CPT* codes. It is very important to distinguish between the various *CPT* and HCPCS codes which describe the different formulations of the influenza vaccines (i.e., pediatric dose, regular

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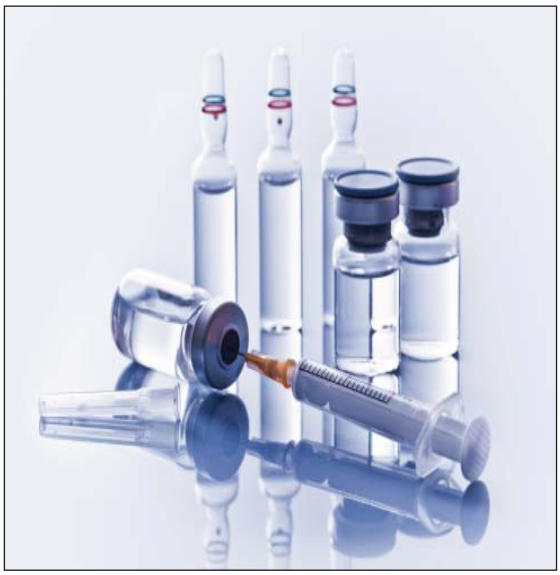
New.... (continued)

dose, high dose, preservative free, etc.). As a reference, the quarterly Part B drug pricing files includes a set of National Drug Code (NDC) to HCPCS crosswalks available online at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/*.



Billing

In general, it is inappropriate for a provider to submit two claims for the same service on the same date. For dates of service between October 1, 2010, and December 31, 2010, the *CPT 90658* and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the *CPT 90658* and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010, and December 31, 2010, the provider may either bill Medicare immediately using *CPT 90658*, or hold the claim and wait until January 1, 2011, to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using *CPT 90658*, then there is no need to use the Q-code for that same service.

For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

Payment

The Medicare Part B payment limits for influenza vaccines are 95 percent of the average wholesale price (AWP) except where the vaccine is furnished in a setting that follows a cost-based or prospective payment system under Medicare. For example, where the vaccine is furnished in the hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), payment for the vaccine is based on reasonable cost.

For dates of service on or after October 1, 2010, the Medicare Part B payment allowances in other situations are:

HCPCS code	Allowance
Q2036	$8.784
Q2037	$13.253
Q2038	$12.593

No national payment limits are available for Q2035 and Q2039. The payment limits for these two codes will be determined by the local claims processing contractor.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for *CPT 90655* is $14.858.

Important notes

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 7324. However, they will adjust such claims that you bring to their attention.

Additional information

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

For complete details regarding this CR please see the official instruction (CR 7234) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to *http://www.cms.gov/Transmittals/downloads/R884OTN.pdf*.

CMS would like providers to be aware that educational products are available through the MLN Catalogue free of charge. The MLN Catalogue is available at *http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf*. The specific products that may be of interest to providers who use the information in MM7234 are as follows:

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New.... (continued)

1. The *Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing* (Influenza, Pneumococcal, and Hepatitis B) is available at *http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

2. The *Adult Immunizations* brochure provides a basic overview of Medicare's influenza, pneumococcal and hepatitis B vaccine benefits and is available at *http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

MLN Matters Number: MM7234 *Revised*
Related Change Request (CR): 7234
Related CR Release Date: April 22, 2011
Effective Date: October 1, 2010 unless otherwise specified
Related CR Transmittal #: R884OTN
Implementation Date: January 3, 2011

Durable Medical Equipment

Power mobility device face-to-face examination checklist

Provider types affected

This special edition (SE) *MLN Matters*® article is intended for physicians or treating practitioners who prescribe a power mobility device (PMD) for Medicare beneficiaries. (In addition to a physician; a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD.) The article should also be of interest to durable medical equipment (DME) suppliers who submit claims to DME Medicare administrative contractors (DME MACs) for such equipment.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article as solely an educational guide to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for their Medicare patients. The article presents a checklist, which is a tool that providers may wish to use for this examination, in addition to some helpful tips to help providers and suppliers avoid denial of their PMD claims. The use of this guide is not mandatory and does not ensure Medicare payment for a PMD, even if signed and dated.

Background

Power wheelchairs and power operated vehicles (also known POVs or scooters) are collectively classified as power mobility devices (PMDs) and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered item of DME that includes a power wheelchair or a POV that a beneficiary uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as mobility assistive equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of portions of the medical record essential for supporting the medical necessity for the PMD in the beneficiary's home. In order to document the need for a PMD there are a few specific statutory requirements that must be met before the prescription is written:

1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.

2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the beneficiary's mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.

Power.... (continued)

3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.
4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination.
5. CMS' national coverage determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiaries mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

CMS offers a checklist that providers may wish to use in the examination and documentation process and can be found in the 'Attachment' section at the end of this article. The checklist contains the information that is essential for Medicare to determine the medical necessity of the PMD. Please note, the checklist contained in this article is a guide and does not replace the underlying medical records. The checklist outlines the information that is essential for Medicare to have in determining whether payment should be made for a PMD. It is provided for educational purposes and serves to help providers understand the types of information which Medicare believes is critical for providers to document the patient's medical need in the home and that the device can be used safely.

The evaluation should be tailored to the individual patient's conditions. The medical history should contain a well-documented description of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

Tips to avoid denial of PMD claims

Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.
The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient's use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD in the home to safely and effectively accomplish Activities of Daily Living (ADLs)?
  - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
  - What are important medical history factors that demonstrate the patient's mobility limitations?
- Do the physical examination findings support the patient's claimed functional status (mobility level)?
  - Physical Examination (PE): The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g. weak, breathless, tired, etc), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g. range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. Included in all exams must be a detailed description of the patient's observed ability or inability to transfer and/or walk. Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:
- Height and weight
- Limb abnormalities
- Strength, tone, coordination, reflexes, balance
- Heart rate, blood pressure, respiratory rate (at rest and with exertion)
- Joint swelling, range of motion, erythema, subluxation
- Description of limb loss, and
- Cardiopulmonary exam
- If the patient is thought to require a PMD due to respiratory illness or injury:
  - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?

continued on next page

Power.... (continued)

- If the patient is thought to require a PMD due to cardiovascular illness or injury:
  - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to neuromusculoskeletal illness or injury or malformed body member:
  - Describe the patient's impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient's functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative example of medical record documentation

This entry may result in a claim **denied**:
Mr. Smith is a male, age 72, with chronic obstructive pulmonary disease (COPD) who over the last few weeks has been having more shortness of breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:
Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.

VS 138/84, Ht rate 88 RR 16 at rest on 3L NC

Vision- sufficient to read newspaper with glasses on

Cognition- OX3. Able to answer my questions without difficulty.
Ht XX Wt YY

Ambulation – Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.

Lung exam – Hyperresonant percussion and distant breath sounds throughout. Occ wheezes.

Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.

Steps carefully around objects in the room.

Alternative MAE equipment – Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.

Assessment – Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.

Accurate and complete documentation in the physician records regarding the face-to-face examination is extremely important to ensure the patient receives an appropriate PMD.

Additional information

If you have any questions, please visit the website of your DME MAC or contact them at their toll-free number. Their Web address and toll-free number are available at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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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.

Power.... (continued)

Attachment – Sample checklist for the PMD examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.
The medical record for the patient includes the following history:

_____ Signs/Symptoms that limit ambulation

_____ Diagnoses that are responsible for these signs/symptoms

_____ Medications or other treatment for these signs/symptoms

_____ Progression of ambulation difficulty over time

_____ Other diagnoses that may relate to ambulatory problems

_____ How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker

_____ Pace of ambulation

_____ History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient

_____ What has changed in the patient's condition that now requires the use of a power mobility device

_____ Reason for inability to use a manual wheelchair; such as assessment of upper body strength

_____ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (a cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair or power operated vehicle (scooter) in the home to satisfy their needs?

_____ Description of the home setting, including the ability to perform activities of daily living in the home, as well as the ability to utilize the PMD in the home

The physical examination is relevant to the patient's mobility needs and the medical record for the patient contains:

_____ Weight and Height

_____ Musculoskeletal examination

- Arm and leg strength and range of motion

_____ Neurological examination

- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include a documented observation of ambulation (with use of cane or walker as appropriate)

MLN Matters® Number: SE1112
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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

Hospice

Proposed rule for fiscal year 2012 hospice wage index

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule addressing the hospice wage index for fiscal year (FY) 2012. The proposed rule would increase Medicare payments to hospices by an estimated 2.3 percent for FY 2012 and establish a new quality reporting system authorized by the Affordable Care Act.

Under the proposed quality reporting system, hospices would be required to submit data on quality measures to CMS or have their annual increase factor reduced by 2 percentage points, starting in FY 2014. The proposed measures include one item endorsed by the National Quality Forum related to pain management and one structural measure related to participation in specific Quality Assessment and Performance Improvement (QAPI) programs.

The rule also proposes to change the way hospice patients are counted for purposes of the 2012 cap year and beyond. Federal law requires that CMS impose a limit on the aggregate Medicare payments a hospice provider receives annually. This rule proposes to change the current calculation of the cap and also proposes that the new counting method be applied to past years in certain instances. In addition, the proposed rule would allow hospice providers who do not want to change their patient counting method to elect to continue using the current methodology.

Finally, the proposed rule would modify the face-to-face encounter requirement for hospices, by proposing to remove the limitation that requires the hospice physician who performs the face-to-face encounter and attests to that encounter be the same physician who certifies the patient's terminal illness.

The proposed rule is now on display today at the Office of the *Federal Register*'s Public Inspection Desk and will be available under "Special Filings," at *www.ofr.gov/inspection.aspx*.

CMS will accept comments on the proposed rule until June 27, 2011. More details about this proposed rule will also be available at *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: CMS PERL 201104-55

Laboratory/Pathology

Adjudication of laboratory tests that are excluded from Clinical Laboratory Improvement Amendment edits

Provider types affected

Clinical laboratories submitting claims to Medicare carriers and/or Medicare Part A/B Medicare administrative contractors (A/B MACs) for laboratory services provided to Medicare beneficiaries are affected by this issue.

What you need to know

Change request (CR) 7325, from which this article is taken, instructs Medicare contractors to remove from Clinical Laboratory Improvement Amendment (CLIA) editing all laboratory tests (and/or their components) that are included on the list of Healthcare Common Procedure Coding System (HCPCS) codes in the 80000 series that are excluded from CLIA editing. You may request contractors to reprocess any claim for services included on the aforementioned list that was previously denied for lack of a CLIA number. Please make sure that your billing staff is aware of the change.

Background

Claims for certain services that are included on the list of HCPCS codes in the 80000 series that are excluded from CLIA edits are being denied for the lack of a CLIA certificate. CR 7325 reiterates the policy that no CLIA

continued on next page

Adjudication.... (continued)

certificate is required for a claim submitted for any test mentioned in the HCPCS codes in the 80000 series that are excluded from CLIA edits list. Contractors must ensure that the codes on this list are not subject to CLIA edits. For a list of the specific HCPCS codes subject to CLIA edits, refer to *http://www.cms.gov/CLIA/downloads/Subject.to.CLIA.pdf*.

For a list of the specific HCPCS codes in the 80000 series that are excluded from CLIA edits, refer to *http://www.cms.gov/CLIA/downloads/cpt4exc.pdf*. This list is also attached to CR 7325.

Additional information

The official instruction, CR 7325, issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R882OTN.pdf*.
If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7325
Related Change Request (CR) #: 7325
Related CR Release Date: April 22, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R882OTN
Implementation Date: October 3, 2011

Screening for the human immunodeficiency virus infection

Note: This article was revised on April 27, 2011, to reflect the revised change request (CR) 6786, which was issued on April 22, 2011. In this article, the CR transmittal number, release date, and the Web address for accessing the CR were changed. All other information is the same. This information was previously published in the March 2011 *Medicare B Update!* pages 27-28.

Provider types affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors [fiscal intermediaries (FI), carriers, and Part A/B Medicare administrative contractors (A/B MAC)] for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Caution – what you need to know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the *National Coverage Determination (NCD) Manual*, Sections 190.14 and 210.7, and the *Medicare Claims Processing Manual* (CPM), Chapter 18, Section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

Go – what you need to do

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

Background

Effective January 1, 2009, the CMS is authorized to add coverage of "additional preventive services" through the NCD process if certain statutory requirements are met, as provided under Section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

continued on next page

Screening.... (continued)

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786.

Note: Eleven full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

Note: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The USPSTF guideline upon which this policy is based contains eight increased-risk criteria. The first seven require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

Note: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates:

- G0432 – infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
- G0433 – infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and
- G0435 – infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Prior to inclusion of the new G-codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code *87999* may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional information

CR 6786 consists of two transmittals, the first of which is at *http://www.cms.gov/Transmittals/downloads/R2163CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*. The other transmittal updates *Medicare NCD Manual* and that is at *http://www.cms.gov/Transmittals/downloads/R131NCD.pdf*.

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

MLN Matters® Number: MM6786 *Revised*
Related Change Request (CR) #: 6786
Related CR Release Date: February 23, 2010
Effective Date: December 8, 2009
Related CR Transmittal #: R2163CP and R131NCD
Implementation Date: July 6, 2010

New waived tests

Provider types affected

This article is for clinical diagnostic laboratories billing Medicare carriers or Medicare administrative contractors (MACs) for laboratory tests.

Provider action needed

Stop – impact to you

Change request (CR) 7349 announces two newly added Clinical Laboratory Improvement Amendments of 1998 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) is notifying contractors of the new tests so that claims can be accurately processed.

Caution – what you need to know

1. On February 8, 2011, the FDA informed CMS that the Teco Diagnostics Uritek TC-101 Urine Analyzer was no longer categorized as a waived test under CLIA. This test has been removed from the list attached to CR 7349.
2. On February 9, 2011, CMS determined that the code to assign to the OraSure Technologies OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test is G0433 effective January 1, 2011. In addition, the code assigned to the Clearview Complete HIV 1/2 test should be G0433. Therefore, the code assigned both tests was changed from *86703QW* to G0433QW in the list attached to CR 7349.

Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 2011 and that you remain current with certification requirements.

Background

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology* (*CPT*) codes that CMS consider to be laboratory tests under CLIA (and, therefore, requiring certification) change each year. CR 7349, from which this article is taken, informs carriers and MACs about the latest new CPT codes that are subject to CLIA edits.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The CPT codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 7349 (i.e., *CPT* codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

CPT code	Effective date	Description
82274QW *G0328QW*	January 1, 2011	Polymedco Poly Stat OC-light FOB Test
87804QW	January 10, 2011	BTNX, Inc. Rapid Response Influenza A Test Cassette
87804QW	January 10, 2011	BTNX, Inc. Rapid Response Influenza B Test Cassette

Note: Medicare contractors will not search their files to either retract payment or retroactively pay claims. They will, however, adjust claims if you bring such claims to their attention.

Additional information

The official instruction, CR 7349, issued to your Medicare carrier or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2196CP.pdf*.

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

MLN Matters® Number: MM7349
Related Change Request (CR) #:7349
Related CR Release Date: April 22, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2196CP
Implementation Date: July 5, 2011

June 15 is National Version 5010 Testing Day

The version 5010 compliance date – Sunday, January 1, 2012 – is fast approaching. All HIPAA-covered entities should be taking steps now to get ready, including conducting external testing to ensure timely compliance. Are you prepared for the transition? Medicare fee-for-service (FFS) trading partners are encouraged to contact their Medicare administrative contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to version 5010.

To assist in this effort, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare FFS program, announces a National 5010 Testing Day to be held Wednesday, June 15, 2011. National 5010 Testing Day is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs.

CMS encourages all trading partners to participate in the National 5010 Testing Day. This includes:

- Providers
- Clearinghouses
- Vendors

More details concerning transactions to be tested are forthcoming from your local MAC. Additionally, there are several state Medicaid agencies that will be participating in the National 5010 Testing Day; more details will follow from them as well.

Again, CMS National 5010 Testing Day does not preclude trading partners from testing transactions immediately with their MAC. Don't wait. You are encouraged to begin working with your MAC now to ensure timely compliance. Note that successful testing is required before a trading partner may be placed into production.

We hope all trading partners will join us on Wednesday, June 15, 2011, and take advantage of this great opportunity to ensure testing and transition efforts are on track. For more information on HIPAA 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 201105-06

HIPAA 5010 & D.0 – implementation calendar and important reminders

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0., you will be periodically reminded of important items and dates that may be of specific interest to the Medicare fee-for-service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken placed during this implementation process.

Important implementation reminders

Announcement: January 1, 2011, marked the beginning of the 5010/D.0. transition year

Announcement: Versions 5010 & D.0 FAQs now available (**New**)
(*https://questions.cms.hhs.gov/app/answers/list/kw/5010*)

Announcement: National Testing Day message now available (**New**)
(*http://www.cms.gov/Versions5010andD0/Downloads/5010_National_Testing_Day_Message.pdf*)

Reminder: 5010/D.0. errata requirements and testing schedule
(*http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf*)

Reminder: Contact your MAC for their testing schedule
(*http://www.cms.gov/Versions5010andD0/Downloads/Reminder-Contact_MAC.pdf*)

Readiness assessment: Have you done the following to be ready for 5010/D.0.?
(*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf)*

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HIPAA....(continued)

Readiness assessment: What do you need to have in place to test with your Medicare administrative contactor (MAC)? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf)*

Readiness assessment: Do you know the implications of not being ready? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf)*

Implementation calendar

Current events

May 2011
May 2-5: 20th Annual WEDI National Conference *
(*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1)*
May 25: CMS-hosted Medicare fee-for-service national call – call to action – test!
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1247188&intNumPerPage=10)*

Upcoming events

June 2011
June 15: National MAC testing day (for vendors, clearinghouses, and billing services, etc.)

July 2011
July 20: MAC hosted outreach and education session -- troubleshooting with your MAC

August 2011
August 24: National MAC testing day (for providers)
August 31: CMS-hosted Medicare fee-for-service national call -- MAC panel

October 2011
October 5: MAC hosted outreach and education session (last push for implementation)
October 24-27: WEDI 2011 fall conference*
(*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11927000002B1)*

December 2011
December 31: End of the transition year, and the beginning of 5010 production environment

Past events

June 2010
June 15: 5010 national call – ICD-10/5010 national provider call
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10)*
June 30: 5010 national call – 837 institutional claim transaction
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1236487&intNumPerPage=10)*

July 2010
July 28: 5010 national call – 276/277 claim status inquiry and response transaction set
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237767&intNumPerPage=10)*

August 2010
August 25: 5010 national call – 835 remittance advice transaction
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1238739&intNumPerPage=10*)

September 2010
September 27: 5010 national call – acknowledgement transactions (TA1, 999, 277CA)
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10*)

October 2010
October 13: 5010/D.0. errata requirements and testing schedule released
(*http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf*)

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HIPAA....(continued)

October 27: 5010 national call – NCPDP version D.0. transaction (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1240794&intNumPerPage=10)*

November 2010

November 4: Version 5010 resource card published (*http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*)
November 8: WEDI 2010 fall conference* (*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C*)
November 17: 5010 national call – coordination of benefits (COB) (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241427&intNumPerPage=10*)

December 2010

December 8: 5010 national call – MAC outreach and education activities and transaction-specific testing protocols (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10*)

January 2011

January 1: Beginning of transition year
January 11: HIMSS 5010 industry readiness update* (*http://www.himss.org/asp/UnknownContent.asp?type=evt*)
January 19: 5010 national call – errata/companion guides (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10*)
January 25-27: 4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation* (*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029*)

February 2011

February 20-24: Healthcare Information and Management Systems Society (HIMSS) 11th Annual Conference & Exhibition* (*http://www.himss.org/ASP/eventsHome.asp*)

March 2011

March 1: New readiness assessment – Do you know the implications of not being ready? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf*)
March 30: CMS-hosted 5010 national call – provider testing and readiness (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1244551&intNumPerPage=10*).

April 2011

April 4-11: Version 5010 test education week
April 27: MAC hosted outreach and education session – are you ready to test?

For older national call information, please visit the 5010 National Calls section of CMS' versions 5010 & D.0 Web page at *http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage.*

* Information about events in which the Centers for Medicare & Medicaid Services (CMS) Medicare FFS staff participates may be applicable to the health care industry at large, though it is geared toward the Medicare FFS audience.

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

Source: CMS PERL 201105-15

Claim adjustment reason code and remittance advice remark code update

Provider types affected

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

Provider action needed

Change request (CR) 7369, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs) that are effective on July 1, 2011 for Medicare. Be sure your billing staff is aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. Additions, deactivations, and modifications to the list may be initiated by any health care organization. The RARC list is updated three times a year – in early March, July, and November, although the committee meets every month.

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these code lists, as announced in CR 7369.

Additional information

To see the official instruction (CR 7369) issued to your Medicare carrier, RHHI, DME MAC, FI and/or MAC, refer to *http://www.cms.gov/Transmittals/downloads/R2213CP.pdf*.

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

CR 7369 changes

New codes – CARC

Code	Current narrative	Effective date per WPC posting
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative.	January 30, 2011

Modified codes – CARC:
None

Deactivated codes – CARC:
None

New codes – RARC:

Code	Current narrative	Medicare initiated
N542	Missing income verification	No
N543	Incomplete/invalid income verification	No

Modified codes – RARC:

Code	Modified narrative	Medicare initiated
M37	Not covered when the patient is under age 35.	No
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.	No
N62	Dates of service span multiple rate periods. Resubmit separate claims.	No

Claim....(continued)

Code	Modified narrative	Medicare initiated
N356	Not covered when performed with, or subsequent to, a non-covered service.	No
N383	Not covered when deemed cosmetic.	No
N410	Not covered unless the prescription changes.	No
N428	Not covered when performed in this place of service.	No
N429	Not covered when considered routine.	No
N431	Not covered with this procedure.	No

Deactivated codes – RARC:
None

MLN Matters® Number: MM7369
Related Change Request (CR) #: 7369
Related CR Release Date: May 6, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2213CP
Implementation Date: July 5, 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.

Get Ready for 5010 – Test now

Visit our new HIPAA 5010 section of the provider website at *http://medicare.fcso.com/Landing/199612*.asp, where you'll learn the latest news about HIPAA 5010, find out how to prepare for 5010 testing, and discover the resources you need to make your the transition to 5010 as smooth as possible. Don't wait – call FCSO's EDI to test now -- 888-670-0940, option-5.

Incentive Programs

How do I get paid for the electronic health record incentive programs?

Payments for the Medicare and Medicaid electronic health record (EHR) incentive programs are distributed based on each year of participation, and follow a specific payment schedule (see *https://www.cms.gov/EHRIncentivePrograms/35_Basics.asp*). Located below are payment details on the Medicare and Medicaid EHR incentive programs. For an overview, see the *Medicare Learning Network (MLN) Matters* Special Edition article (SE1111) – Medicare Electronic Health Record (EHR) Incentive Payment Process, available at *http://www.cms.gov/MLNMattersArticles/Downloads/SE1111.pdf*.

Medicare EHR incentive program

- Eligible professionals (EPs): EPs can receive up to $44,000 over five years under the Medicare EHR incentive program. There's an additional incentive for EPs who provide services in a health professional shortage area (HPSA).To get the maximum incentive payment, Medicare EPs must begin participation by 2012.
- Eligible hospitals and critical access hospitals (CAHs): Incentive payments to eligible hospitals and CAHs may begin as early as 2011, and are based on a number of factors, beginning with a $2 million base payment.

Medicaid EHR incentive program

- EPs: The Medicaid EHR incentive program is voluntarily offered by states and territories. EPs can receive up to $63,750 over the six years that they choose to participate in the program. Medicaid EPs must initiate the program by 2016.
- Eligible hospitals: Medicaid hospitals that qualify for incentive payments may begin receiving incentive payments as early as fiscal year (FY) 2011. Hospital payments are based on a number of factors, beginning with a $2 million base payment. Medicaid hospitals must initiate the payments by 2016.

Important note: Medicare administration contractors (MACs), carriers, and fiscal intermediaries (FIs) will not be making Medicare EHR incentive 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

- Hours of operation: 7:30 a.m.-6:30 p.m. (Central Time) Monday through Friday, except federal holidays.
- 888-734-6433 (primary number) or 888-734-6563 (TTY number).

A revised FAQ on payment for the EHR incentive programs has been posted to the EHR website
Question: For the 2011 payment year, how and when will incentive payments for the Medicare EHR incentive program be made?

Answer: For EPs, incentive payments for the Medicare EHR incentive program will be made approximately four to eight weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Read the rest of the answer to this FAQ at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/session/L3NpZC9Gb3hCb0Rzaw%3D%3D*.

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.

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

Source: CMS PERL 201104-53

New materials posted to the EHR website

New Medicare attestation resources

The Centers for Medicare & Medicaid Services (CMS) has developed attestation worksheets to help providers successfully attest to meeting meaningful use through the CMS Web-based attestation system.

These attestation worksheets allow eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to log additional data for core and menu measures that might not be obtained only through their certified electronic health record (EHR) system. In order to provide complete and accurate information for certain of these measures, EPs and hospitals may have to include information from paper-based patient records or from other areas. (Please note that clinical quality measures must be reported directly from certified EHR technology.)

You can fill out the attestation worksheets electronically or manually, and then keep the worksheet on hand as you attest so your data is easily accessible.

You can find the worksheets by clicking the links below. Make sure to use the worksheet that pertains to you:

- *Attestation Worksheet for Eligible Professionals* (*https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_Worksheet.pdf*)
- *Attestation Worksheet for Eligible Hospitals and Critical Access Hospitals* (*https://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf*)

Updates to the comprehensive EHR incentive program frequently asked questions (FAQs) document

CMS has also posted the latest FAQs document at *http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf*. This interactive document provides updated FAQs up to the end of April 2011. Each FAQ is sorted by topic to help you more easily review information about various aspects of the EHR Incentive Programs. CMS will continue to provide updates as new FAQs are added.

Want more information about the EHR incentive programs?

Make sure to visit the CMS EHR Incentive Programs website 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 201105-25

Get motivated by Medicare …

Find out about Provider Incentive Programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

Available at *http://medicare.fcso.com/Landing/191460.asp*

EHR incentive program – new FAQs added

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. New FAQs have been added to its website this month. Take a minute and review the new FAQs on attestation, meaningful use, certified EHR technology, and the path to payment.

Attestation

1. To what attestation statements must an eligible professional (EP), eligible hospital, or critical access hospital (CAH) agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR Incentive Program? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10589/p/21%2C26%2C11*.
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.hhs.gov/app/answers/detail/a_id/10474*.

Meaningful use

1. For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid EHR Incentive Program, how should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10284/p/21%2C26%2C11*.
2. For the meaningful use objective to "record and chart changes in vital signs" for the Medicare and Medicaid EHR Incentive Programs, can an EP claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10593/p/21%2C26%2C11*.
3. In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified EHR technology for the Medicare and Medicaid EHR Incentive Programs, how should patient encounters be calculated? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10592/p/21%2C26%2C11*.
4. If an eligible hospital or CAH has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10591/p/21%2C26%2C11*.

Certified EHR technology

1. If a provider purchases a certified complete EHR or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10590/p/21%2C26%2C11*.

Path to payment

1. For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/p/21%2C26%2C11*.

Additional information

Want more information about the EHR incentive programs? Make sure to visit the CMS EHR Incentive Program at *http://www.cms.gov/EHRIncentivePrograms/* website for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201105-01

Medicare electronic health record incentive payments to be issued

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the Medicare electronic health record (EHR) incentive program will be sent out the week of May 16. Providers who have successfully attested to having met meaningful use, and who have met all the other program requirements, can expect to receive their 2011 incentive payments soon.

What kind of payment can I expect?
Eligible professionals (EPs) participating in the Medicare EHR incentive program receive a payment based on 75 percent of their total Medicare allowed charges submitted no later than two months after the end of the 2011 calendar year. The maximum allowed charges used for a 2011 incentive payment is $24,000. This means that the maximum incentive payment an EP can receive for the first participation year is $18,000.

Please note that incentive payments will not be made to an EP until the EP meets the $24,000 threshold in allowed Medicare charges. Incentive payments to eligible hospitals and critical access hospitals are based on a number of factors, beginning with a $2 million base payment.

How are payments made?
Participants will receive their Medicare EHR incentive program payment the same way they receive payments for Medicare services, via electronic funds transfer or by paper check. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected during registration for the Medicare EHR incentive program. For electronic transfers, CMS will deposit incentive payments in the first bank account on file and it will appear on the bank statement as "EHR Incentive Payment."

Important: Medicare administrative contractors (MACs), carriers, and fiscal intermediaries will not be making these payments**.** CMS is working with a payment file development contractor to make these payments. Please do not contact your MAC regarding EHR incentive payments.

Medicaid EHR incentive program payments
Since January 2011, several states that started their Medicaid EHR incentive programs have made payments to many EPs and eligible hospitals who have met the requirements for the Medicaid EHR incentive program. To date, over $83 million in Medicaid incentive payments have been issued to EPs and eligible hospitals participating in the EHR incentive program.

To view a checklist of how to participate in the Medicare or Medicaid EHR incentive program, look at the Path to Payment section at *http://www.cms.gov/EHRIncentivePrograms/10_PathtoPayment.asp* of the EHR website.

Additional information
Make sure to visit the CMS EHR incentive programs website 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 201105-32

Try the Meaningful Use Attestation Calculator

CMS has launched a new attestation resource for the Medicare electronic health record (EHR) incentive program

All eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR incentive program must attest to having met meaningful use requirements in order to receive their EHR incentive payments.

The Meaningful Use Attestation Calculator, available at *http://www.cms.gov/apps/ehr/*, helps Medicare EPs, eligible hospitals, and CAHs determine if they have met all of the objectives and their associated measures for meaningful use prior to completing attestation for the Medicare EHR incentive program. It is important to note that the tool does not calculate clinical quality measures (CQMs). For additional information, visit *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp*. These measures are reported directly from a certified EHR and will need to be entered in the Web-based attestation system in order to receive an incentive payment. This calculator is not the same as the actual attestation; rather it is a tool that allows Medicare EPs to assess their readiness to successfully complete the attestation process.

continued on next page

Medicare....(continued)

The Meaningful Use Attestation Calculator will help prepare EPs, eligible hospitals, and CAHs for the attestation system. After entering their core and menu measure meaningful use data, the calculator will display whether a provider has met the necessary criteria for these objectives. The user can then print a copy of the measures they have entered and whether they have passed or failed each specific measure.

The calculator will indicate in red those measures for which the input values did not meet the required thresholds and will mark them as "failed."

You may find the **Meaningful Use Attestation Calculator** and more information about the attestation process on the Attestation page at *https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage*.

In order to better understand the meaningful use criteria, EPs, eligible hospitals, and CAHs can also review the Stage 1 Meaningful Use Specification Sheets for:

EPs – *https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf*

Eligible hospitals and CAHs – *https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf*)

These specification sheets contain detailed information on each core and menu meaningful use measure.

Want more information about the EHR incentive programs?
Make sure to visit the CMS EHR incentive programs website at *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs.

This service is provided to you by the Medicare and Medicaid EHR incentive programs, which you may visit at *https://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 201104-38

Medicare EHR incentive program attestation began April 18

Attestation for the Medicare electronic health record (EHR) incentive program

This means that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) can attest through the Centers for Medicare & Medicaid Services (CMS) Web-based attestation system and be on their way to receiving Medicare EHR incentive payments.

CMS can help you successfully attest
Several new CMS resources can help you successfully navigate the Medicare EHR incentive program:

- A new attestation page on the CMS EHR website at *https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp*, where participants in the Medicare EHR incentive program may find important information on attestation.
- The Meaningful Use Attestation Calculator at *http://www.cms.gov/apps/ehr/* allows EPs and eligible hospitals to check whether they have met meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary.
- The Eligible Professional User Guide at *https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_User_Guide.pdf* and the Eligible Hospital and Critical Access Hospital User Guide at *https://www.cms.gov/EHRIncentivePrograms/Downloads/HospAttestationUserGuide.pdf* provide step-by-step guidance for EPs and eligible hospitals on navigating the attestation system.

Coming soon

- Attestation worksheets for EPs and eligible hospitals allow users to fill out their meaningful use measure values, so they have a quick reference tool to use while attesting.
- Attestation video webinars will provide a video version of the user guides for EPs, eligible hospitals and CAHs. The videos show EP and eligible hospital representatives completing the attestation process.

If you are not ready to attest, follow these steps to participate in the programs:

- **Make sure you're eligible for the EHR incentive programs**. View eligibility guidelines on the Eligibility page at *http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp* and select the program in which you want to participate.
- **Get registered**. Registration is open for EPs, eligible hospitals, and CAHs. Visit the Registration page at *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp* for more details.

continued on next page

Medicare....(continued)

- **Use certified EHR technology**. To receive incentive payments, make sure the EHR technology you're using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit our Certified EHR Technology page at *http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp for 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 years) to receive EHR incentive payments. Visit our 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 through Medicare's secure website that you've demonstrated meaningful use with certified EHR technology.

Want more information about the EHR incentive programs?

Make sure to visit the EHR incentive program website 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

Indiana and Ohio launched Medicaid EHR incentive programs

On May 2, Indiana and Ohio opened their Medicaid electronic health record (EHR) incentive programs for registration to Medicaid eligible professionals (EPs) and eligible hospitals. EPs and eligible hospitals in these states are now able to receive Medicaid EHR incentive payments after successfully registering and attesting at the state level to having adopted, implemented, or upgraded certified EHR technology. More information about the Medicaid EHR incentive program can be found on the Medicare and Medicaid EHR Incentive Program Basics Web page at *http://www.cms.gov/EHRIncentivePrograms/35_Basics.asp#TopOfPage* of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you provide health care services to Medicaid beneficiaries in Indiana or Ohio, and want more information about participating in your state's Medicaid EHR incentive program, visit your state Medicaid agency website here:

- Indiana (*http://provider.indianamedicaid.com/general-provider-services/ehr-incentive-program.aspx*)
- Ohio (*http://jfs.ohio.gov/OHP/HIT%20Program.stm*)

As of May 2, 15 states have launched their Medicaid EHR incentive programs, and seven states have issued incentive payments to Medicaid EPs and eligible hospitals that have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

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.

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

Source: CMS PERL 201105-07

Physician Quality Reporting System and eRx incentive program announcement

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2009 Physician Quality Reporting System & Electronic Prescribing Incentive (eRx) Programs Reporting Experience Report is now available.

The 2009 experience report summarizes the experience of eligible professionals in the 2009 Physician Quality Reporting System and eRx incentive programs, as well as trends in the program over time, including early results from 2010.

The 2009 experience report is available in the "Downloads" section of the "Overview" page on the Physician Quality Reporting System Web page, located at *http://www.cms.gov/PQRS/*. It is also posted as a download on the "Overview" page under "Related Links Inside CMS" on the eRx Web page, located at *http://www.cms.gov/ERxIncentive/*.

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

Source: CMS PERL 201105-13

General Information

Affordable Care Act gives providers new options to better coordinate health care

New accountable care organization models will improve patient care and save Medicare up to $430 million

The Centers for Medicare & Medicaid Services (CMS) announced three Affordable Care Act initiatives designed to help put doctors, hospitals, and other healthcare providers on the path to becoming accountable care organizations (ACOs) and improve healthcare for Americans with Medicare.

First, The Center for Medicare & Medicaid Innovation (*http://innovations.cms.gov/*) is requesting applications for the new Pioneer ACO Model (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/*) that provides a faster path for mature ACOs that have already begun coordinating care for patients and are ready to move forward.

Second, the innovation center is seeking comment on the idea of the Advance Payment Initiative (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/*) that gives certain ACOs participating in the Medicare Shared Savings Program access to their shared savings up front, helping them make the infrastructure and staff investments crucial to successfully coordinating and improving care for patients.

Finally, providers interested in learning more about how to coordinate patient care through ACOs can attend free new accelerated development learning sessions (*https://acoregister.rti.org/*). These sessions will teach providers interested in becoming ACOs what steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care.

Together with the Medicare Shared Savings Program (*http://www.cms.gov/sharedsavingsprogram/*), the initiatives announced today give providers a broad range of options and support that reflect the varying needs of providers in embarking on delivery system reforms. CMS issued a proposed rule to implement the Medicare Shared Savings Program in March 2011 and is continuing to encourage and accept comments from providers and the public that will help strengthen the final rule.

These initiatives are part of a broader effort by the Obama Administration, made possible by the Affordable Care Act, to improve care and lower costs. For more information about all of these initiatives, visit the Center for Medicare & Medicaid Innovation website at *http://innovations.cms.gov/*.

Go to *http://www.cms.gov/apps/media/press/release.asp?counter=3957* to read the full CMS press release issued May 17.

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

Source: CMS PERL 201105-28

Reporting of recoupment for overpayment on the remittance advice

Note: This article was revised on April 25, 2011, to correct a statement on page 2 that stated the RAC must report a recoupment in two steps. Actually, it is the remittance advice that reports the recoupment in two steps and the article has been corrected accordingly. All other information is the same. This information was previously published in the March 2011 *Medicare B Update!*, pages 67-68.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries. CR 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.

Provider action needed

This article is based on CR 6870 which instructs Medicare system maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC Program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You may review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm*. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. See the *Medicare Learning Network*® (*MLN*) *Matters*® article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*.

Under the scenario just described, the remittance advice (RA) has to report the actual recoupment in two steps:

- **Step I:** Reversal and correction to report the new payment and negate the original payment (actual recoupment of money does not happen here);
- **Step II:** Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the RA to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare system maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:

Claim level:
The original payment is taken back and the new payment is established

continued on next page

Reporting....(continued)

Provider level:
PLB03-1 – PLB reason code FB (forward balance)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II:

Claim level:
No additional information at this step

Provider level:
PLB03-1 – PLB reason code WO (overpayment recovery)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional information

CMS provides more information including an overview of and recent updates for the RAC program at http://www.cms.gov/RAC/. You may find the *Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers* at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R866OTN.pdf*.

You may also want to review *MLN Matters*® article MM 7068, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7068.pdf*. It instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

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: MM6870 *Revised*
Related Change Request (CR) #: 6870
Related CR Release Date: March 4, 2011
Effective Date: July 1, 2010
Related CR Transmittal #: R866OTN
Implementation Date: July 6, 2010, except October 3, 2011, for claims processed by the FISS system used by FIs and A/B MACs

Final reminder: Time is running out – have you responded to the MCPSS?

Do you have any thoughts on your interactions with the services you experience with us? Have any feedback, positive or constructive, to give the Centers for Medicare & Medicaid Services (CMS) about your experiences with us?

Don't miss your chance to tell – your opportunity to participate in the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly coming to an end and CMS still needs your feedback. If you have already responded to the 2011 MCPSS, thank you. If you have not, don't pass up this golden opportunity to let your voice be heard.

If you or your office received notification from CMS that you were randomly selected to participate in the 2011 MCPSS, this is your last chance to respond before the survey closes. Your feedback is very important. The MCPSS is your opportunity to tell CMS about your satisfaction with the processing and payment services you receive from us.

Completion of the survey should only take a few minutes, and can be done by yourself or your designee; just follow the instructions in your survey invitation. (If you do not have your invitation letter, contact the MCPSS provider helpline today at 800-654-1431 or *mcpss@scimetrika.com* for assistance.)

CMS will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law.

(Note that only providers and suppliers who have been randomly selected and notified can participate in the 2011 MCPSS.)

For more information about the MCPSS, please visit *http://www.CMS.gov/MCPSS*.

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

Source: CMS PERL 201104-15

Get motivated by Medicare …

Find out about Provider Incentive Programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

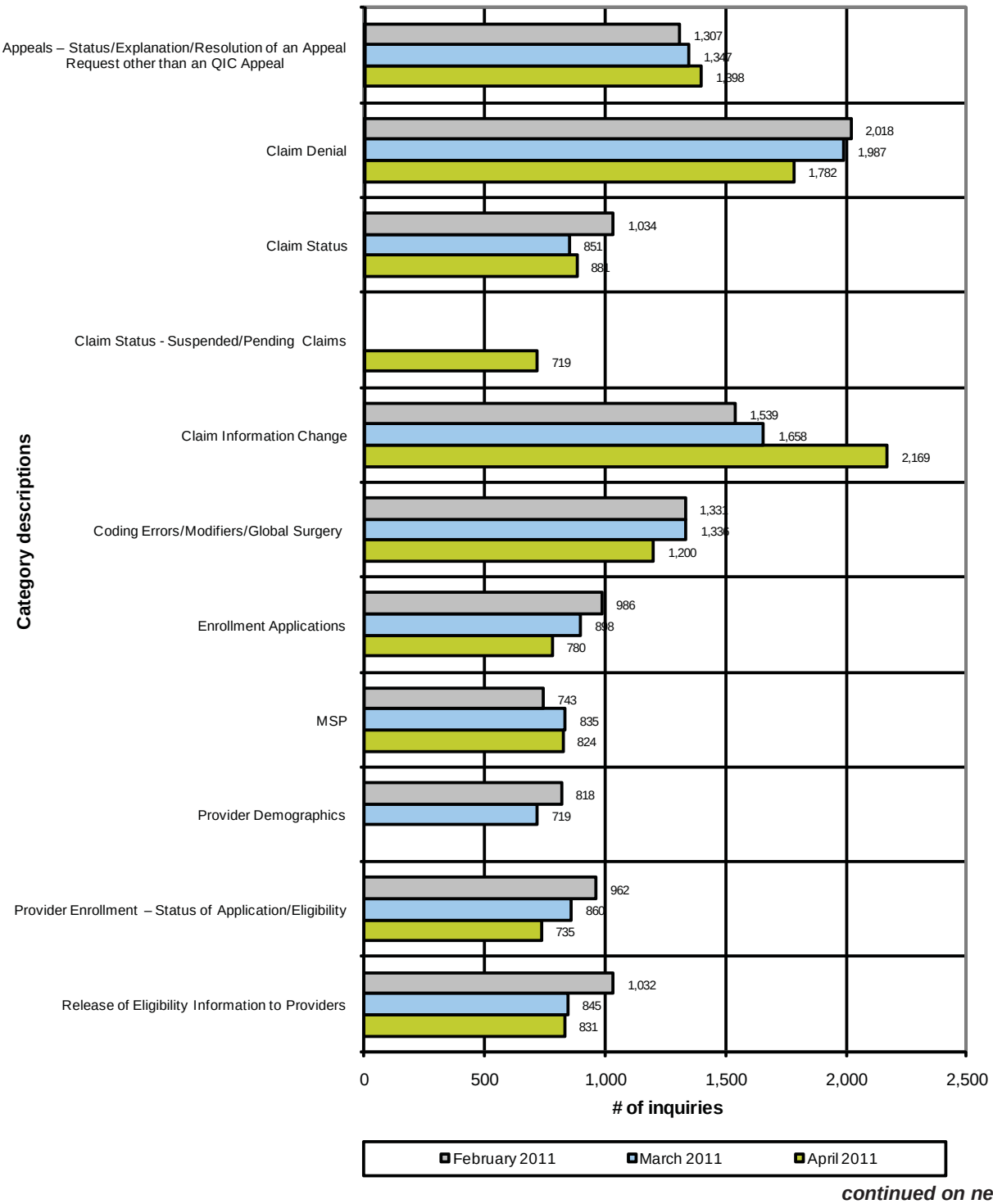
Available at *http://medicare.fcso.com/Landing/191460.asp*

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 February-April 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 February-April 2011



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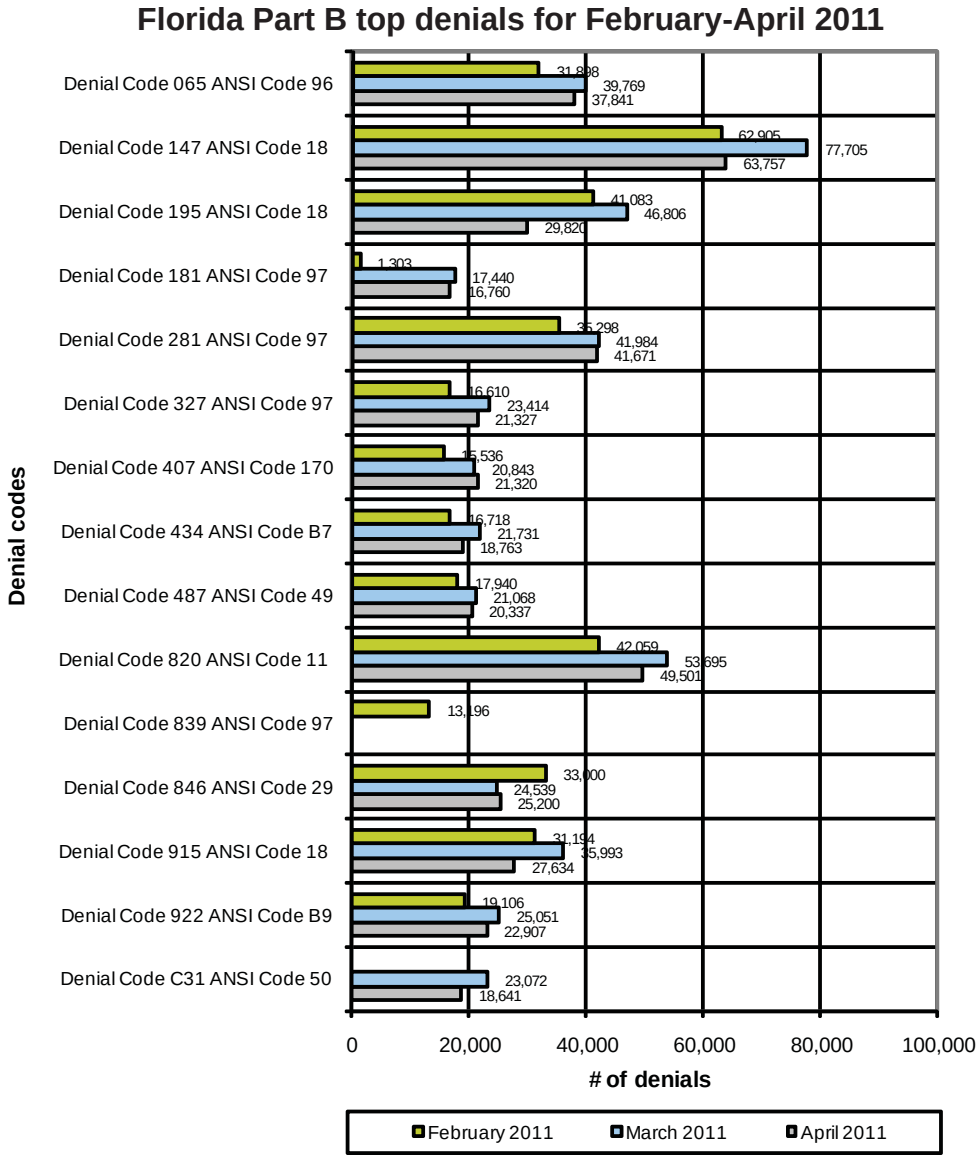


Steps to reduce the number of claim submission errors

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

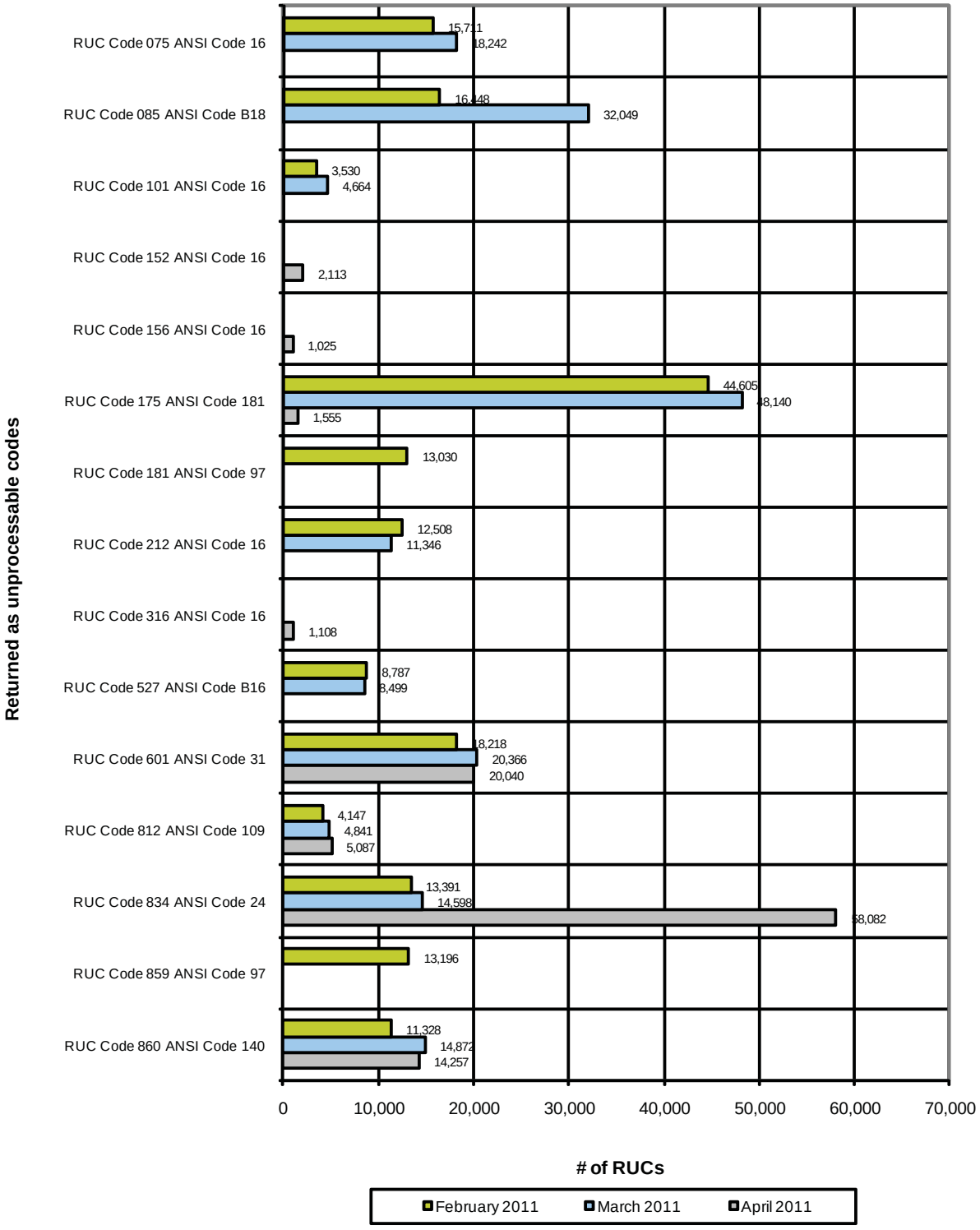
Did you review your batch detail control listing?
Claims submission errors may be obtained in a timely fashion through your electronic data interchange (EDI) gateway mailbox on a report titled batch detail control listing. Referring to this report will allow you to correct and resubmit claims quickly, 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.

Top....(continued)

Florida Part B top return as unprocessable claims for February-April 2011



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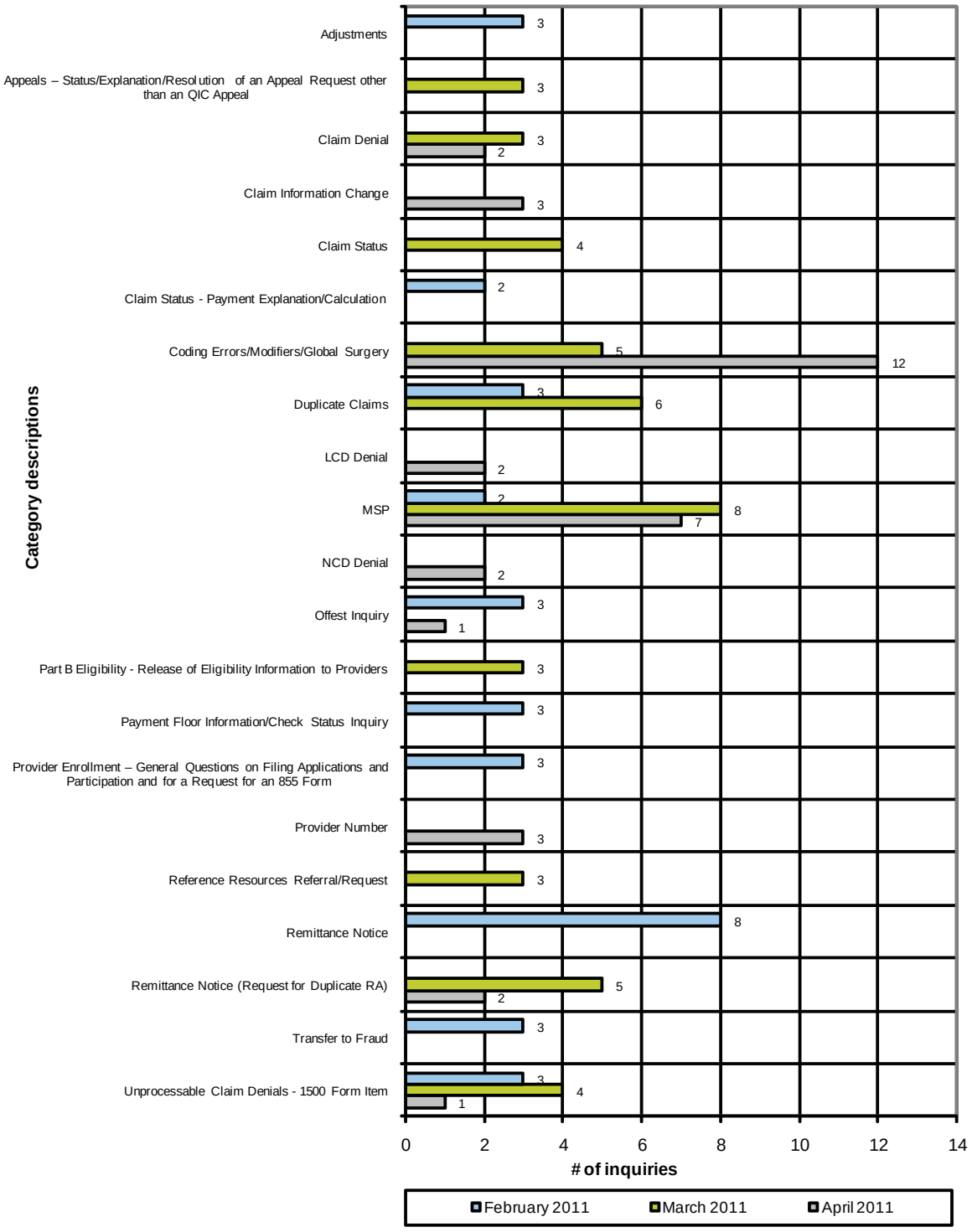
U.S. Virgin Islands Part B top inquiries for February-April 2011



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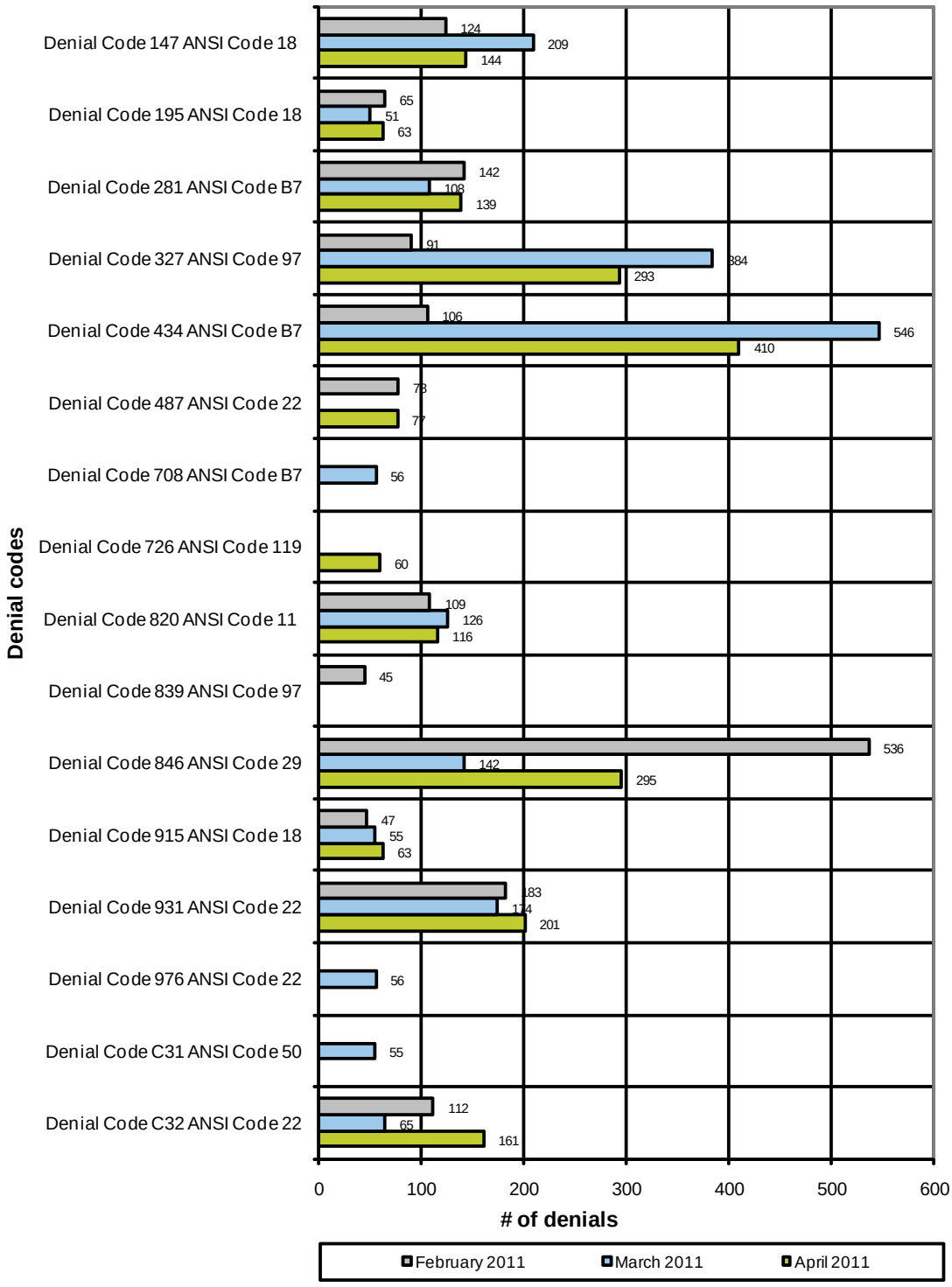
U.S. Virgin Islands Part B top denials for February-April 2011



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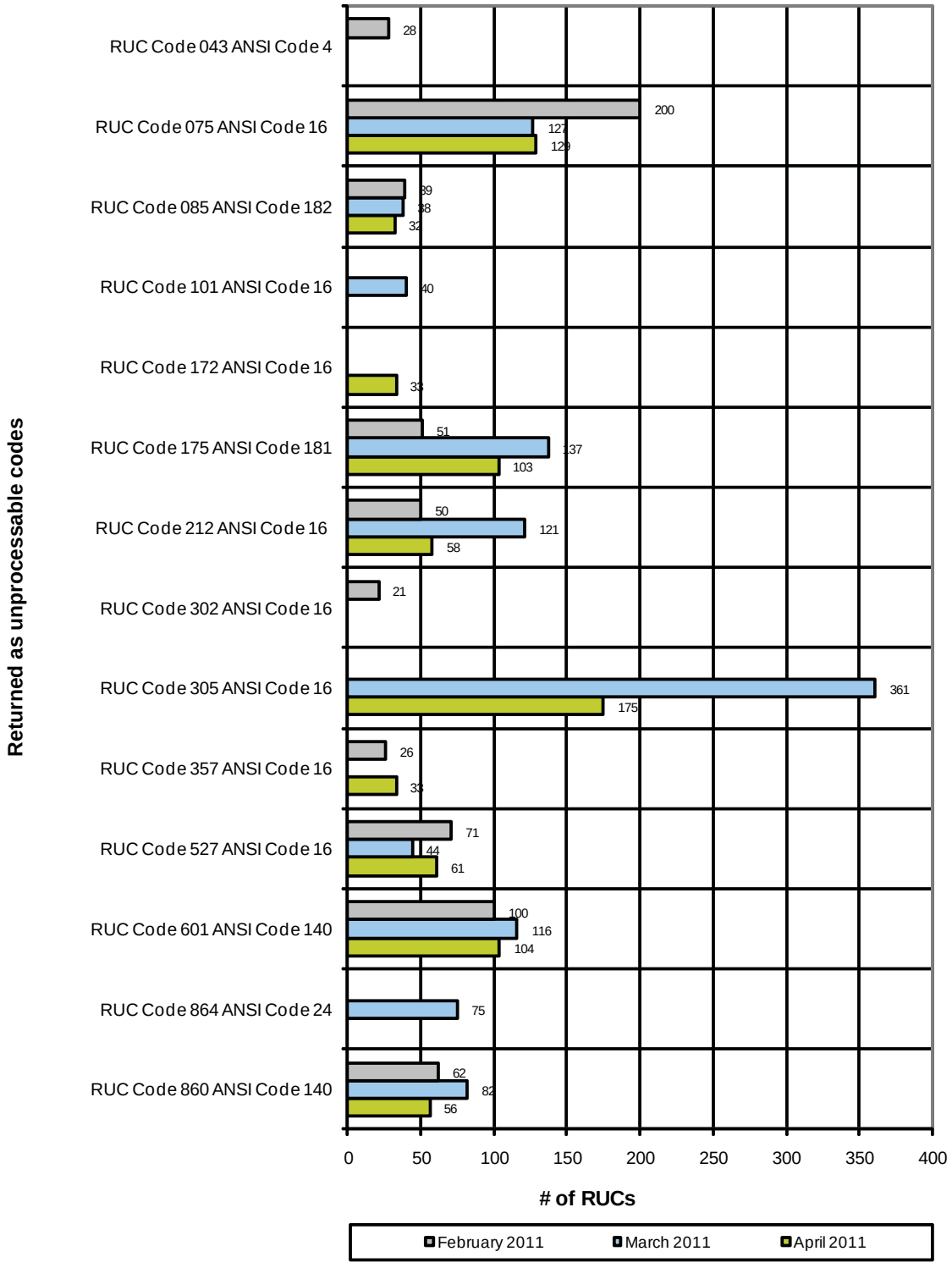
U.S. Virgin Islands Part B top return as unprocessable claims for February-April 2011



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.

Note: Effective July 1, 2011, line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when 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.

Additional Information

Physician-billed rehabilitation services

In an effort to protect the Medicare Trust Fund and ensure proper payments, the Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program. CERT measures the accuracy of Medicare fee-for-service (FFS) payments. CERT contractors generate a number of measurements and statistics that reflect how effectively providers submit their claims and how Medicare contractors review and pay those claims.

First Coast Service Options Inc. (FCSO's) analysis of CERT errors identified a trend of increased claim payment errors in the November 2010 CERT sample when therapy services are billed by a physician. Physical and occupational therapy specialties represented 30 percent of the dollars incorrectly paid for therapy services with an 8.2 percent claim payment error rate (based on dollars). Services billed by physician specialties represented 70 percent of the dollars incorrectly paid for therapy services with a 19.05 percent claim payment error rate (based on dollars). Additionally, past medical review experience has identified high claim error rates when therapy services are billed by a physician. The most common reasons for an error to be assigned are insufficient documentation, including failure to meet Medicare's documentation requirements specific to therapy services and failure to meet medical necessity.

The following is a brief summary of Medicare requirements for therapy services. See CMS' Internet-only Manual (IOM) System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Sections 220-230 and FCSO's Therapy and Rehabilitation Services local coverage determination (LCD) for additional information.

Therapy services shall be payable when the medical record and the information on the claim form consistently and accurately report covered therapy services. Documentation must be legible, relevant and sufficient to justify the services billed.

The patient receiving outpatient therapy services must be under the care of a physician/ nonphysician practitioner (NPP signifies a physician assistant, clinical nurse specialist or nurse practitioner, who may, **if** state and local law permit it, and when appropriate rules are followed, provide, certify or supervise therapy services).

Therapy services must relate directly and specifically to a written treatment plan. The plan (also known as a plan of care or plan of treatment) must be established before treatment is started. The plan is established when it is developed (e.g., written or dictated). The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan.

Various entities may request documentation to support services billed to the Medicare program (e.g., Medicare administrative contractor [MAC], CERT, recovery audit contractor [RAC], zone program integrity contractors [ZPIC], or office of inspector general [OIG]). The following documentation must be submitted in response to any requests for documentation, unless the requesting contractor specifies otherwise.

- Evaluation and plan of care (POC) (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed. Refer to the IOM and FCSO's LCD for specific elements required to be documented in the evaluation and POC;
- Certification (physician/NPP approval of the plan) and recertification when records are requested after the certification/recertification is due;
- Progress reports (including discharge notes, if applicable) when records are requested after the reports are due;
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes). Daily treatment notes must indicate the individual modalities performed that day. Minutes must be documented for each modality that represents a time-based code and the total time in treatment must be documented; and
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands the reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation. If the patient is expected to exceed the therapy cap, the record must clearly indicate the medical necessity for the patient to receive covered services above the cap.

Note: Excessive use of modifier KX (Requirements specified in the medical policy have been met) may indicate abusive billing.

continued on next page

Physician....(continued)

Therapy services have their own benefit under section 1861 of the Social Security Act and shall be covered when provided according to the standards and conditions of the benefit described in Medicare manuals. The statute 1862 (a) (20) requires that payment be made for a therapy service billed by a physician/NPP only if the service meets the standards and conditions – other than licensing – that would apply to a therapist.

Medicare is authorized to pay only for services provided by those trained specifically in physical therapy, occupational therapy or speech-language pathology. That means that the services of athletic trainers, massage therapists, recreational therapists, kinesiotherapists, low vision specialists or any other profession may not be billed as therapy services.

There is no coverage for services provided "incident to" the service of a therapist. Although physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) work under the supervision of a therapist and their services may be billed by the therapist, their services are covered under the benefit for therapy services and not by the benefit for services "incident to" a physician/NPP. The services furnished by PTA's and OTA's are not incident to the therapist's services.

A physical therapist must supervise PTAs and an occupational therapist must supervise OTAs. The level and frequency of supervision differs by setting (and by state or local law). General supervision is required for PTAs in all settings except private practice (which requires direct supervision) unless state practice requirements are more stringent, in which case state or local requirements must be followed.

The service of a PTA and OTA shall not be billed as services "incident to" a physician/NPP's service, because they do not meet the qualifications of a therapist. Only services provided by a licensed therapist or an individual who has completed an accredited PT or OT curriculum and are qualified for licensure may provide services "incident to" the physician/NPP.

During CERT and MAC jurisdiction 9 (J9) medical review, it has become apparent that some physicians billing therapy services are billing for services performed by unqualified individuals (e.g., licensed massage therapists [LMTs], PTAs/OTAs). Therefore, in an effort to reduce the MAC J9 error rate for therapy services and improve CERT error rates in the future, providers may be subject to a specialty specific prepayment edit and/or probe review. Providers are encouraged to review the complete requirements for billing rehabilitation services. The entire LCD is available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

All providers billing therapy services should also be thoroughly knowledgeable of the requirements found in IOM, Pub. 100-02, Chapter 15, Sections 220-230.

Self-administered drug (SAD) list – Part B: J1559

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 18, 2011**, the following drug has been added to the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part B self-administered drug (SAD) list.

- J1559 Injection, immune globulin, (hizentra), 100 mg

The evaluation of drugs for addition to the SAD list is an on-going 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 through the CMS Medicare Coverage Database at:
http://www.cms.gov/medicare-coverage-database/search/search-results.aspx?SearchType=Advanced&CoverageSelection=Local&ArticleType=SAD&s=---&Cntrctr=197&DateTag=C&kq=true&bc=IAAAAAAAAAAA&.

Educational Events

Upcoming provider outreach and educational events
June 2011

National 5010 Testing Day
When: Wednesday, June 15
Time: 10:00-11:00 a.m.

Recovery audit contractor (RAC) open forum
When: Wednesday, June 15
Time: 11:30 a.m.-12:30 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.fcsouniversity.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: _____

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 offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

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Preventive Services

National Women's Health Week and National Women's Checkup Day

Mothers Day is Sunday, May 8, which kicks off the 12th annual National Women's Health Week and National Women's Checkup Day, Monday, May 9. "It's Your Time!" is the theme for the 2011 National Women's Health Week. This week-long national health observance empowers women to make their health a top priority. It also encourages them to take steps to improve their physical and mental health and lower their risks of certain diseases. Although Medicare is now helping to pay for more preventive services and screenings, many women with Medicare are not taking full advantage of them, leaving significant gaps in prevention. With your help, we can begin to close the prevention gap. Please join with the Centers for Medicare & Medicaid Services in helping women learn how they can live longer healthier lives through disease prevention, early detection, and lifestyle modifications.

Medicare coverage
Medicare provides coverage of many preventive services and screenings that are especially meaningful to women, including but not limited to:

- Bone mass measurements
- Cancer screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical and vaginal (Pap test and pelvic exam)
  - Colorectal
- Cardiovascular disease screenings
- Diabetes screening
- HIV screening
- Immunizations
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Tobacco-use cessation counseling
- Yearly wellness exam (new for 2011)

Note: While coverage by Medicare is subject to certain eligibility criteria, many preventive services and screenings can now be received with no out-of-pocket costs to the beneficiary.

What can you do?
As a provider of health care services to people with Medicare, CMS needs your help to ensure that women with Medicare are informed about the preventive services and screenings for which they may be eligible, they understand the importance of utilizing these services, and they are encouraged to use the services that are appropriate for them. Please remember to provide referrals for services when required.

For more information

- CMS Preventive Services Website (*http://www.cms.gov/PrevntionGenInfo/*)

- Quick Reference Information: Medicare Preventive Services (*http://www.cms.gov/PrevntionGenInfo/*)
- *Medicare Learning Network*® (*MLN*) Preventive Services Educational Products *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*
- National Women's Health Week (*http://www.womenshealth.gov/whw/*)
- National Women's Checkup Day (*http://www.womenshealth.gov/whw/check-up-day/*)

This Mothers Day we can make a positive difference in the health of the women in our lives. Thank you.

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

Source: CMS PERL 201105-04

May is National Osteoporosis Awareness and Prevention Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting National Osteoporosis Awareness and Prevention Month. Estimates indicate that as many as 50 percent of Americans older than 50 will be at risk for osteoporosis fractures during their lifetimes. Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms, but early diagnosis and treatment can reduce or prevent fractures from occurring.

Medicare coverage
Medicare provides coverage for bone mass measurements once every 24 months (or more often if medically-necessary) for a qualified Medicare beneficiary when ordered by a physician or qualified non-physician practitioner.

What can you do?
As a health care professional, you play a crucial role in helping your patients maintain strong, healthy bones throughout their life. While osteoporosis is not curable, it can be treated and managed. Here's how you can help:

- Talk with your patients about their risk factors.
- Encourage all eligible Medicare patients to take full advantage of Medicare's bone mass measurements benefit.
- Visit the websites listed below to learn more about National Osteoporosis Awareness and Prevention Month and Medicare coverage of bone mass measurements.

For more information
- Bone Mass Measurement Web page (*http://www.cms.gov/BoneMassMeasurement/*) – this CMS Web page provides an overview of information on provider resources for bone mass measurements.
- *Bone Mass Measurements Brochure* (*http://www.cms.gov/MLNProducts/downloads/Bone_Mass.pdf*) – this brochure provides fee-for-service health care professionals with an overview of Medicare's coverage of bone mass measurements.
- *Quick Reference Information: Medicare Preventive Services* (*http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*) – this chart provides coverage and coding information on Medicare-covered preventive services, including bone mass measurements.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals* (*http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*) – this comprehensive resource provides coverage and coding information on the array of Medicare-covered preventive services and screenings, including bone mass measurements.
- NIH Osteoporosis and Related Bone Diseases National Resource Center (*http://www.niams.nih.gov/Health_Info/Bone/default.asp*)
- The National Osteoporosis Foundation (*http://www.nof.org/*)

Together we can promote better awareness and healthier bones. Thank you for your support.

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

Source: CMS PERL 201105-20

New *Interactive Guide to the Medicare Learning Network* CD-ROM

The *Medicare Learning Network*® has released a new CD-ROM titled The Interactive Guide to the *Medicare Learning Network*. This CD-ROM allows for a two-way flow of information between fee-for-service (FFS) providers and the MLN. Providers and other health care professionals can link directly from the products described on the CD-ROM to the *MLN* Web pages and the *MLN* catalog of products. Once there, users can then confidently download and print copies of the most up-to-date and accurate *MLN* products. To order the CD-ROM through the *MLN* product ordering system, visit *http://www.CMS.gov/MLNProducts*.

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

Source: CMS PERL 201104-48

Other Educational Resources

Provider compliance *Fast Facts* and newsletter

"Fast Facts" now available on *MLN* provider compliance Web page

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 educational products, CMS encourages you to visit the *Medicare Learning Network*® (MLN) provider compliance Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp*. It contains educational FFS provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can now review quick tips on relevant provider compliance issues and corrective actions directly from this Web page. Be sure to bookmark this page and check back often as a new "fast fact" will be added each month.

April 2011 issue of *Quarterly Provider Compliance Newsletter* released

The next issue of the *Medicare Quarterly Provider Compliance Newsletter* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf*. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program and is released on a quarterly basis. In this issue, a number of recovery audit findings that affect inpatient rehabilitation facilities, inpatient hospitals, physicians, non-physician practitioners, and outpatient hospitals are presented. The newsletter now features a series of tips and suggestions on relevant topics and an interactive index of previously-issued newsletters, which may be found at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.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 201105-09

New fast fact now available on *MLN* Provider Compliance Web page

A new fast fact has been added to the *Medicare Learning Network*® (*MLN*) Provider Compliance Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp*, which contains educational fee-for-service (FFS) provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this Web page – and be sure to bookmark this page and check back often as a new fast fact will be added each month.

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

Source: CMS PERL 201105-21

New *Signature Requirements* fact sheet

A new publication titled *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 health care 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 201104-48

Three new fact sheets related to the Medicare Shared Savings Program

The *Medicare Learning Network*® has released three new fact sheets related to the recently released Notice of Proposed Rulemaking (NPRM) for the Medicare Shared Savings Program. All are available to view, download, and print, free of charge, from the MLN.

- *Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program* provides an overview of the NPRM. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_NPRM_Summary_Factsheet_ICN906224.pdf*.
- *What Providers Need to Know: Accountable Care Organizations* provides information important to Medicare fee-for-service providers who may participate in the program. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf*.
- *Federal Agencies Address Legal Issues Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* provides information about the Center for Medicare & Medicaid Services' (CMS) coordination with the Office of Inspector General, the Federal Trade Commission, and Department of Justice, and the Internal Revenue Service regarding issues related to the Shared Savings Program. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Federal_Agencies_Factsheet_ICN906225.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 201104-48

EHR incentive payment fact sheets now available in Spanish

Medicare EHR Incentive Payments for Eligible Professionals fact sheet

The *Medicare Electronic Health Record Incentive Payments for Eligible Professionals* fact sheet is now available in a Spanish version (ICN 906386). This fact sheet is designed to provide education on the **Medicare** electronic health record (EHR) incentive program for eligible professionals, and can be accessed on the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedicareEHRProgForEPs-ICN906388-sp.pdf*.

Medicaid EHR Incentive Payments for Eligible Professionals fact sheet

The *Medicaid Electronic Health Record Incentive Payments for Eligible Professionals* fact sheet is now available in a Spanish version (ICN 906388). This fact sheet is designed to provide education on **Medicaid** EHR incentive payments for eligible professionals, and can be accessed on the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Medicaid_EHRIncentivePayments_ICN906386-Sp.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 201105-09

Improving Quality of Care for Medicare Patients: Accountable Care Organizations fact sheet

The *Improving Quality of Care for Medicare Patients: Accountable Care Organizations* fact sheet, which is designed to provide education on quality of care standards for Accountable Care Organizations under the Medicare Shared Savings Program as proposed in the notice of proposed rulemaking, is now available in downloadable format from the *Medicare Learning Network*®. The sheet outlines information on proposed quality measures and proposed quality performance scoring under the five proposed domains, which include patient/caregiver experience, care coordination, patient safety, preventive health, and at risk population/frail elderly. It is available for viewing, printing, or downloading at: *http://www.CMS.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN906104.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 201105-21

Revised *Form CMS-1500 At A Glance* fact sheet

The revised publication titled *Form CMS-1500 At A Glance* (revised February 2011) is now available from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf*. This fact sheet provides education on the CMS-1500, which is the standard paper claim form used by healthcare professionals to bill for Medicare Part B services. The sheet includes background information and a descriptive crosswalk of fields in the paper versus the electronic form.

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

Source: CMS PERL 201105-21

Medicare Enrollment Guidelines for Ordering/Referring Providers fact sheet released

A new publication titled *Medicare Enrollment Guidelines for Ordering/Referring Providers* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers, and includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A home health agency, Part B, and durable medical equipment, prosthetics, orthotic, and supplies (DMEPOS) beneficiary 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 201105-34

Revised *Telehealth Services* fact sheet

The revised publication titled *Telehealth Services* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*. This fact sheet is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system, including originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, and billing and payment for the originating site facility fee.

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

Source: CMS PERL 201105-09

Medicare Physician Fee Schedule fact sheet now available in print

The publication titled *Medicare Physician Fee Schedule* is now available in print format from the *Medicare Learning Network*®. This fact sheet is designed to provide education on the Medicare physician fee schedule (PFS) including physician services, therapy services, Medicare PFS payment rates, and the Medicare PFS rates formula. 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 201104-48

Medicare Shared Savings Program and Rural Providers fact sheet released

The *Medicare Learning Network*® has released the *Medicare Shared Savings Program and Rural Providers* fact sheet, which is designed to provide education on how the Medicare Shared Savings Program (as proposed in the Notice of Proposed Rulemaking) impacts rural providers. To view, print, or download the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Rural_Factsheet_ICN906565.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 201105-34

Clinical Laboratory Fee Schedule, Ambulance Fee Schedule, and Federally Qualified Health Center fact sheets now available in hard copy

The following fact sheets are now available in print format from the *Medicare Learning Network*®:

- *Clinical Laboratory Fee Schedule* (revised February 2011) – which is designed to provide education on the clinical laboratory fee schedule including background information, coverage of clinical laboratory services, and how payment rates are set.
- *Ambulance Fee Schedule* (March 2011) – which is designed to provide education on the ambulance fee schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.
- *Federally Qualified Health Center* (March 2011) – which is designed to provide education on federally qualified health centers (FQHC) including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC prospective payment system; FQHC payments; and Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact FQHCs.

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 201105-34

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 - 5010 testing

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

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

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 - 5010 testing

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