Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers July 2011

Features

CMS announces national version 5010 testing week

Monday, August 22 through Friday, August 26

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, announce a national 5010 testing week to be held Monday, August 22 through Friday, August 26. National 5010 testing week 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 week, which include the following:

- Providers
- Clearinghouses
- Vendors

More details concerning transactions to be tested are forthcoming from your local MAC. There are several state Medicaid agencies who will also be participating in the national 5010 testing week; more details on Medicaid testing will become available soon.

Again, CMS national 5010 testing week does not preclude trading partners from testing transactions immediately with their MAC. Don't wait until August. CMS encourages you 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 CMS during the week of Monday, August 22, 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 the CMS dedicated 5010 website at *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.

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Contents

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

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

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 the 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 Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *http://www.cms.gov/manuals/downloads/clm104c30.pdf#page=41.*

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/02_ABN.asp*.

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: 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.

'Place of Service Codes' on the CMS website

A new section for the *Place of Service Codes* is now available on the Centers for Medicare & Medicaid Services (CMS) website. This section is located under the "Coding" category on the Medicare tab of the CMS website at: *http://www.cms.gov/place-of-service-codes/*. From that section, you can access a print-friendly version of the *"Place of Service Codes for Professional Claims"* document. This document is also available in the *Downloads* section on the following two Web pages: *HCPCS General Information* and *Physician Fee Schedule - Overview*. This *Place of Service Codes* section was formerly located on the Medicaid website.

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

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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.

Ambulatory Surgical Center

Proposed policy and payment changes for outpatient care in hospitals and ambulatory surgical centers

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2012. The proposed rule would continue to emphasize the importance of ensuring that beneficiaries receive high quality care without regard to the setting in which that care is provided.

The proposed rule also contains proposals that would strengthen the Hospital Value-Based Purchasing (HVBP) Program. The HVBP program, which was required by the Affordable Care Act of 2010, will tie a portion of a hospital's payment for inpatient stays under the inpatient prospective payment system in fiscal year (FY) 2014 to its performance score on a set of quality measures. CMS issued a final rule establishing this program in April of this year.

CMS is also proposing changes to the Medicare Electronic Health Record Incentive Program that would allow eligible hospitals and critical access hospitals (CAHs) to report clinical quality measures for 2012 by participating in an electronic reporting pilot.

The proposed rule would continue to strengthen the Hospital Outpatient Quality Reporting Program and for the first time establish a quality reporting program for ASCs.

Finally, the proposed rule would implement certain provisions in the Affordable Care Act affecting the expansion of physician-owned hospitals. The Affordable Care Act narrows access to the "rural provider" and "whole hospital" exceptions, in part by limiting the ability of existing physician-owned hospitals to expand their capacity. However, the Affordable Care Act also requires CMS to create a process for certain physician-owned hospitals to apply for an exception to the prohibition on expansion of facility capacity. The proposed exception process for expanding a physician-owned hospital's facility capacity mirrors the statutory criteria.

You may read the entire CMS press release issued July 1 at *http://www.cms.gov/apps/media/press_releases.asp*.

Also, for additional information please see CMS fact sheets at *http://www.cms.gov/apps/media/fact_sheets.asp*.

OPPS/ASC rule at *Federal Register* (PDF): *http://www.ofr.gov/OFRUpload/OFRData/2011-16949_PI.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 201107-04

Chiropractic Services

Overview of Medicare policy regarding chiropractic services

Provider types affected

Chiropractors and other practitioners billing Medicare for chiropractic services are affected by this special edition article. No new policies are contained in this article.

Provider action needed

Stop – impact to you

This special edition article highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

Caution – what you need to know

Please review this article and go to the links listed in the *Additional information* section for further details.

Go – what you need to do

Please review your clinical documentation and billing practices. Ensure that your office staffs are aware of the

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Chiropractor.... (continued)

correct use of codes and modifiers and of Medicare policy regarding chiropractic services coverage.

Background

Numerous audits of claims submitted by chiropractors for Medicare payment have demonstrated a significant portion of the claims to have been paid inappropriately. Correct claim payment depends largely on providers complying with Medicare requirements for coverage, coding, and documentation of services they report to Medicare. The goal of this article is to translate published Medicare coverage and payment requirements for chiropractic services into a few practical tips for better Medicare compliance and lower measured payment error rate.

The most common errors noted by Medicare auditors of chiropractic service claims generally fall into three broad categories:

- Technical errors such as missing signatures, date of service on the claim not found in the record, etc.
- Insufficient or absent documentation that all procedure(s) reported were performed.
    - No documentation or insufficient documentation that all spinal levels of manipulation reported had been performed.
    - No documentation that each manipulation reported related to a relevant symptomatic spinal level.
    - Noncovered devices or techniques applied in performing manipulation.
- Insufficient or absent documentation that all procedures services were medically reasonable and necessary.
    - Required elements of the history and examination were absent
    - Treatment plan absent or insufficient
    - Treatment was “maintenance”

A recent study by the Office of Inspector General (OIG) titled *Inappropriate Medicare Payments for Chiropractic Services* found inappropriate Medicare payments for chiropractic services. Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. You must use the acute treatment modifier AT to identify services that are active/corrective treatment of acute or chronic subluxation and must document services in accordance with the Centers for Medicare & Medicaid Services’ (CMS’) *Medicare Benefit Policy Manual* when submitting claims. When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not payable under Medicare.

The OIG study found that:

- Claims lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy, and
- There is lack of compliance with the Manual documentation requirements. Treatment plans, an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals, were either missing or lacked treatment goals, objective measures, or the recommended level of care.

The *Key points* section reviews Medicare policy for coverage of chiropractic services, and emphasizes the billing and documentation requirements.

Key points

Limits of chiropractic coverage by Medicare

Medicare covers only treatment by means of manual manipulation (i.e., by use of the hands) of the spine to correct a subluxation. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine, are altered, although contact between joint surfaces remains intact.

Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. No additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. If you order, take, or interpret an X-ray, or any other diagnostic test, the X-ray or other diagnostic test can be used for documentation, but Medicare coverage and payment are not available for those services. This does not affect the coverage of X-rays or other diagnostic tests furnished by other practitioners under the program.

Subluxation may be demonstrated by X-ray or physician’s examination

X-rays

As of January 1, 2000, an X-ray is not required by Medicare to demonstrate the subluxation. However, an X-ray may be used for this purpose if you so choose. The X-ray must have been taken reasonably close to (within 12 months prior or three months following) the beginning of treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted if the beneficiary’s health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

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Chiropractor.... (continued)

Physical examination
To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required:

1. Pain/tenderness evaluated in terms of location, quality, and intensity
2. Asymmetry/misalignment identified on a sectional or segmental level
3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility), and
4. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

Documentation requirements must be placed in the patient's file
Initial visit
The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

The history includes the following:
a) Symptoms causing patient to seek treatment
b) Family history if relevant
c) Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
d) Mechanism of trauma
e) Quality and character of symptoms/problem
f) Onset, duration, intensity, frequency, location, and radiation of symptoms
g) Aggravating or relieving factors, and
h) Prior interventions, treatments, medications, secondary complaints.

Description of the present illness, including:
a) Mechanism of trauma
b) Quality and character of symptoms/problem
c) Onset, duration, intensity, frequency, location, and radiation of symptoms
d) Aggravating or relieving factors
e) Prior interventions, treatments, medications, secondary complaints, and
f) Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

Evaluation of musculoskeletal/nervous system through physical examination

Diagnosis

The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

Treatment Plan should include the following:
a) Recommended level of care (duration and frequency of visits)
b) Specific treatment goals, and
c) Objective measures to evaluate treatment effectiveness.

Date of the initial treatment.
The patient's medical record.

- Validate all of the information on the face of the claim, including the patient's reported diagnosis(s), physician work (*Current Procedural Terminology* [*CPT*] code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.
- National policy – for relevant chiropractic service policy see MLN Matters® Number SE1101 or Internet Only Manuals (CMS website) as follows:
  - IOM 100-02, Chapter 15, Sections 30.5 and 240
  - IOM 100-04, Chapter 12, Section 240
  - Local policy – refer to MAC or carriers' website or CMS coverage database.

Subsequent visits
The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

History
a) Review of chief complaint
b) Changes since last visit, and
c) Systems review if relevant.

Physical examination
a) Examination of area of spine involved in diagnosis
b) Assessment of change in patient condition since last visit
c) Evaluation of treatment effectiveness.

Documentation of treatment given on day of visit.

Necessity for treatment
Acute and chronic subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by X-ray or physical examination, as described above.

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Chiropractor.... (continued)

Most spinal joint problems fall into the following categories:

Acute subluxation – A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic subluxation – A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the modifier AT may not in all instances indicate that the service is reasonable and necessary.

Maintenance therapy

Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

The modifier AT must not be placed on the claim when maintenance therapy has been provided. Claims without the modifier AT will be considered as maintenance therapy and denied.

You should consider providing the advance beneficiary notice of noncoverage (ABN) to the beneficiary. Chiropractors who give beneficiaries an ABN will place the modifier GA (or in rare instances modifier GZ) on the claim. The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The beneficiary can then make a reasonable and informed decision about receiving and paying for the service. If the beneficiary decides to receive the service, you must submit a claim to Medicare even though you expect that Medicare will deny the claim and that the beneficiary will pay.

Since March 3, 2008 CMS has issued one form with the official title *Advanced Beneficiary Notice of Noncoverage (ABN)* (form CMS-R-131). A properly executed ABN must use this form for each date an ABN is issued and all the required fields on the form must be completed including a mandatory filed for cost estimates of the items/services at issue and a valid specific reason why the chiropractor believes chiropractic manipulative treatment (CMT) will denied on this date for this beneficiary. ABNs should not be issued routinely citing the same reason for each occurrence. One ABN cannot be used with added lines for future dates of services and the form CMS-R-131 should not be altered in any way for the ABN to properly execute. For additional instructions, visit *http://www.cms.gov/BNI/01_overview.asp*.

Key billing requirements

In addition to other billing requirements explained in the Manual, it is important that you include the following information on the claim:

- The primary diagnosis of subluxation
- The initial visit or the date of exacerbation of the existing condition
- The appropriate *CPT* code that best describes the service
    - *98940*: *Chiropractic manipulative treatment (CMT); spinal, one or two regions*
    - *98941*: *spinal, three to four regions*
    - *98942: spinal, five regions*, or
    - *98943*: *CMT, extraspinal, one or more regions is not covered by Medicare*.
- The appropriate modifier that describes the services:
    - Modifier AT used on a claim when providing active/corrective treatment to treat acute or chronic subluxation
    - GA modifier used to indicate that you expect Medicare to deny a service (e.g., maintenance services) as not reasonable and necessary and that you have on file an advance beneficiary notice (ABN) signed by the beneficiary; or
    - Modifier GZ used to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary), as appropriate.

Beneficiary responsibility

For Medicare-covered services, the beneficiary pays the Part B deductible and then 20 percent of the Medicare-approved amount. The beneficiary also pays all costs for any services or tests you order.

If you provide an ABN, you must submit a claim to Medicare, even though you expect the beneficiary to pay and you expect Medicare to deny the claims.

Additional information

Providers improving their documentation in the three general categories above should lower the likelihood of continued audit identified shortcomings. In this regard, consider the following suggestions:

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Chiropractor.... (continued)

Signatures
CMS published national provider signature requirements in April 2010. For details, please refer to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1.B.c. at *http://www.cms.gov/manuals/downloads/pim83c03.pdf*.

Documenting procedures
Document procedures as soon as possible after performing them, the code the service based on that documentation. Periodically self-auditing claims against records to determine if the codes chosen are supported by the records is a helpful technique for assuring good documentation. Auditing and correcting non-conforming office practices helps minimize claim errors occurring with the clerical task of preparing and submitting the claim. For practitioners who use devices to assist manipulations, clearly documenting the device's name, and, if necessary, sending with records to auditors a device description or other information describing how the device meets CMS requirements for assistive devices can be helpful.

Medical necessity
Thoughtful documentation of clinically relevant and CMS required documentation elements serve to create a clear portrait of the patient's baseline condition, treatments provided, and a treatment timeline in terms of the patient's symptomatic functional response. The patient's condition (symptoms, physical signs, and function) must be described with objective, measurable terms along with pertinent subjective information.

Documentation must provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment including treatment goals (expected duration and frequency) and the clinical milestones to be used as measures of progress is also necessary. Demonstrate progress in objective rather than conclusory terms. Document modifications in the treatment plan when needed because of failure to satisfactory progress in the clinically reasonable and predicted timeframe. Adequately demonstrate that treatments provide more than short term symptom control unaccompanied by durable functional improvement.

Documentation of the initial evaluation and periodic reevaluations at reasonable intervals is essential. Evaluation/reevaluation elements above need not documented at each treatment. However, they must be documented often enough to show measurable progress or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

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

CMS manual references
The *Medicare Benefit Policy Manual*, Chapter 15, Section 240 – Chiropractic Services, may be found at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

The *Medicare Claims Processing Manual*, Chapter 12, Section 220 – Chiropractic Services, may be found at *http://www.cms.gov/manuals/downloads/clm104c12.pdf*.

Other references
Office of Inspector General, May 2009, *Inappropriate Medicare Payments for Chiropractic Services*, may be found at *http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf*.

The *Medicare Learning Network®* (MLN) educational product titled, *Advance Beneficiary Notice of Noncoverage (ABN)*, may be found at *http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf*.

The MLN educational product titled, *Addressing Misinformation Regarding Chiropractic Services and Medicare*, may be found at *http://www.cms.gov/MLNProducts/downloads/Chiropractors_fact_sheet.pdf*.

MLN Matters® article MM3449, *Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063*, may be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM3449.pdf*.

MLN Matters® Number: SE1101
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

Diagnostic Services

Accreditation requirements for advanced diagnostic imaging

January 1, 2012 deadline

If you're a provider or supplier that furnishes the technical component of advanced diagnostic imaging (ADI) services and bill Medicare under the physician fee schedule for these services, you must be accredited by Sunday, January, 1, 2012. Those not accredited by that deadline will not be able to bill Medicare until they become accredited.

For those planning on seeking accreditation to continue performing the technical component of ADI services, know that accreditation is dependent on the demonstration of quality standards, including (but not limited to):

- Qualifications and responsibilities of medical directors and supervising physicians;
- Qualifications of medical personnel who are not physicians;
- Procedures to ensure that equipment used meets performance specifications;
- Procedures to ensure the safety of beneficiaries;
- Procedures to ensure the safety of person who furnish the imaging; and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity and accuracy of the technical quality of the image.

Additionally, the accreditation process may include:

- Unannounced, random site visits;
- Review of phantom images;
- Review of staff credentialing records and maintenance records;
- Review of beneficiary complaints and patient records;
- Review of quality data and ongoing data monitoring; and
- Triennial surveys.

For more information about ADI accreditation, including details of the accreditation process and the organizations approved by CMS to grant accreditation, please visit *http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp*. An MLN special edition article (SE1122), "Important Reminders about Advanced Diagnostic Imaging (ADI) Accreditation Requirements," has also been published and is available at *http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.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 201107-41

Drugs and Biologicals

Autologous cellular immunotherapy treatment of metastatic prostate cancer

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7431 regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. It is therefore reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)) effective for services performed on or after June 30, 2011.

Go – what you need to do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

CR 7431 instructs that, effective for services performed on or after June 30, 2011, CMS concludes that the evidence is adequate to support the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

Medicare contractors will continue to process claims for PROVENGE® with dates of service on June 30, 2011, as they do currently when providers submit Not Otherwise Classified Healthcare Common Procedure Coding System (HCPCS) code(s) J3590, J3490 or C9273. HCPCS code C9273 will be deleted on June 30, 2011.
The new HCPCS code Q2043 will:

- Replace C9273 (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion)
- Be implemented in the July 2011 Update of Quarterly HCPCS Drug/Biological Code Changes (CR 7303 [Transmittal R2227CP]; see *http://www.cms.gov/transmittals/downloads/R2227CP.pdf*), and

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- Have an effective date of July 1, 2011.

The ambulatory surgical center (ASC) payment system will be updated to reflect these coding changes, and these changes will be announced in the ASC quarterly update CR for July 2011.

Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one treatment regimen in a patient's lifetime, consisting of three doses with each dose administered approximately two weeks apart for a total treatment period not to exceed 30 weeks from the first administration.

The language given in the long descriptor of PROVENGE® that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs associated with its administration. Thus contractors will not pay separately for any claims of routine costs associated with PROVENGE®, such as *Common Procedure Terminology* (*CPT*) code *96365*, "*Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour*".

Note: For a local coverage determination by an individual MAC to cover PROVENGE® "off-label" for the treatment of prostate cancer, the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code must be either 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate). ICD-9 diagnosis code 233.4 may not be used for "on-label" coverage claims.

Coding and billing information

ICD-9 diagnosis coding

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - The spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung – Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.
197.7	Malignant neoplasm of liver secondary – Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney – The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow – Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland

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ICD-9	Description
198.82	Secondary malignant neoplasm of genital organs

Coding for off-label PROVENGE® services
At the discretion of the local Medicare administrative contractors, claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE® services must be billed with either ICD-10 code D075 (carcinoma in situ of prostate) or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 diagnosis coding
The appropriate ICD-10 code(s) that are listed below are for future implementation.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

Types of bill (TOB) and revenue codes
The applicable TOBs for PROVENGE® are: 12x, 13x, 22x, 23x, 71x, 77x, and 85x.
On institutional claims, TOBs 12x, 13x, 22x, 23x, and 85x, use revenue code 0636 - drugs requiring detailed coding.

Payment methods
Payment for PROVENGE® is as follows:

- TOBs 12x, 13x, 22x and 23x – based on the average sales price (ASP) + 6 percent
- TOB 85x – based on reasonable cost
- TOBs 71x and 77x – based on all-inclusive rate (drugs/supplies are not reimbursed separately).
- For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6 percent.

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Note: Medicare contractors will not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.

Remittance advice remark codes (RARCs), claim adjustment reason codes (CARCs), and group codes
Medicare will use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table shown above:

- RARC 167 – This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code – contractual obligation (CO)

Medicare will use the following messages when denying line items on claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4 or 185:

- RARC 167 – This (these) diagnosis (es) are not covered. **Note**: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code – CO

When denying claims for PROVENGE®, HCPCS Q2043 that exceed three payments in a patient's lifetime, contractors shall use the following messages:

- RARC N362 – The number of Days or Units of Service exceeds our acceptable maximum.
- CARC 149 – Lifetime benefit maximum has been reached for this service/benefit category.
- Group code – CO.

When denying claims for PROVENGE®, HCPCS Q2043 that are provided more than 30 weeks from the date of the 1st PROVENGE® administration, contractors shall use the following messages:

- CARC B5 – Coverage/program guidelines were not met or were exceeded.
- Group code – CO.

Additional information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the *National Coverage Determinations Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R133NCD.pdf*. The second updates the *Medicare Claims Processing Manua*l and it is at *http://www.cms.gov/Transmittals/downloads/R2254CP.pdf*.

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

MLN Matters® Number: MM7431
Related Change Request (CR) #: CR 7431
Related CR Release Date: July 8, 2011
Effective Date: June 30, 2011
Related CR Transmittal #: R2254CP and R133NCD
Implementation Date: August 8, 2011

Pharmacy billing for drugs provided "incident to" a physician service

Note: This article was revised on July 5, 2011, to reflect the revised change request (CR) 7397 issued on July 1. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. This information was previously published in the June 2011 *Medicare B Connection*, pages 11-12.

Provider types affected

Pharmacies that submit claims for drugs to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), A/B Medicare administrative contractors (A/B MACs), and durable medical equipment MACs) are affected.

What you should know

This article is based on CR 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided "incident to" a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

continued on next page

Pharmacy.... (continued)

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background

Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the DME MAC. The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers, and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered "incident to" a physician's service and pharmacies may not bill Medicare Part B under the "incident to" provision.

Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under the outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional information

The official instruction, CR 7397, issued to your Medicare contractor regarding this issue may be viewed at *http://www.cms.gov/Transmittals/downloads/R2251CP.pdf*.

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

The following manual sections regarding billing drugs and biological and "incident to" services may be helpful:

- *Medicare Claims Processing Manual*, Chapter 17, Sections 20.1.3 and 50.B, available at *http://www.cms.gov/manuals/downloads/clm104c17.pdf*.
- *Medicare Benefit Policy Manual*, Chapter 15, Sections 50.3 and 60.1, available at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

MLN Matters® Number: MM7397 *Revised*
Related Change Request (CR) #: 7397
Related CR Release Date: July 1, 2011
Effective Date: August 15, 2011
Related CR Transmittal #: R2251CP
Implementation Date: August 15, 2011

Durable Medical Equipment

First quarter health outcomes results for DMEPOS competitive bidding

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program in nine different areas of the country.

Since program implementation, CMS has been conducting real-time claims analysis for groups of Medicare beneficiaries potentially affected by the program. CMS has now issued the 2011 first quarter DMEPOS Competitive Bidding Program health outcomes results, which show no significant changes in health outcomes for these groups. To view the results, please visit *http://www.cms.gov/DMEPOSCompetitiveBid/01A3_Monitoring.asp*.

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

Source: CMS PERL 201106-55

Laboratory/Pathology

Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests (fully rescinds and replaces CR 7413)

Note: Change request (CR) 7516 fully rescinds and replaces CR 7413. Information on CR 7413 was previously published in the June 2011 *Medicare B Connection*, pages 21-23.

Provider types affected

Clinical laboratories, hospitals and physicians submitting claims to fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs) for certain complex diagnostic tests provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7516 which announces that the Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning January 1, 2012, or until the one hundred million dollars ($100,000,000) payment ceiling established by the Affordable Care Act has been reached. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Section 3113 of the Affordable Care Act requires CMS to conduct a demonstration under Part B, title XVIII of the Social Security Act (the Act) for two years subject to a $100 million total payment limit. This demonstration will allow a separate payment to laboratories performing certain complex laboratory tests billed with a date of service that would, under standard Medicare rules (at 42 CFR414.510(b)(2)(i)(A)), be bundled into the payment to the hospital or critical access hospital (CAH). Payment under the demonstration begins January 1, 2012. Once the demonstration has ended, payment for these tests will be made under the existing non-demonstration process. Under the Affordable Care Act (Section 3113), the term “complex diagnostic laboratory test” means a diagnostic laboratory test that is:

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Affordable.... (continued)

Under the Affordable Care Act (Section 3113), the term "complex diagnostic laboratory test" means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay
- Determined by the Secretary of Health and Human Services to be a laboratory test for which there is not an alternative test having equivalent performance characteristics
- Billed using a Healthcare Common Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System
- Approved or cleared by the Food and Drug Administration (FDA) or covered under title XVIII of the Social Security Act, and
- Described in Section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). See *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*.

Section 3113(a)(3) defines separate payment as "direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act [(the Act)] by reason of Sections 1862(a)(14) and 1866(a)(1)(H)(i)" of the Act. In general terms, Sections 1862(a)(14) and 1866(a)(1)(H) of the Act state that no Medicare payment will be made for non-physician services, such as diagnostic laboratory tests, furnished to a hospital or CAH patient unless the tests are furnished by the hospital or CAH, either directly or under arrangement.

The date of service (DOS) rule at 42 CFR 414.510(b)(2)(i)(A) defines the date of service of a clinical laboratory test as the date the test was performed only if a test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital or CAH. When a test is ordered by the patient's physician less than 14 days following the date of the patient's discharge from the hospital, the hospital or CAH must bill Medicare for a clinical laboratory test provided by a laboratory and the hospital or CAH would in turn pay the laboratory if the test was furnished under arrangement. Under the demonstration, a laboratory may bill Medicare directly for a complex clinical laboratory test which is ordered by the patient's physician less than 14 days following the date of the patient's discharge from the hospital or CAH.

Laboratories choosing to directly bill Medicare under this demonstration must submit a claim with a project identifier 56. By submitting a claim with the Section 3113 demonstration project identifier "56," the laboratory agrees to cooperate with the independent evaluation and the implementation contractors. This may include providing data needed to assess the impact of the demonstration and participating in surveys and/or site visits as requested by these contractors.

Laboratories shall report the demonstration project identifier 56 in item 19 on the CMS-1500 form, in locator 63 on the UB04, on the electronic claim in X12N 837P (HIPAA version) Loop 2300, REF02, REF01=P4 and in X12N 837I (HIPAA version) Loop 2300, REF02, G1 in REF01 DE 128. Claims billed for this demonstration cannot include non-demonstration services on the same claim/bill.

All test codes included in this demonstration will be on the "Section 3113 Demonstration Fee Schedule (also referred to or known as the Demonstration Test List)." This fee schedule will be used to pay for test codes included in the demonstration and billed using the demonstration project identifier 56. Participation in this demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule (or test list). All payments will be made under locality "DE" on the demonstration fee schedule. Changes to the 3113 demonstrations fee schedule, if any, will be made on a prospective basis, and will not be implemented retroactively.

All other Medicare rules for adjudicating laboratory claims continue to apply. For the purpose of CR 7516, the period of the two year demonstration period is effective for dates of service between January 1, 2012, and December 31, 2013.

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Affordable.... (continued)

Additional information

The official instruction, CR 7516, was issued in two transmittals to your FI, carrier and/or A/B MAC. The first transmittal updates the *Demonstrations Manual* and is at *http://www.cms.gov/Transmittals/downloads/R78DEMO.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R2261CP.pdf*.

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

MLN Matters® Number: MM7516
Related Change Request (CR) #: 7516
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R78 DEMO and R2261CP
Implementation Date: January 3, 2012

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Medicare Physician Fee Schedule

Proposed policy and payment rate changes for the physician fee schedule

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for physicians and non-physician practitioners (NPPs) for services paid under the Medicare physician fee schedule (MPFS) in calendar year (CY) 2012. More than one million providers of vital health services to Medicare beneficiaries – including medical and osteopathic physicians, limited license practitioners such as podiatrists, and NPPs such as nurse practitioners and physical therapists – are paid under the MPFS. CMS projects that total payments under the MPFS in CY 2012 will be $80 billion.

CMS is required to issue a proposed rule that reflects current law. Under current law, providers would face steep across-the-board reduction in payment rates, based on a formula – the sustainable growth rate (SGR) – that was adopted in the Balanced Budget Act of 1997. If it goes into effect, Medicare payment rates are projected to be reduced by 29.5 percent for services in 2012. This is the eleventh time the SGR formula resulted in a payment cut, although the cuts have been averted through legislation in all but CY 2002. In 2010, three separate pieces of legislation were necessary to avert the payment cuts, followed by two additional enactments that authorized increases in the physician update, resulting in higher payment rates for physicians' services performed between June 1, 2010, through December 31, 2011.

The proposed rule would update a number of physician incentive programs including the Physician Quality Reporting System, the e-Prescribing Incentive Program and the Electronic Health Records Incentive Program. Additionally, it includes proposed quality and cost measures that would be used in establishing a new value-based modifier that would reward physicians for providing higher quality and more efficient care. The Affordable Care Act requires CMS to begin making payment adjustments to certain physicians and physician groups on January 1, 2015, and to apply the modifier to all physicians by January 1, 2017. CMS intends to work closely with physicians to ensure that efforts to improve the quality, safety, and efficiency of care do not have unintended consequences for patient access to care.

CMS will accept comments on the proposed rule until August 30, 2011, and will review and respond to all comments in a final rule to be issued by November 1, 2011.

continued on next page

Proposed.... (continued)

To read the entire CMS press release issued July 1 click here: *http://www.cms.gov/apps/media/press_releases.asp*.

Also, for additional information please see CMS fact sheets at *http://www.cms.gov/apps/media/fact_sheets.asp*.

OPPS/ASC rule at *Federal Register* (PDF): *http://www.ofr.gov/OFRUpload/OFRData/2011-16972_PI.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 201107-05

Mental Health

Medicare proposes coverage of screening/counseling for alcohol misuse and screening for depression

The Centers for Medicare & Medicaid Services (CMS) has proposed to add alcohol screening and behavioral counseling, and screening for depression, to the comprehensive package of preventive services now covered by Medicare. These proposed national coverage determinations (NCDs) are issued under authority granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which allows CMS to add coverage of new preventive benefits that are recommended by the U.S. Preventive Services Task Force and are appropriate for Medicare beneficiaries.

Under the new proposals, Medicare would cover an annual alcohol misuse screening by a beneficiary's primary care provider. The benefit would also include four behavioral counseling sessions per year if a beneficiary screens positive for alcohol misuse. Medicare would also cover an annual screening for depression in primary care settings that offer staff-assisted depression care, so beneficiaries can receive an accurate diagnosis, effective treatment, and follow-up.

Public comments are invited on these proposed decisions for 30 days. CMS will issue final coverage decisions later this year.

Public comments are invited on today's proposed decisions for 30 days. CMS will issue final coverage decisions later this year. The proposal for screening and counseling for alcohol misuse is available on the CMS website at: *https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%20and%20Behavioral%20Counseling%20Interventions%20in%20Primary%20Care%20to%20Reduce%20Alcohol%20Misuse&bc=ACAAAAAAIAAA&NCAId=249&*.

The proposal for screening and counseling for depression is available on the CMS website at: *https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%20for%20Depression%20in%20Adults&bc=ACAAAAAAIAAA&NCAId=251&*.

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

Source: CMS PERL 201107-42

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.

Therapy Services

Adjustment of therapy claims subject to 2010 Medicare physician fee schedule changes

On Tuesday, March 23, 2010, President Obama signed into law the Affordable Care Act. Various provisions of the new law were effective Thursday, April 1, 2010, or earlier and, therefore, were implemented some time after their effective date. In addition, corrections to the 2010 Medicare physician fee schedule (MPFS) were implemented at the same time as the Affordable Care Act revisions to the MPFS, with an effective date retroactive to Friday, January 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims are being reprocessed. We expect that this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

We have previously advised providers that, in the majority of cases, they will not have to request adjustments because Medicare claims administration contractors will automatically reprocess claims, and that remains the case. However, there have been situations where the original claim for a service subject to the therapy cap as per the *Medicare Claims Processing Manual* Publication 100-04, Chapter 5, Section 10.2 (*http://www.CMS.gov/manuals/downloads/clm104c05.pdf*) was processed without a modifier KX, presumably because the beneficiary had not yet reached the therapy cap and, therefore, no modifier KX was necessary. When processing adjustments for such claims, Medicare contractors have found that the therapy cap was often subsequently reached, causing the adjustment claim to reject, and in some cases for the original claim to be subject to overpayment recovery.

In order to prevent this, contractors will not be automatically processing Affordable Care Act adjustments on claims for services subject to the therapy cap. If you performed services subject to the therapy cap between Friday, January 1 and Monday, May 31, 2010, and if you believe you are entitled to an additional payment as a result of the change to the fee schedule in that year, then you will need to request that your Medicare contractor reopen those claims in order to receive the adjustment. When doing so, you should also indicate which of those services would have been subject to the modifier KX if the therapy cap had been reached when the original claim was processed. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, CMS believes that these circumstances fall under the "good cause" criteria described in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 34, Section 10.11 (*http://www.CMS.gov/manuals/downloads/clm104c34.pdf*). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

In some cases the Medicare contractor may generate an adjustment claim without the provider requesting it and either return it to the provider (RTP) or deny it. If you receive such a notice, believe you are entitled to an adjustment, and want to pursue the matter, you should contact the Medicare contractor and request it be reopened. You should also indicate whether the service would have qualified for the modifier KX.

The Centers for Medicare and Medicaid Services wants to remind physicians, practitioners, and other providers impacted by the retroactive increases in payment rates by the Affordable Care Act and the 2010 MPFS changes of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. The policy may be found by visiting *http://oig.HHS.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf*.

Please contact your Medicare claims administration contractor with any questions about this information.

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

Source: CMS PERL 201107-19

General Coverage

Reopening requests for certain claims to be reprocessed under the Affordable Care Act no longer being accepted

In May 2011, First Coast Service Options (FCSO) began accepting fax requests for reopenings of claims with dates of service in January-May 2010 to be reprocessed under the Affordable Care Act (ACA). Since that time, mass adjustments have been executed that automatically reprocess claims where the billed amount was greater than the new (post-ACA) allowances. To reduce workloads and costs associated with manually reprocessing faxed requests, the Centers for Medicare & Medicaid Services (CMS) has authorized contractors to stop performing manual reopening of those claims that are scheduled to be mass-adjusted.

Therefore, effective July 15, 2011, FCSO will no longer accept fax reopenings of claims where the original amount submitted was sufficient to allow mass adjustments to provide additional moneys due as a result of the ACA changes.

Providers continue to be required to request a reopening for claims containing services where the original amount submitted was less than the new ACA allowance, indicating that the billed amount should be increased to at least the new payment rate.

For additional information concerning the ACA fee changes and the national reprocessing effort, see *Claims reprocessing questions and answers* at *http://medicare.fcso.com/Processing_Issues/202317.asp*.

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

Source: TDL 11371

Medicare contractor annual update of the ICD-9-CM

Provider types affected

All Medicare providers and suppliers submitting claims to fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, A/B Medicare administrative contractors (MAC) and durable medical equipment (DME) MACs are affected by this article.

Provider action needed

This article, based on change request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) update that is effective for the dates of service on and after October 1, 2011, effective for discharges on or after October 1, 2011, for institutional providers. Please be sure to inform your staffs of these updates.

Background

ICD-9 information

The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised and discontinued ICD-9-CM diagnosis codes annually at *http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp*. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at *http://www.cdc.gov/nchs/icd.htm*. The NCHS will post the new ICD-9-CM Addendum on their website in June.

You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

ICD-10 information

CMS has posted a list of 2011 International Classification of Diseases, Tenth Revision (ICD-10) code descriptions in tabular order (the order they appear in the code book) at *http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp*. The tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. In addition, a list of 2012 ICD-10-PCS codes is at *http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp*. The 2012 ICD-10-CM list should be posted later this year and its posting will be conveyed via listserv notices.

continued on next page

Medicare.... (continued)

Additional information

The official instruction, CR 7454, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2246CP.pdf*.

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

MLN Matters® Number: MM7454
Related Change Request (CR) #: 7454
Related CR Release Date: June 24, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2246CP
Implementation Date: October 3, 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.

Medicare data to calculate your primary service areas

The Centers for Medicare & Medicaid Services (CMS) has posted to its website Medicare data that allows applicants of the Medicare Shared Savings Program to calculate their share of services in each applicable primary service area (PSA), as described in the *Federal Trade Commission/Department of Justice (FTC/DOJ) Proposed Antitrust Enforcement Policy Statement Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*. Data sets available include:

- Physician file – all physician fee-for-service claims for calendar year 2010 (1/1/2010-12/31/2010)
- Inpatient facility file – all Inpatient fee for service claims for Federal fiscal year (FY) 2010 (10/1/2009-9/30/2010)
- Outpatient facility file – all outpatient fee for service claims for calendar year 2010 (1/1/2010-12/31/2010)

Crosswalk files of inpatient and outpatient services treatment codes include:

- Crosswalk from ambulatory surgical center (ASC) Healthcare Common Procedure Coding System (HCPCS) codes to outpatient categories
- Crosswalk from ambulatory payment classifications (APCs) to outpatient categories
- Crosswalk from diagnosis-related groups (DRGs) to major diagnostic categories (MDCs)

To access this data, visit the CMS Shared Savings Program website at *www.cms.gov/sharedsavingsprogram*, select the “Medicare Data to Calculate Your Primary Service Area” tab, and scroll to the bottom of the page to the “Downloads” section.

For detailed instructions on how to use this data to calculate PSA shares, applicants should refer to the *FTC/DOJ Policy Statement*.

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

Source: CMS PERL 201106-56

The countdown has begun …

Are you ready for January 1?
Schedule your HIPAA-5010 testing today!
Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at *http://medicare.fcso.com/HIPAA/*

Delayed implementation of X12N version 5010 paperwork segment

The Centers for Medicare & Medicaid Services (CMS) is delaying the implementation of the PWK (paperwork) segment associated with the X12N version 5010 837 professional and institutional electronic claim transaction originally scheduled for July and October 2011. This means Medicare billers will continue to submit additional documentation needed for claims adjudication following the existing process established by their Medicare claims administration contractor.

CMS will give Medicare billers ample notice before implementing change requests (CR) 7041 and 7306, which change how additional documentation for claims adjudication is submitted. For additional information related to CR 7041 and 7306, please refer to the *MLN Matters* articles associated with these CRs:

MM7041 – *http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf*
MM7306 – *http://www.cms.gov/MLNMattersArticles/downloads/MM7306.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 201107-09

Act now to prepare for transition to version 5010

The version 5010 transition is less than six months away for all HIPAA covered entities. This means that to submit transactions electronically, all covered entities must upgrade from version 4010/4010A to version 5010. Unlike version 4010, version 5010 accommodates the new ICD-10 medical code sets and the transition to 5010 is a required preliminary step for the use of ICD-10 codes.

You should conduct internal and external 5010 transaction testing within your organization and with your billing partners – including payers, vendors, clearinghouses, and providers – before the January 1, 2012, compliance deadline. External testing should take place now in order to make sure that you are able to send and receive compliant transactions effectively. Testing now will help identify any potential issues that may arise and allow the necessary time to address them.

The *ICD-10 page*, located on CMS' website, has resources to support providers, payers, and vendors as they make the transition to version 5010 and ICD-10.

Keep up-to-date on version 5010 and ICD-10: Please visit *www.cms.gov/ICD10* for the latest news and resources to help you prepare.

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

Source: CMS PERL 201107-47

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.

Announcements

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

Reminders

Versions 5010 & D.0 FAQs Now Available!

National Testing Day Message Now Available!

5010/D.0 Errata requirements and testing schedule can be found here

continued on next page

HIPAA....(continued)

Contact your MAC for their testing schedule

Readiness assessment

Have you done the following to be ready for 5010/D.0.?

What do you need to have in place to test with your Medicare administrative contactor (MAC)?

Do you know the implications of not being ready?

Implementation calendar

Current events

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

Upcoming events

August 2011
August 24: National MAC testing day
August 31: CMS-hosted Medicare fee-for-service national call – MAC panel questions & answers

September 2011
September 14: CMS-hosted Medicare fee-for-service national call – question & answer session

October 2011
October 5: MAC hosted outreach and education session – last push for implementation
October 24-27: *WEDI 2011 fall conference* *

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*
June 30: *5010 national call – 837 institutional claim transaction*

July 2010
July 28: *5010 national call – 276/277 claim status inquiry and response transaction set*

August 2010
August 25: *5010 national call – 835 remittance advice transaction*

September 2010
September 27: *5010 national call – acknowledgement transactions (TA1, 999, 277CA)*

October 2010
October 13: *5010/D.0. errata requirements and testing schedule released*

October 27: *5010 national call – NCPDP version D.0. transaction*

November 2010
November 4: *Version 5010 resource card published*
November 8: *WEDI 2010 fall conference* *
November 17: *5010 national call – coordination of benefits (COB)*

December 2010
December 8: *5010 national call – MAC outreach and education activities and transaction-specific testing protocols*

January 2011
January 1: Beginning of transition year
January 11: *HIMSS 5010 industry readiness update* *
January 19: *5010 national call – errata/companion guides*
January 25-27: *4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation*

February 2011
February 20-24: *Healthcare Information and Management Systems Society (HIMSS) 11th Annual Conference & Exhibition* *

March 2011
March 1: New readiness assessment – *Do you know the implicationsof not being ready?*
March 30: *CMS-hosted 5010 national call – provider testing and readiness*

April 2011
April 4-11: Version 5010 test education week
April 27: MAC hosted outreach and education session – are you ready to test?

May 2011
May 2-5: *20th Annual WEDI National Conference* *
May 25: *Medicare fee-for-service national call – call to action – test*

June 2011
June 15: National MAC Testing Day
June 29: CMS-hosted Medicare fee-for-service national call – question & answer session

For older national call information, please visit the *5010 National Calls section of CMS' versions 5010 & D.0. Web page*

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

* 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.

Source: CMS PERL 201107-10

Incentive Programs

2011 eRx incentive program update – 2012 payment adjustment

In 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the electronic prescribing (eRx) incentive program, which is a program that uses incentive payments and payment adjustments to encourage the use of electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each CY will be applied to an eligible professional's Medicare Part B physician fee schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 will result in an eligible professional or group practice receiving 99.0 percent, 98.5 percent, and 98.0 percent respectively of their Medicare Part B PFS-covered professional services.

The 2012 eRx payment adjustment

The reporting period for reporting the electronic prescribing measure for purposes of the 2012 payment adjustment ended on June 30, 2011. All applicable claims for dates of service between January 1, 2011, and June 30, 2011, must be processed by July 29, 2011.

However, on May 26, 2011, CMS released a proposed rule entitled "Proposed Changes to the 2011 Electronic Prescribing Incentive Program" to address concerns stakeholders have expressed regarding the implementation of the 2012 eRx payment adjustment.

The proposed rule proposes to do the following:

1. **Modify the existing electronic prescribing measure to allow for the use of certified electronic health record (EHR) technology as defined at 45 CFR 170.102.**
2. **Provide the following additional significant hardships to the 2012 eRx payment adjustment:**
   - (i) Eligible professionals who register to participate in the Medicare or Medicaid EHR incentive program and adopt certified EHR technology;
   - (ii) Inability to electronically prescribe due to local, state, or federal law or regulation;
   - (iii) Limited prescribing activity; or
   - (iv) Insufficient opportunities to report the electronic prescribing measure due to limitations in the measure's denominator.
3. **Allow eligible professionals until October 1, 2011, to submit a request for a significant hardship exemption.**

Please note that CMS is not currently accepting exemption requests based on the proposed significant hardship exemptions stated above. If finalized, CMS will provide instructions for submitting significant hardship requests in a final rule.

The proposed rule may be viewed at *2011 eRx Proposed Rule – CMS-3248-P [PDF 224KB]*. The public has until July 25, 2011, to provide comments on the proposed rule. Upon consideration of the public comments received, CMS will publish a final rule before these proposed changes would go into effect.

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

Source: CMS PERL 201107-44

Electronic Prescribing Incentive Program 2011 updates

Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing (eRx) Incentive Program are affected.

Provider action needed

CMS is issuing this special edition article to alert providers that it is not too late to start participating in the eRx incentive program to potentially qualify to receive a full-year incentive payment. Eligible professionals may begin reporting the electronic prescribing measure at any time throughout the 2011 program year of January 1, 2011, through December 31, 2011, to be incentive eligible.

This article also provides updated information about changes to the eRx incentive program for 2011 as authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx incentive program is a separate incentive program from the Physician Quality Reporting System (Physician Quality Reporting, formerly called Physician Quality Reporting Initiative or PQRI), which has different reporting requirements.

For 2011, eligible professionals who successfully report the electronic prescribing measure will become eligible to receive an eRx incentive equal to 1.0 percent of their total Medicare Part B physician fee schedule (PFS) allowed charges for services performed during the reporting period.

Be aware that beginning in 2012, eligible professionals may be subject to a 1.0 percent PFS payment adjustment if they do not meet the reporting requirements for the 2012 eRx Payment Adjustment by June 30, 2011.

Background

The Medicare eRx incentive program began January 1, 2009, and is authorized under the MIPPA. The program provides a combination of incentives and payment adjustments for eligible professionals who are successful electronic prescribers. A Web page dedicated to providing all the latest news on the eRx incentive program is available at *http://www.cms.gov/ERxIncentive*.

eRx incentive program eligibility criteria for 2011

Reporting requirements

- To be considered a successful electronic prescriber and be eligible to receive an incentive payment, eligible professionals must generate and report one or more electronic prescriptions associated with an eligible patient visit - a minimum of 25 unique visits per year (see denominator codes below) for an individual eligible professional or 75-2,500 (varies) for the group practice reporting option (GPRO) I and II. Each visit must be accompanied by the eRx G-code (numerator code) attesting that during the patient visit at least one prescription was electronically prescribed. (See Reporting mechanisms section)
- Electronically generated refills without an associated face-to-face visit do not count and faxes originating at the eligible professional's office do not qualify as eRx. New prescriptions not associated with the denominator codes in the measure specification are not accepted as an eligible patient visit and do not count toward the minimum 25 unique eRx events.
- The eligible professional's Medicare Part B PFS allowed charges for services in the eRx measure's denominator should be comprised of 10 percent or more of the eligible professional's total 2011 estimated allowed charges. (See denominator codes)

Qualified reporting system requirements

- Eligible professionals must have adopted a "qualified" eRx system.
- There are two types of systems: A system for eRx only (stand-alone) or an electronic health record (EHR) system with eRx functionality.
- Regardless of the type of system used, to be considered "qualified" it must have **ALL** of the following capabilities:
    - Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers if available
    - Selects medications, prints prescriptions, electronically transmits prescriptions, and conducts all alerts
    - Provides information related to lower cost and therapeutically appropriate alternatives (if any). The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2011, and
    - Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

continued on next page

Electronic....(continued)

Note: For the capabilities listed above, the system must employ the eRx standards adopted by the Secretary of the Department of Health and Human Services for Medicare Part D by virtue of the 2003 Medicare Modernization Act (MMA).

Reporting mechanisms for 2011

If you have not yet participated in the eRx program, you can begin by reporting eRx data for January 1, 2011, through December 31, 2011, using any of the following three options:

- Claims-based reporting involves the addition of a quality-data code (QDC) to claims submitted for services (occurring during the reporting period) when billing Medicare Part B. For 2011, report G-code G8553 (At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system)
- Registry-based reporting using a CMS Physician Quality Reporting System qualified registry. Eligible professionals have the option of using a qualified registry to assist in collecting eRx measure data and submitting 2011 data to CMS during the first quarter of 2012. The registry will submit quality data directly to Medicare, eliminating the need for adding the QDC to the Medicare Part B claim, and
- EHR-based reporting using a CMS Physician Quality Reporting System qualified EHR product submitting 2011 data to CMS during the first quarter of 2012.

Eligible professionals do not need to sign up or pre-register to participate in the 2011 eRx incentive program. Reporting one QDC (G8553) for the eRx measure to CMS through claims-based reporting, or submission via a qualified registry or a qualified EHR will indicate intent to participate.

Avoiding the 2012 eRx payment adjustment

An **eligible professional** can avoid the 2012 eRx payment adjustment if he or she:

- Is a successful electronic prescriber (submit required number of electronic prescriptions via **claims** before June 30, 2011)
- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES)
- Does not have prescribing privileges and reports G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim prior to June 30, 2011
- Does not have at least 100 cases containing an encounter code in the measure's denominator
- Becomes a successful electronic prescriber (submits required number of electronic prescriptions (10 for individual) via claims and reports this to CMS before June 30, 2011), or
- Claims a hardship as described below.

A **group practice** that is participating in eRx GPRO I or GPRO II during 2011:

- **MUST** become a successful electronic prescriber (submit required number of electronic prescriptions via **claims** before June 30, 2011)
  - Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique visits via **claims** for patients in the denominator of the measure.

CMS created two hardship G-codes for the 2011 program, including:

- G8642: The eligible professional practices in a rural area without sufficient high-speed Internet access and requests a hardship exemption from the application of the payment adjustment under Section 1848(a)(5)(A) of the Social Security Act
- G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under Section 1848(a)(5)(A) of the Social Security Act

The option of reporting via the GPRO I or II is no longer available for the 2011 program year. The group practices have already been selected for 2011.

Note: Only registries and EHR vendors selected by CMS for the 2011 Physician Quality Reporting System/eRx and posted on the list of registries/EHR vendors are eligible to be considered "qualified" for purposes of the 2011 eRx incentive program. Reporting via a qualified registry or EHR system is only applicable for the eRx incentive program, not to avoid the 2012 eRx payment adjustment. Please see *http://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp* (Downloads).

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Electronic....(continued)

eRx measure denominator codes (eligible cases) for 2011

Patient visit during the reporting period (*Current Procedural Terminology* (*CPT*) or Healthcare Common Procedure Coding System (HCPCS) G-codes):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Summary

If you are routinely using a qualified system (as described above) and expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS-allowed charges for 2011, you may be eligible for an incentive payment equal to one percent of your Medicare Part B PFS-allowed charges for services furnished during the reporting period and you should report the eRx measure.

If you are routinely using a qualified system (as described above) but do not expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS-allowed charges for 2011, you may not be eligible for the incentive payment. However, CMS encourages you to report the measure. In the event that your Medicare Part B PFS charges for the codes in the denominator of the measure do make up at least 10 percent of your total Medicare Part B PFS-allowed charges for 2011, you may be eligible for the incentive payment.

Note: For the years 2012, 2013, and 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year will be less than the PFS amount that would otherwise apply over the next several years by: (1) 1.0 percent for 2012; (2) 1.5 percent for 2013; and (3) 2.0 percent for 2014.

The reporting period and criteria CMS will use in 2012 to determine whether an eligible professional (or group practice) is subject to this payment adjustment (including the circumstances under which an eligible professional or group practice could seek a hardship exemption) are addressed in the Medicare PFS proposed rule for 2011.

Additional information

If you have questions about how to get started with eRx, contact the **QualityNet Help Desk** at **866-288-8912** (TTY 1-877-715-6222) from 7:00 a.m.-7:00 p.m. CST or via email at *qnetsupport@sdps.org*.

There are two fact sheets that detail the eRx Program for 2011. The 2011 *eRx Incentive Program Made Simple* fact sheet and the 2011 *eRx Incentive Program Fact Sheet: What's New for 2011 eRx Incentive Program* factsSheet may be found by visiting *http://www.cms.gov/ERxIncentive/09_Educational_Resources.asp* and then selecting *Downloads*.

Previously issued *MLN Matters* articles that outline the specifics of the program are:

SE0922 *Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) Feedback Reports* found at *http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf*

SE1107 *2011 Electronic Prescribing (eRx) Incentive Program Update – Future Payment Adjustments* at *http://cms.gov/MLNMattersArticles/downloads/SE1107.pdf*.

Eligible professionals may refer to the specification for the reporting method applicable to their practice at:

- Claims- and registry-based at *http://www.cms.gov/ERxIncentive/06_E-Prescribing_measure.asp*, or
- EHR-based at *http://www.cms.gov/ERxIncentive/08_Alternative Reporting Mechanism.asp*.

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

MLN Matters Number: SE1120
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

2010 Electronic Prescribing Incentive Program updates

Note: This article was revised on June 27, 2011, to include a link to the Electronic Prescribing (eRx) Incentive Program 2011 Updates article as shown in the "Additional Information" section. All other information remains the same. This information was previously published in the July 2010 *Medicare B Update!* pages 36-38.

Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician e-Prescribing (eRx) Incentive Program.

Provider action needed

CMS is issuing this special edition article to alert providers that it is not too late to start participating in the eRx incentive program to potentially qualify to receive a full-year incentive payment. Eligible professionals may begin reporting eRx at any time throughout the 2010 program year of January 1, 2010, through December 31, 2010, to be incentive eligible.

This article also provides updated information about changes to the eRx Incentive Program for 2010 as authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx is a separate incentive program from the Physician Quality Reporting Initiative (PQRI), with different reporting requirements.

For 2010, eligible professionals who successfully report the eRx measure will become eligible to receive an eRx incentive equal to 2.0 percent of their total Medicare Part B physician fee schedule (PFS) allowed charges for services performed during the reporting period.

Be aware that beginning in 2012, eligible professionals who are not successful electronic prescribers will be subject to a PFS payment adjustment, or penalty.

Background

The Medicare eRx began January 1, 2009, and is authorized under the MIPPA. The program provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the eRx Incentive Program is available at *http://www.cms.gov/ERXincentive/*.

For 2010, changes have been made, regarding the eRx measure (numerator) and its reporting requirements, reporting options, reporting mechanisms, and changes to the denominator codes. These are described in detail below.

eRx incentive program eligibility criteria for 2010

Reporting requirements

- To be considered a successful eRx prescriber and be eligible to receive an incentive payment, you must generate and report one or more electronic prescriptions associated with an eligible patient visit - a minimum of 25 unique visits per year (see denominator codes below). Each visit must be accompanied by the eRx G-code (numerator code) attesting that during the patient visit at least one prescription was electronically prescribed. (See Report mechanism for 2010 below)
- Electronically generated refills do not count and faxes do not qualify as eRx. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25 unique Rx events.
- The eligible professional's Medicare Part B PFS allowed charges for services in the eRx measure's denominator should be comprised of 10 percent or more of the eligible professional's total 2010 estimated allowed charges. (See denominator codes below.)

Qualified reporting system requirements

- Eligible professionals must have adopted a "qualified" eRx system.
- There are two types of systems: A system for eRx only (stand-alone) or an electronic health record (EHR) system with eRx functionality.
- Regardless of the type of system used, to be considered "qualified" it must be based on ALL of the following capabilities:
- Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers if available;
- Selects medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts;
- Provides information related to lower cost, therapeutically appropriate alternatives (if any). The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010; and
- Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

Note: For the capabilities listed above, the system must employ the eRx standards adopted by the Secretary of the Department of Health and Human Services for Medicare Part D by virtue of the 2003 Medicare Modernization Act (MMA).

Reporting mechanisms for 2010

If you have not yet participated in the eRx program, you can begin by reporting eRx data for January 1, 2010, through December 31, 2010, using any of the following three options:

continued on next page

2010....(continued)

- **Claims-based reporting of the eRx measure**. Claims-based reporting involves the addition of a quality-data code (QDC) to claims submitted for services (occurring during the reporting period) when billing Medicare Part B. For 2010, only report one G-code (G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.);
- **Registry-based reporting using a CMS-PQRI qualified registry**. EPs have the option of using a qualified registry to assist in collecting eRx measure data and submitting 2010 data to CMS during the first quarter of 2011. The registry will submit this quality data directly to Medicare, eliminating the need for adding the QDC to the Medicare Part B claim; and
- **EHR-based reporting**, using a CMS-PQRI qualified EHR product, submitting 2010 data to CMS during the first quarter of 2011.

Eligible professionals do not need to sign up or pre-register to participate in the 2010 eRx. Reporting one QDC (G8553) for the eRx measure to CMS through claims-based reporting, or submission via a qualified registry or a qualified EHR will indicate intent to participate.

The option of reporting via the group practice reporting option (GPRO) is no longer available for the 2010 program year. The group practices have already been selected for 2010.

Note: Only registries and EHR vendors who have been selected by CMS for the 2010 PQRI/eRx and are on the posted list of registries/EHR vendors are eligible to be considered "qualified" for purposes of the 2010 eRx Incentive Program you may go to *http://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage* (*Downloads*).

eRx measure denominator codes (eligible cases) for 2010

Patient visit during the reporting period (*Current Procedural Terminology* [*CPT*] or Healthcare Common Procedure Coding System [HCPCS] G-codes):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Summary

If you are routinely using a qualified system (as described above) and expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for an incentive payment equal to two percent of your Medicare Part B PFS-allowed charges for services furnished during the reporting period and you should report the eRx measure.

If you are routinely using a qualified system (as described above) but do not expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS-allowed charges for 2010, you may not be eligible for the incentive payment. However, CMS encourages you to report the measure. In the event that your Medicare Part B PFS charges for the codes in the denominator of the measure do make up at least 10 percent of your total Medicare Part B PFS-allowed charges for 2010, you may be eligible for the incentive payment.

Note: For the years 2012, 2013, and 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year will be less than the PFS amount that would otherwise apply over the next several years by: (1) 1.0 percent for 2012; (2) 1.5 percent for 2013; and (3) 2.0 percent for 2014.

The reporting period and criteria CMS will use in 2012 to determine whether an eligible professional (or group practice) is subject to this penalty (including the circumstances under which an eligible professional or group practice could seek a hardship exemption) are addressed in the Medicare PFS proposed rule for 2011.

Additional information

If you have questions about how to get started with eRx, contact the **QualityNet Help Desk at 866-288-8912** from 7:00 a.m.-7:00 p.m. CST or via e-mail at *qnetsupport@sdps.org*.

There are two fact sheets that detail the eRx program for 2010:
The *2010 eRx Incentive Program Made Simple Fact Sheet* may be found at *http://www.cms.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS032310f.pdf.*

2010 eRx Incentive Program Fact Sheet: What's New for 2010 eRx Incentive Program may be found at *http://www.cms.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS032310f.pdf*.

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2010....(continued)

Previously issued *MLN Matters* articles that outline the specifics of the program are:

- **SE0922** – Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports at *http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf*
- **MM6394** – Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) And The 2009 Electronic Prescribing (E-Prescribing) Incentive Program at *http://www.cms.gov/MLNMattersArticles/downloads/MM6394.pdf*.
- **MM6514** – Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs at *http://www.cms.gov/MLNMattersArticles/downloads/MM6514.pdf*.
- **SE1120** – Electronic Prescribing (eRx) Incentive Program 2011 Updates at *http://www.cms.gov/MLNMattersArticles/downloads/SE1120.pdf*.

Eligible professionals may refer to the specification for the reporting method applicable to your practice at:

- Claims- and registry-based at *http://www.cms.gov/ERxIncentive/Downloads/2010_eRx_MeasureSpecificationsandReleaseNotes_121709.zip*.
- EHR-based at *http://www.cms.gov/ERxIncentive/Downloads/2010EHRMeasureSpecificationforeRxandReleaseNotes.zip*.
- Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program at *http://www.cms.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf*.

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

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Implementation Date: N/A

Save the date: National provider call on Medicare and Medicaid EHR incentive programs

"Understanding Meaningful Use"
Thursday, August 18, 1:30-3:00 p.m. ET

Providers have received more than $273 million in Medicare and Medicaid EHR incentive payments. You may be eligible for a payment, too. Join the Centers for Medicare & Medicaid Services (CMS) for a national provider call on the Medicare and Medicaid EHR incentive program meaningful use requirements.

Agenda

- Defining "meaningful use"
- The requirements for stage 1 of meaningful use (2011 and 2012)
- Attestation for meaningful use
- Goals of the Meaningful Use Objectives Specification Sheets
- *Stage 1 EHR Meaningful Use Specification Sheets for Eligible Professionals*
- *Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals*
- A question and answer session

Registration information will be made available soon, and will be shared via Listserv announcement and the *Spotlight and Upcoming Events Page* of the EHR incentive programs website.

Source: CMS PERL 201107-40

CMS' attestation resources for electronic health records

Are you an eligible professional (EP) or eligible hospital participating in the Medicare Electronic Health Record (EHR) Incentive Program? The Centers for Medicare & Medicaid Services (CMS) has resources to help you attest to having met meaningful use requirements in order to receive your EHR incentive payment.

Attestation resources located on the CMS EHR website include:

An *Attestation page* on the CMS EHR website, where participants in the Medicare EHR incentive program can find important information on attestation.

The *Meaningful Use Attestation Calculator* 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 *Attestation User Guide for Medicare Eligible Professionals* and the *Attestation User Guide for Eligible Hospitals* provide step-by-step guidance for EPs and eligible hospitals participating in the Medicare EHR incentive program on navigating the attestation system.

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.

An *Eligible Professional Medicare EHR Incentive Program Attestation Webinar*, which is a video version of the user guides for EPs and walks viewers through how to complete the attestation process.

Attestation is currently open for all participants in the Medicare EHR incentive program. You can attest via *CMS' Medicare & Medicaid EHR Incentive Program Registration and Attestation System*.

Want more information about the EHR incentive programs?
Make sure to visit the *EHR incentive programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201107-46

New FAQ on payment for the Medicare EHR incentive program

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with information on the Medicare and Medicaid electronic health record (EHR) incentive programs. Take a minute and review CMS' new frequently asked question (FAQ) on receiving an incentive payment in the Medicare EHR incentive program.

Question: I am an eligible professional (EP) who has successfully attested for the Medicare EHR incentive program, so why haven't I received my incentive payment yet?

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.

The Medicare EHR incentive payments to EPs are based on 75 percent of the estimated allowed charges for covered professional services furnished by the EP during the entire payment year. Therefore, to receive the maximum incentive payment of $18,000 for the first year of participation in 2011 or 2012, the EP must accumulate $24,000 in allowed charges. If the EP has not met the $24,000 threshold in allowed charges at the time of attestation, CMS will hold the incentive payment until the EP meets the $24,000 threshold in order to maximize the amount of the EHR incentive payment the EP receives. If the EP still has not met the $24,000 threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March 2012 (allowing 60 days after the end of the 2011 calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic health professional shortage area (HPSA) will be made as separate lump-sum payments no later than 120 days after the end of the calendar year for which the EP was eligible for the bonus payment.

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New....(continued)

Want more information about the EHR incentive programs?
Make sure to visit the *CMS EHR Incentive Programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201106-47

Medscape modules available on CMS EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that through Medscape education, providers now have the opportunity to earn continuing medical education (CME) credits by learning more about the Electronic Health Records (EHR) Incentive Programs.

On *Medscape's EHR Learning Center website*, leading physician experts in medical informatics provide information, resources, and tools to help providers determine eligibility for the EHR incentive programs, understand the requirements for participating, take steps to participate, and recognize the immediate benefits of participation and future consequences of not participating.

By completing the module "From Meaningful Use to Meaningful Care," providers can earn CME credit while gaining a better understanding about the purpose of the EHR Incentive Programs, the stages of meaningful use, a timeline of key dates, and, most importantly, how patients will benefit.

Providers can also use the Medscape Learning Center to determine their comprehension of the EHR incentive programs by taking the "Medicare and Medicaid EHR Incentives: What Do You Know and Do You Know Enough?" participant self-assessment. By completing the assessment, providers can help to shape the content of future CME activities to best address the educational and clinical performance gaps identified.

The site also offers interviews, in which physician EHR experts explain why it's important to register for the programs and the significance of EHRs to healthcare overall. Expert interviews include:

- Registering for the EHR Incentive Program – Ready, Set, Go: An Expert Interview With Jason M Mitchell, MD, and Richard Paula, MD
- Are You an Eligible Professional Who Hasn't Registered for the EHR Incentive Program? What Are You Waiting For? – An Expert Interview With William F Bria II, MD

In the next few weeks, new CME modules on meaningful use will also be made available; look out for a message to announce these new learning resources. Membership on Medscape is free, but you must register to view content; you do not have to be a health professional.

Want more information about the EHR Incentive Programs?

Visit the *CMS EHR Incentive Programs website* for the latest news and updates on the EHR Incentive Programs; also sign up for the *EHR Incentive Programs email update listserv* .

Source: CMS PERL 201107-17

Four new state Medicaid EHR incentive programs launched in July

On Monday, July 4, the Medicaid electronic health record (EHR) incentive program launched in Arizona, Connecticut, Rhode Island, and West Virginia. This means that eligible professionals and eligible hospitals in these four states will be able to complete their EHR incentive program registration at the state level and receive incentive payments. More information about the Medicaid EHR incentive program can be found on the *Medicare and Medicaid EHR incentive program basics* page of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you are a resident of Arizona, Connecticut, Rhode Island, or West Virginia and are eligible to participate in the Medicaid EHR incentive program, visit your state Medicaid agency website for more information on your state's participation in the Medicaid EHR incentive program:

Arizona
Connecticut
Rhode Island
West Virginia

Twenty-one states have launched Medicaid EHR incentive programs, and 14 states have issued incentive payments to Medicaid-eligible professionals and eligible hospitals that have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launch of additional states' programs in the coming months. For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the *Medicaid State Information.*

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Four....(continued)

Want more information about the EHR incentive programs? Visit the CMS EHR incentive programs website *(http://www.cms.gov/EHRIncentivePrograms/)* for the latest news and updates on the EHR incentive programs; also sign up for the *EHR incentive programs email update Listserv.*

Source: CMS PERL 201107-26

General Information

Important reminders about advanced diagnostic imaging accreditation requirements

Provider types affected

Physicians, non-physician practitioners, and independent diagnostic testing facilities (IDTF) who are suppliers of imaging services and submitting claims for the technical component (TC) of advanced diagnostic imaging (ADI) procedures to Medicare contractors (carriers and A/B Medicare administrative contractors [MACs]) are affected by this article.

What you need to know

Stop – impact to you

This article provides suppliers who furnish the technical component (TC) of ADI services assistance in meeting the accreditation requirements established in Section 135 (a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Caution – what you need to know

In order to furnish the TC of ADI services for Medicare beneficiaries, you must be accredited by January 1, 2012, to submit claims with a date of service on or after January 1, 2012.

Go – what you need to do

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

Background

What are the requirements for ADI accreditation?

The MIPPA required the Secretary of the Department of Health and Human Services to designate organizations to accredit suppliers that furnish the TC of ADI services.

- ADI procedures include magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, including positron emission tomography.
- The MIPPA expressly excludes X-ray, ultrasound, and fluoroscopy procedures.
- Suppliers of imaging services include, but are not limited to, physicians, non-physician practitioners, and IDTFs.

Who do the requirements affect?

The accreditation requirements apply only to the suppliers of the images themselves (TC) and not the physician's interpretation (professional component) of the image.

- The accreditation requirement applies to all suppliers of the technical component who submit claims to Medicare.
- The accreditation requirement applies only to those suppliers of ADI paid under the Medicare physician fee schedule (MPFS).
- The accreditation requirements do not apply to ADI services furnished in a hospital outpatient setting.

When are the requirements mandatory?

In order to furnish the TC of ADI services for Medicare beneficiaries, you must be accredited by January 1, 2012, to submit claims with a date of service on or after January 1, 2012.

How do I comply with the requirements?

You should apply for accreditation now if you are not already accredited. Visit the "Advanced Diagnostic Imaging Accreditation Enrollment Procedures," available at *http://www.cms.gov/medicareprovidersupenroll*, and review each of the three designated accreditation organizations. Then,

Reporting....(continued)

- Call or email each of the accreditation organizations to determine the one that best fits your business needs. The accreditation organizations each have their own published standards.
- Follow all of the application requirements so that your application is not delayed. It may take up to five months to be accredited. So, you really must start now to be sure in meeting the January 1, 2012, date.

Who are the three national accreditation organizations approved by CMS?
The approved accreditation organizations are:

- The American College of Radiology
- The Intersocietal Accreditation Commission
- The Joint Commission

What are the quality standards that I must meet?
There are many quality standards, for which you must be in compliance, and you will need to show that compliance to the accreditation organization. The quality standards at a minimum address:

- Qualifications of medical personnel who are not physicians
- Qualifications and responsibilities of medical directors and supervising physicians
- Procedures to ensure that equipment used meets performance specifications
- Procedures to ensure the safety of personnel who furnish the imaging
- Procedures to ensure the safety of beneficiaries, and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity, and accuracy of the technical quality of the image.

What does the accreditation process consist of?
First, you are expected to complete the entire application prior to the accreditation organization commencing the review process. The length of the approval process depends on the completeness and readiness of the supplier.

- Make certain that you understand how to comply with each of the accreditation organizations quality standards.
- If you are non-compliant with any of the standards, you may be required to complete a corrective action plan, which will need to be approved and possibly require another site visit.

Make certain to review all of your ADI procedures to determine if you will need to be accredited.

- Accreditation is given at the facility for each modality that is supplied.
- The accreditation is not attached to the machine. If you purchase another machine within the same modality, it most likely will not require another accreditation decision.
- You must notify the accreditation organization after the initial accreditation decision of any changes to your facility.

The accreditation process *may* include:

- An un-announced site visit
- Random site visits
- Review of phantom images
- Review of staff credentialing records
- Review of maintenance records
- Review of beneficiary complaints
- Review of patient records
- Review of quality data
- Ongoing data monitoring, and
- Triennial surveys.

What else do I need to know?
Here are some helpful facts about the ADI accreditation:

- Hospitals are exempt from this requirement, since hospitals generally are not paid under the MPFS.

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Reporting....(continued)

- The accreditation requirement does not apply to the radiologists, per se. However, the interpreting physicians must meet the accreditation organization's published standards for training and residency.
- If you are accredited before January 1, 2012, by one of the designated accreditation organizations, you are considered to have met the accreditation requirement. However,
  - You must apply for reaccreditation if your accreditation is due to expire before this date, and
  - You must remain in good standing.
- The accreditation organization will transmit all necessary data to CMS on an ongoing basis. Your Medicare billing contractor will receive these data from CMS.
- The *Current Procedural Terminology* (*CPT*) codes that are affected by this requirement are published on the CMS website.
- **No suppliers are exempt.**
- Oral surgeons and dentists must be accredited if they perform the technical component of MRI, CT or nuclear medicine for the technical component of the codes that require ADI accreditation.
- If your facility uses an accredited mobile facility, you, as a Medicare supplier billing for the TC of ADI, must also be accredited. The accreditation requirement is attached to the biller of the services.

What does it cost to be accredited?
The accreditation costs vary by accreditation organization. The average cost for one location and one modality is approximately $3,500 every three years.

When will claims for Medicare services be affected?
Medicare contractors will begin denying claims for services on or after January 1, 2012, for modalities that are not accredited.

- Denial code N290 will be used ("Missing/incomplete/invalid rendering provider primary identifier.")
- Contractors will deny codes submitted for the Technical Component if the code is not listed as "accredited."

Additional information

For more information about the enrollment procedures, see the *Medicare Learning Network*® (MLN) article MM7177, *Advanced Diagnostic Imaging Accreditation Enrollment Procedures*, available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7177.pdf*.

If you are a physician or non-physician practitioner supplying the technical component of ADI, see the *MLN* article MM7176, *Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) Service*, available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7176.pdf*.

To obtain additional information about the accreditation process, please contact the accreditation organizations listed on the Medicare Provider-Supplier Enrollment page, Advanced Diagnostic Imaging Accreditation, available at *http://www.cms.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp*.

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: SE1122
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: Accreditation Date, January 1, 2012
Related CR Transmittal #: N/A
Implementation Date: N/A

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2010, must be paid before the end of business on March 31, 2010.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.625 percent is in effect through June 30, 2011.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Source: Publication 100-04, Chapter 1, Section 80.2.2

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Partnership for Patients meets goal of over 2,000 hospitals participating

Obama Administration's initiative aims to improve patient safety and lower costs

U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced on Friday, July 8, that nearly 4,500 organizations – including more than 2,000 hospitals – have pledged their support for the Partnership for Patients, the Obama Administration's new nationwide patient safety initiative. In less than three months, the Administration has met its goal of having 2,000 hospitals pledge their support.

On a conference call with leaders of major hospitals, employers, health plans, physicians, nurses, patient advocates, and state government officials, the Secretary reported on the progress of the Partnership for Patients, encouraging them to reach out to colleagues and to get started on the challenging but critical work of making care safer, more reliable, and less costly for all Americans.

The Partnership for Patients also has the potential to save up to $35 billion in health care costs, including up to $10 billion for Medicare. Over the next ten years, the Partnership for Patients could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings.

The Partnership for Patients has announced two funding opportunities created by the Affordable Care Act:

- The Community-Based Care Transitions Program provides up to $500 million in funding for community based organizations in partnership with hospitals to help patients safely transition between settings of care. To read more about this program and how to apply, visit *http://www.Healthcare.gov/center/programs/partnership/safer/transitions_.html*. Applications will be accepted on a rolling basis.
- The Centers for Medicare & Medicaid Services (CMS) Innovation Center has posted a request for bids for state, regional, national, or hospital system organizations to manage improvement projects that affiliated hospitals may join. To read the solicitation, visit *https://www.FBO.gov/spg/HHS/HCFA/AGG/APP111513/listing.html*.

For more information on the Partnership for Patients initiative and success stories, or to join, visit *http://www.Healthcare.gov/partnershipforpatients*.

The full text of this excerpted press release can be found on the CMS website at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4019*.

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

Source: CMS PERL 201107-28

CMS to release an ordering physician spinal orthotic comparative billing report

In July, the Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) centered on physicians ordering spinal orthotic devices billed to Medicare. The CBRs will be released to approximately 5,000 ordering physicians nationwide.

The CBRs, produced by SafeGuard Services under contract with CMS, provide comparative data on how an individual health care provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

These reports are not available to anyone but the provider who receives them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients.

For more information and to review a sample of the spinal orthotic CBR, please visit the CBR Services website at *http://www.CBRservices.com* or call the SafeGuard services provider help desk, CBR support team at 530-896-7080.

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

Source: CMS PERL 201107-24

Letter from the CMS administrator to health care professionals posted to website

The Centers for Medicare & Medicaid Services (CMS) has posted online the Monday, June 20, letter from CMS Administrator, Donald M. Berwick, M.D., that highlights opportunities for providers, Medicare beneficiaries, and patients not covered by Medicare as a result of the Affordable Care Act. The letter was sent to Medicare fee-for-service providers by the Medicare administrative contractors (MACs) during the week of Monday, June 20, and may now be found at *http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp*.

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

Source: CMS PERL 201106-51

Specialty code for advanced diagnostic imaging services

Note: This article was revised on June 30, 2011, to reflect a revised change request (CR) 7175 issued on June 24, 2011. In this article, the CR release date, transmittal number, the effective and implementation dates, and the Web address for accessing CR 7175 have changed. In addition, specialty code 95 is changed to "open" status. This information was previously published in the April 2011 *Medicare B Connection* page 18.

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) will keep specialty code 95 as "open" as opposed to using it to designate advanced diagnostic imaging (ADI) accreditation. (Note: Previously, CMS had designated this specialty code for the Competitive Acquisition Program for drugs project.) Instead of gathering this information through a second Medicare enrollment under a separate specialty code, the information that is used to verify accreditation will be sent by the three recognized accrediting organizations that accredit these providers/suppliers.

Additional information

The official instruction, CR 7175, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2248CP.pdf*.

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

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Related CR Transmittal #: R2248CP
Implementation Date: April 4, 2011

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

Claims returned as unprocessable as appeal requests

Recently, First Coast Service Options, Inc. (FCSO) has found that a large volume of appeals have been filed on claims that were returned as unprocessable. An unprocessable claim is one that was filed with incomplete and/or invalid information. The Medicare guidelines for unprocessable claims may be found in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 1, Section 80.3, available at *http://www.cms.gov/manuals/downloads/clm104c01.pdf*. The Medicare guidelines for completion of CMS-1500 form may be found at *http://www.cms.gov/manuals/downloads/clm104c26.pdf*.

Claims that are unprocessable cannot be appealed. Therefore, when a provider files an appeal on an unprocessable claim, the correspondence is returned to the provider with a letter instructing the provider to refile a new claim. Response letters are typically not generated for at least 30-40 business days after the original request was submitted. To avoid delays in payments, providers must resubmit claims returned as unprocessable. Filing an appeal only delays payment on claims and could result in a timely filing denial if the incomplete/invalid claim is not re-filed with the correct information with the timely filing period.

Identifying an unprocessable claim

Claims returned as unprocessable will typically include the MA130 remittance advice message with a corresponding reason code message to denote why the claim was incomplete or invalid.

Communication letters to top providers that file appeals on unprocessable claims

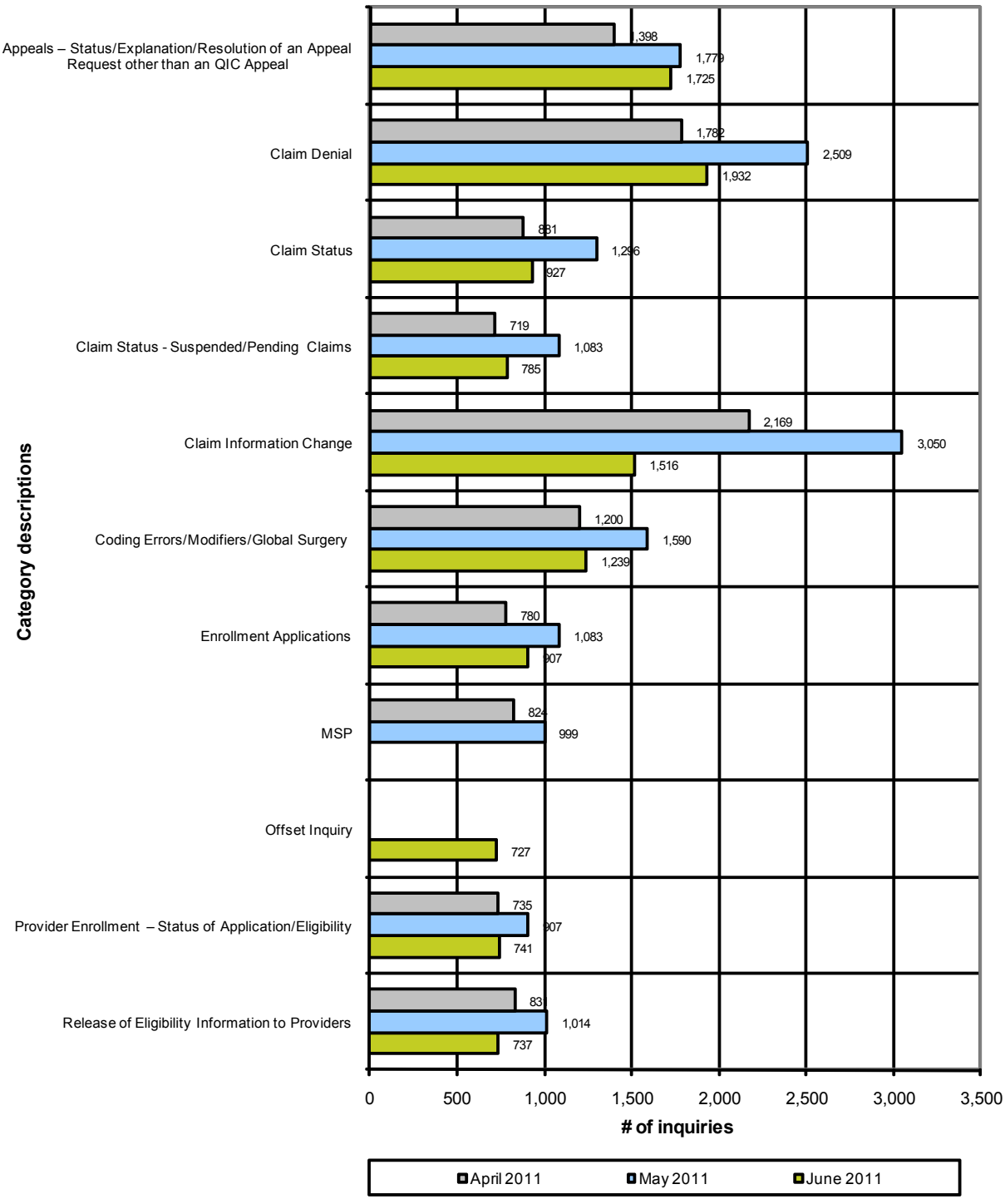
FCSO will be sending communication letters to providers in the future if appeals are continually filed on unprocessable claims. These letters will provide details on the number of appeals requests received on unprocessable claims by the applicable providers and the impacts that such requests have on regular appeal and inquiry inventories.

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 April-June 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 April-June 2011



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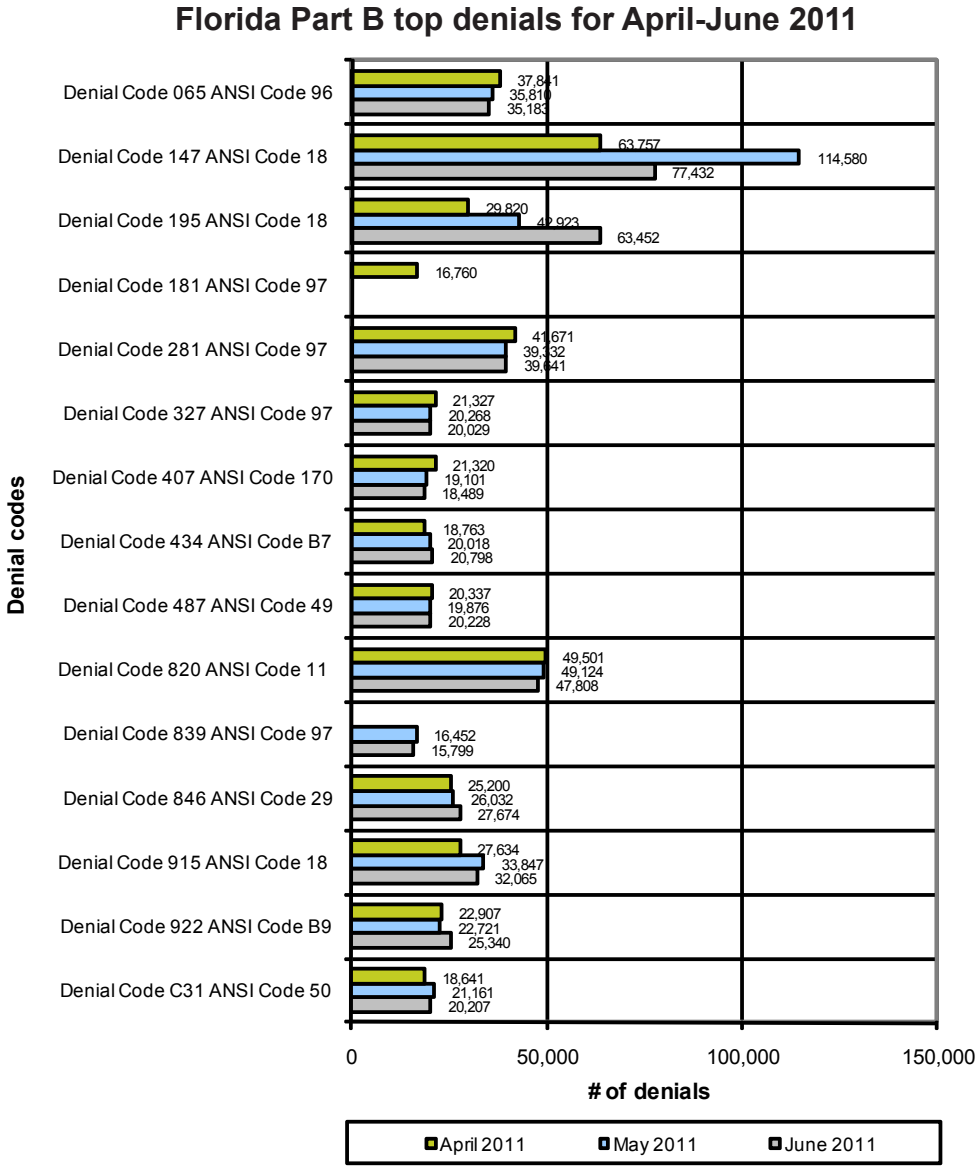


Steps to reduce the number of claim submission errors

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.

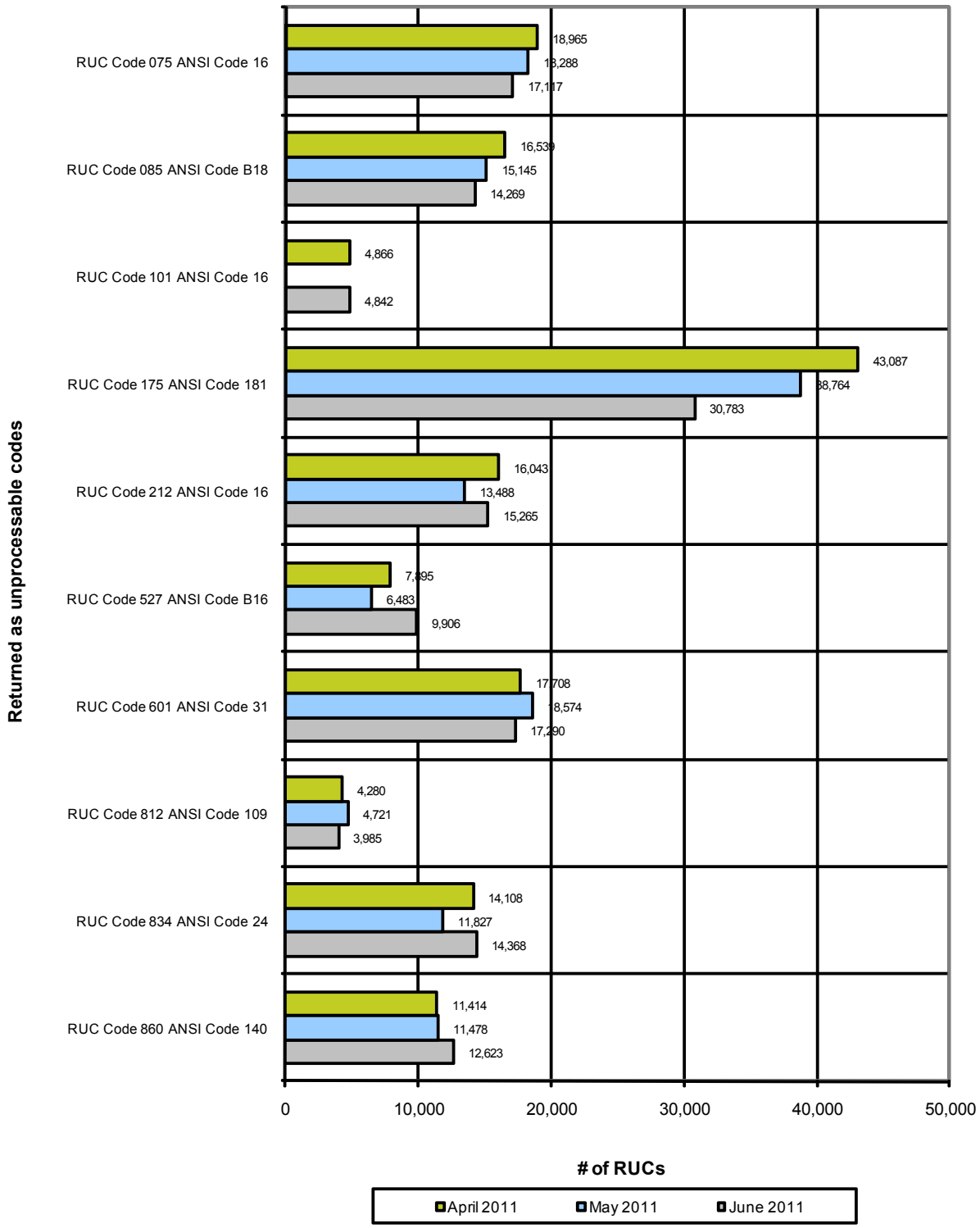
Did you know you can now create an account and receive your personalized Provider Data Summary report?
The Provider Data Summary (PDS) is a comprehensive billing report designed to be utilized along with Medicare Remittance Notices (MRNs) and other provider-accessible billing resources to help identify 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 April-June 2011

Note: The RUC volumes reported for April and May in the May and June issues of the *Medicare B Connection* were incorrect. This error impacted Florida volumes only. The chart below reflects the appropriate corrections.



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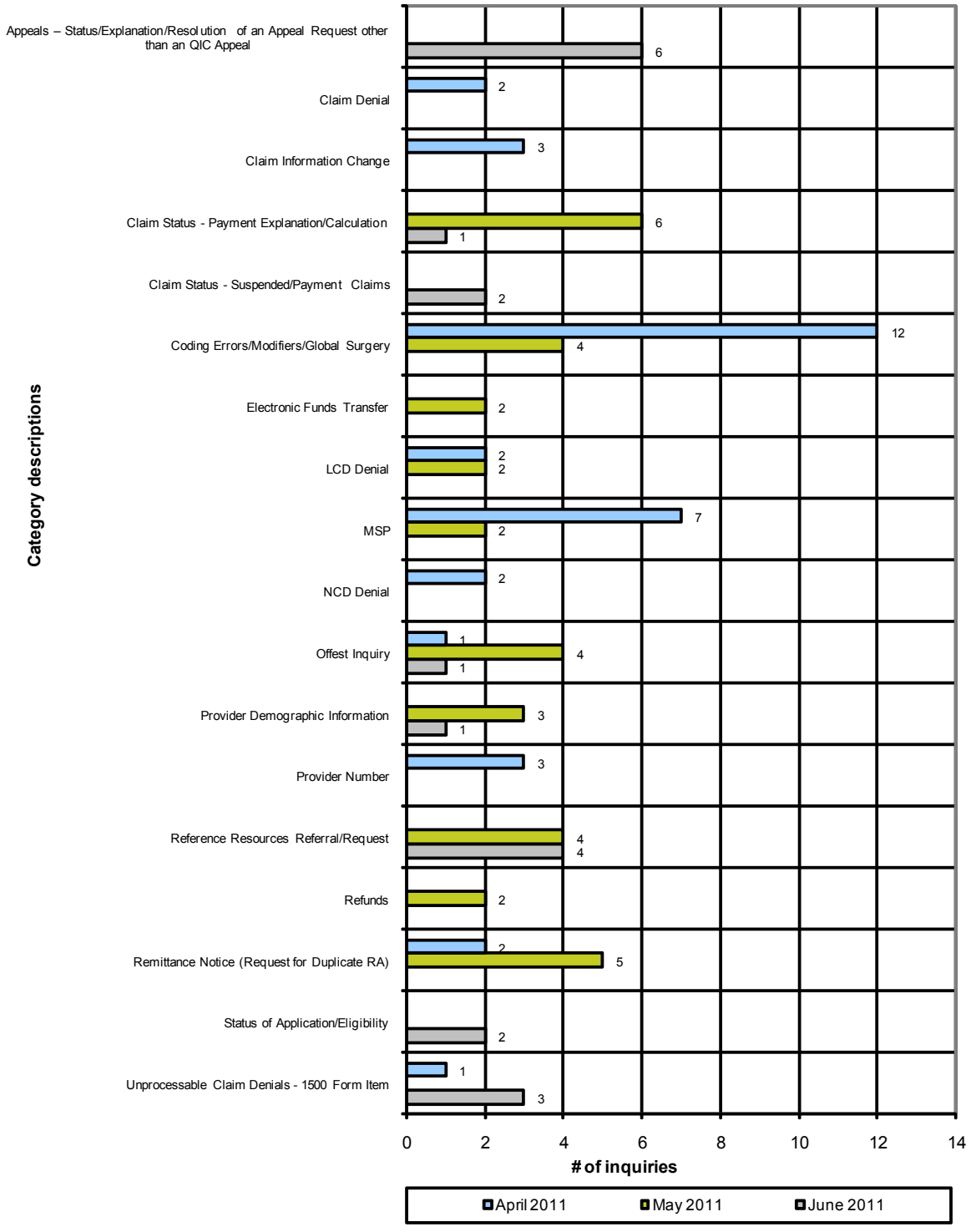
U.S. Virgin Islands Part B top inquiries for April-June 2011



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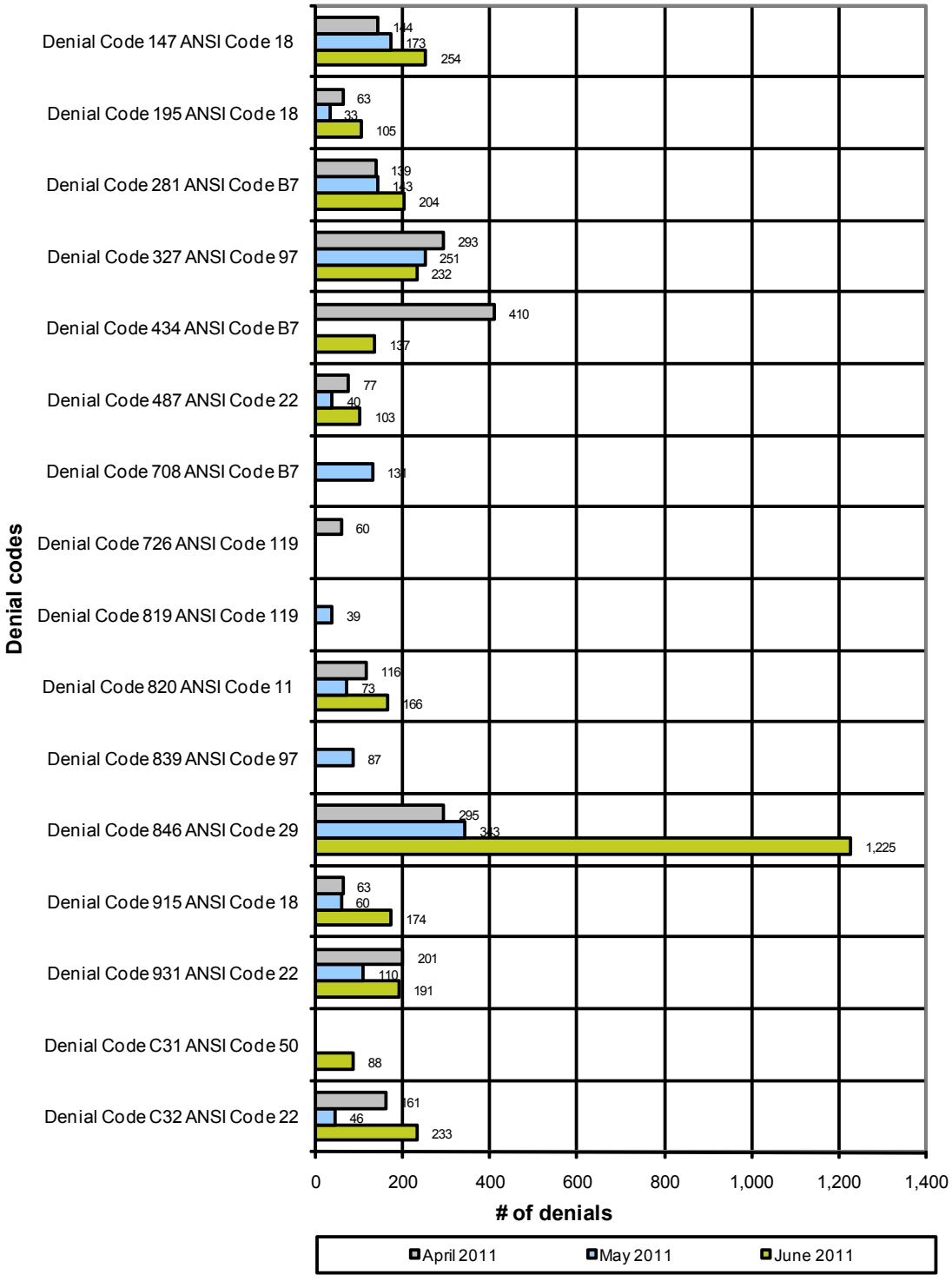
U.S. Virgin Islands Part B top denials for April-June 2011



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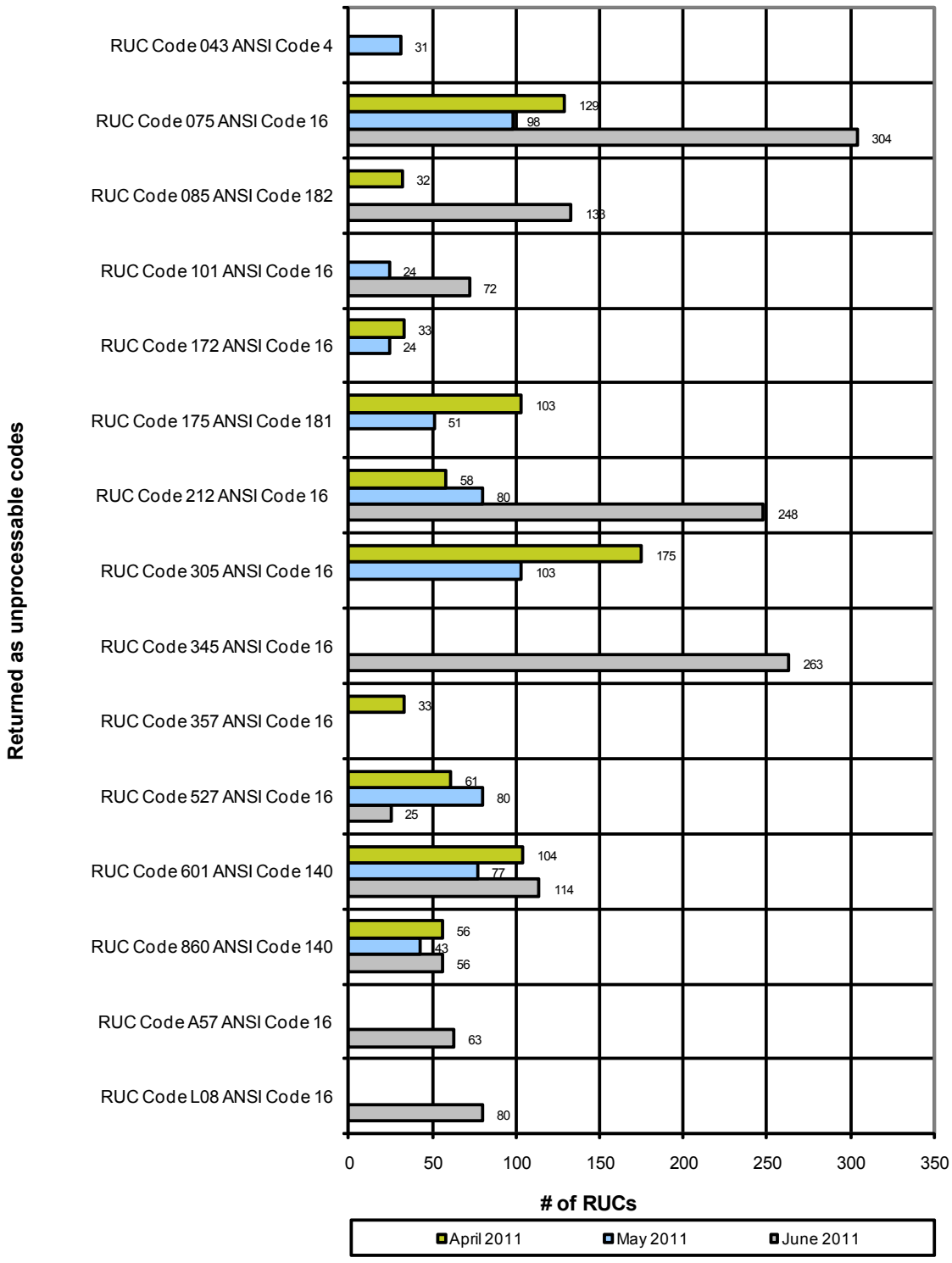
U.S. Virgin Islands Part B top return as unprocessable claims for April-June 2011



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: 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.

Revisions to LCDs

J7187: Hemophilia clotting factors – retirement of coding guidelines

LCD ID number: L29187 (Florida)
LCD ID number: L29345 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for hemophilia clotting factors was most recently revised on July 1, 2011. Since that time, the "Coding Guidelines" attachment has been retired based on the Centers for Medicare & Medicaid Services (CMS) JSM/TDL-10239, dated April 19, 2010, indicating that the "Least Costly Alternative" (LCA) provision no longer applies.

Effective date

The retirement of the "Coding Guidelines" attachment is effective for claims processed **on or after July 26, 2011**. Although the retirement of the "Coding Guidelines" attachment is effective July 26, 2011, the effective date of the CMS instruction to contractors for removal of the LCA provision was **April 19, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

NCSVCS: Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised on July 1, 2011. Since that time, the following revision was made.

- Since *CPT* code *97024* (Diathermy/Microwave) is also referenced in the therapy and rehabilitation services LCD, *CPT* code *97024* (*Application of a modality to one or more areas; diathermy [eg, microwave]*) has been removed from the noncovered services LCD.

The noncovered services LCD "coding guidelines" attachment for services that are noncovered based on national coverage determinations (NCDs) was most recently revised on April 12, 2011. Since that time, the following revisions were made to the "coding guidelines" attachment.

- *CPT* code *82435* (Sweat test as predictor of efficacy of sympathectomy in peripheral vascular disease [PVD]) has been changed to *CPT* code *82438*. This is based on the national coverage determination (NCD) for sweat test (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 190.5). In addition, First Coast Service Options Inc. has identified ICD-9-CM codes 443.0-443.9 to represent PVD based on this NCD.
- HCPCS code P9033 (Transfer factor for treatment of multiple sclerosis) has been changed to *CPT* code *95199*. This is based on the national coverage determination (NCD) for transfer factor (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 160.20). In addition, First Coast Service Options Inc. has identified ICD-9-CM code 340 to represent multiple sclerosis based on this NCD.
- Since chelation therapy ethylenediamine-tetra-acetic acid (EDTA) (HCPCS code J0600) used as a treatment and prevention of atherosclerosis is also referenced in the chelation therapy LCD, *CPT* code *93799* (Chelation therapy [EDTA] for treatment of arteriosclerosis) has been removed from the noncovered services LCD "coding guidelines" attachment. This is based on the national coverage determination (NCD) (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 20.21).
- Since the procedure status indicator for *CPT* code *96902* (Hair analysis to detect mineral traces as an aid in diagnosing human disease) is a "B" (Payment for covered services are always bundled into payment for other services not specified) *CPT* code *96902* was removed from the noncovered services LCD "coding guidelines" attachment.
- Since *CPT* code *97024* (Diathermy or ultrasound treatments performed for respiratory conditions or diseases) is also referenced in the therapy and rehabilitation services LCD based on the national coverage determination (NCD) (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 240.3, *CPT* code *97024* has been removed from the noncovered services LCD "coding guidelines" attachment.

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NCSVCS....(continued)

- Since HCPCS code G0283 (Electrotherapy for the treatment of facial nerve paralysis [Bell's Palsy]) is also referenced in the therapy and rehabilitation services LCD based on the national coverage determination (NCD) (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 160.15, HCPCS code G0283 has been removed from the noncovered services LCD "coding guidelines" attachment.

Effective date

This article serves as a 45-day notice that sweat test as a predictor of efficacy of sympathectomy in PVD (ICD-9-CM codes 443.0-443.9) is unproven and that transfer factor for treatment of multiple sclerosis (ICD-9-CM 340) is still experimental and, therefore, they are not covered. These revisions to the LCD/coding guidelines are effective for services rendered **on or after September 5, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

64561: Sacral neuromodulation – revision to the LCD

LCD ID number: L29273 (Florida)
LCD ID number: L29389 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for sacral neuromodulation was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor for jurisdiction 9 (MAC J9). Since that time, the LCD has been revised based on a reconsideration request to add a new Food and Drug Administration (FDA) approved indication for fecal incontinence. Appropriate evidence-based, peer-reviewed literature was submitted and reviewed along with the appropriate FDA approval letters and the review supported the request.

The LCD has been revised to add "Indications" and "Limitations" under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. The following new indication has been added to the "Indications" section of the LCD for sacral nerve stimulation: "treatment of fecal incontinence in those patients who have failed or are not candidates for conservative treatments (i.e., biofeedback, dietary management, pharmacotherapy, strengthening therapy). The patient must also have a weak but structurally intact sphincter." In addition to this new indication being added, the "Limitations" section of the LCD has been revised to outline limitations of coverage for fecal incontinence. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to include diagnosis code 787.60 (Full incontinence of feces) to the list of medically necessary diagnosis codes. Lastly, the "Documentation Requirements", "Utilization Guidelines" and "Sources of Information and Basis for Decision" sections of the LCD have all been revised accordingly for the addition of this new indication.

Effective date

This LCD revision is effective for claims processed **on or after July 22, 2011**, for services rendered **on or after March 14, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

70544: Magnetic resonance angiography (MRA) – revision to the LCD

LCD ID number: L29218 (Florida)
LCD ID number: L29447 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was most recently revised on October 1, 2010. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add a "Limitations" section. The "*CPT*/HCPCS Codes" section of the LCD has also been revised to add a section, "*CPT*/HCPCS Codes that Do Not Support Medical Necessity". This notification serves as a 45-day notice that the procedures represented by the *CPT*/HCPCS codes listed in this section (i.e., *72159* and *73225*, and C8931-C8936 [for ambulatory surgical centers]) are not considered medically reasonable and necessary.

Effective date

This LCD revision is effective for services rendered **on or after September 12, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Additional Information

J3095: Vibativ (telavancin) – clarification on billing

Vibativ is a lipoglycopeptide antibacterial indicated for the treatment of adult patients with complicated skin and skin structure infections caused by susceptible Gram-positive bacteria. The food and drug administration (FDA) label lists the following Gram-positive microorganisms that are susceptible isolates of vibativ: staphylococcus aureus (including methicillin-susceptible and resistant isolates), streptococcus pyogenes, streptococcus agalactiae, streptococcus anginosis group (includes s. angiosus, s. intermedius, and s. constellatus), or enterococcus faecalis (vancomycin-susceptible isolates only). In the absence of local coverage determinations, national coverage determinations or specific Medicare manual language, coverage of drugs is generally limited to the indications outlined on the FDA approved label. The Medicare administrative contractor for jurisdiction 9 (MAC J9) considers the following ICD-9-CM diagnosis codes as consistent with the FDA approved indications. The medical record must support that the service is reasonable and necessary for the given patient.

ICD-9-CM codes to be considered for complicated skin or wound infection: 680.0-682.9, 707.00-707.09, 707.10-707.19, 707.8, 707.9, 872.10-872.11, 873.1, 873.50-873.59, 873.9, 875.1, 876.1, 877.1, 879.1, 879.3, 879.5, 879.7, 879.9, 880.10-880.13, 880.19, 881.10-881.12, 882.1, 883.1, 884.1, 890.1, 891.1, 892.1, 893.1, or 894.1

ICD-9-CM codes to report the Gram-positive microorganism: 041.01, 041.02, 041.04, 041.05, 041.10, 041.11, 041.12, or 041.19

According to the 2011 ICD-9-CM book, the disease being treated should be reported first, then the bacterium. It is expected that these diagnosis codes are reported on the same claim and in the situation where they are not billed together on the same claim, the claim will be denied. Per ICD-9-CM guidelines, diagnosis codes are to be used to their highest number of digits available, and can be clearly supported in review of the medical record. As a reminder, medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration.

Educational Events

Upcoming provider outreach and educational events
August 2011

Transition to HIPAA version 5010 technical seminar
When: Monday, August 15 **(two classes)**
Time: 10:00-11:30 a.m. & 2:00-3:30 p.m. **Type of Event:** Face-to-face

Medifest Tampa 2011
When: August 16-18
Time: 8:00-4:30 p.m. **Type of Event:** Face-to-face

5010 Testing Support
When: Wednesday, August 24
Time: 10:00-11:00 a.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.

Preventive Services

Annual Wellness Visit brochure and *Medicare Preventive Services* booklet available

***New Annual Wellness Visit* brochure**
The new publication titled *Annual Wellness Visit* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Annual_Wellness_Visit.pdf*. This brochure is designed to provide education on the annual wellness visit and providing personalized prevention plan services, at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update their personalized prevention plan.

***Quick Reference Information Resources: Medicare Preventive Services* booklet available in hard copy**
The *Quick Reference Information Resources: Medicare Preventive Services* booklet, which is designed to provide education on coverage, coding, and billing criteria for Medicare-covered preventive services, is now available in print, free of charge, from the *Medicare Learning Network*® (*MLN*). It includes the following four quick reference information charts: *Preventive Services*, *Medicare Immunization Billing*, *The ABCs of Providing the Initial Preventive Physical Examination*, and *The ABCs of Providing the Annual Wellness Visit*.

To order your copy, visit the *MLN General Information* page at *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," and choose "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 201106-49

'Preventive Immunizations' brochure updated

The *Preventive Immunizations* brochure – which is designed to provide education on Medicare's influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine benefits – has been updated and is now available in downloadable format, free of charge. To view, download, or print the brochure, please visit *http://www.CMS.gov/MLNProducts/downloads/adult_immunization.pdf*. This brochure will also be made available in print at a later date.

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

Source: CMS PERL 201107-18

Preventive services resources updated

The *Medicare Learning Network* (MLN) has recently updated several educational tools related to Medicare-covered preventive services:

- The *Quick Reference Information: Preventive Services* offers coverage, coding, and payment information on the wide variety of preventive services Medicare covers; view, download, or print at *http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- The *Quick Reference Information: The ABCS of Providing the Initial Preventive Physical Examination (IPPE)* offers a list of the elements included in the IPPE, along with some frequently asked questions; view, download, or print at *http://www.CMS.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.
- The *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (AWV)* offers a list of the elements included in the AWV, along with some frequently asked questions; view, download, or print at *http://www.CMS.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*.
- The *Quick Reference Information: Medicare Immunization Billing* offers coverage, coding, and payment information for the seasonal influenza, pneumococcal, and hepatitis B vaccines; view, download, or print at *http://www.CMS.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

The MLN also offers these charts in a laminated, ring-bound booklet titled *Quick Reference Information Resources: Medicare Preventive Services*. This booklet contains all four of the preventive services charts listed above in a single, easy-to-use format. To order your free copy, visit the Preventive Services MLN page at *http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp*, then scroll to MLN Product Ordering Page in the Related Links Inside CMS section. Please note that, aside from the Medicare Immunization Billing chart, these charts are no longer offered individually in hard copy.

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

Source: CMS PERL 201107-23

Cancer Screenings brochure revised

The *Cancer Screenings* brochure has been updated and is now available, free of charge, from the *Medicare Learning Network*. This brochure is designed to provide education on Medicare's mammography screening, screening Pap test, pelvic screening examination, and prostate cancer screening benefits. To view, download, or print the brochure, visit *http://www.CMS.gov/MLNProducts/downloads/cancer_screening.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 201107-23

Tobacco-Use Cessation Counseling Services brochure revised

The *Tobacco-Use Cessation Counseling Services* brochure – which is designed to provide education on tobacco-use cessation counseling services – has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network*. To view, download, or print the brochure, please visit *http://www.CMS.gov/MLNproducts/downloads/smoking.pdf*. This brochure is suggested for all Medicare providers, and will also be made available in print at a later date.

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

Source: CMS PERL 201107-23

Other Educational Resources

Advance Beneficiary Notice of Noncoverage – Part A and Part B booklet revised

The *Advance Beneficiary Notice of Noncoverage (ABN) – Part A and Part B* booklet, which is designed to provide education on the ABN, has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network*® (*MLN*). To view, download, or print the brochure, visit *http://www.CMS.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf*. A hard copy version of this product will be made available at a later date.

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

Source: CMS PERL 201106-49

Provider-supplier enrollment fact sheets revised

The fact sheets below provide education to specific provider types on how to enroll in the Medicare program and maintain their enrollment information using internet-based Provider Enrollment, Chain, and Ownership System (PECOS). They have been recently updated and are available in downloadable format from the *Medicare Learning Network*®:

- *Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record* advises FFS physicians and non-physician practitioners on how to ensure their enrollment records are secure and up-to-date, and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf*.
- T*he Basics of Medicare Enrollment for Physicians and Other Part B Suppliers* explains general Medicare enrollment information relevant to physicians and other Part B suppliers and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf*.
- *The Basics of Internet-Based PECOS for DMEPOS Suppliers* describes general Medicare enrollment information relevant to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*.
- *The Basics of Medicare Enrollment for Institutional Providers* explains general Medicare enrollment information relevant to institutional providers and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf*.
- *The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement* describes general Medicare enrollment information relevant to those physicians required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_Phys_Infreq_Reimb_FactSheet_ICN006881.pdf*.
- *The Basics of Internet-Based PECOS for Physicians and Non-Physician Practitioners* provides an overview of how physician and non-physician practitioners can enroll in Medicare using Internet-based PECOS and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.
- *The Basics of Internet-Based PECOS for Provider and Supplier Organizations* describes how provider and supplier organizations can enroll in Medicare using internet-based PECOS and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.
- *Internet-Based PECOS Contact Information* provides contact information for technical assistance with internet-based PECOS and can be found at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf*.

Please visit *http://www.CMS.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf* for a complete list of all MLN products related to Medicare provider-supplier enrollment.

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

Source: CMS PERL 201106-49

Revised fact sheet and brochures from the *Medicare Learning Network®*

***Medicare Billing for Speech-Language Pathologists in Private Practice* fact sheet revised**
The *Medicare Billing for Speech-Language Pathologists in Private Practice* fact sheet has been revised and is now available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/SpeechLangPathfctsht.pdf*. This fact sheet is designed to provide education on enrollment and billing procedures specific to speech-language pathologists (SLPs) and includes general billing and enrollment information and what services can be billed directly by an SLP.

***Glaucoma Screening* brochure revised**
The *Glaucoma Screening* brochure, which is designed to provide education on Medicare-covered glaucoma screening, has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network®*. To view, download, or print the brochure, visit *http://www.CMS.gov/MLNProducts/downloads/glaucoma.pdf*.

***Expanded Benefits* brochure revised**
The revised publication titled *Expanded Benefits* is now available in downloadable format from the Medicare Learning Network® at *http://www.CMS.gov/MLNProducts/downloads/Expanded_Benefits.pdf*. This brochure is designed to provide education on three preventive services: the initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" physical exam or the "Welcome to Medicare" visit), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.

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

Source: CMS PERL 201106-49

2011 Physician Quality Reporting System fact sheet are now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that three new educational resources on the 2011 Physician Quality Reporting System are now available on the CMS website.

- *Physician Quality Reporting System: Satisfactorily Reporting 2011 Physician Quality Reporting System Measures – Claims and Registry fact sheet*

This fact sheet provides guidance on claims-based and registry-based reporting, and describes steps that eligible professionals/practices should take prior to undertaking Physician Quality Reporting System reporting. This also provides helpful tips for eligible professionals and their billing staff.

- *2011 Physician Quality Reporting System: Made Simple for Reporting the Preventive Care Measures Group fact sheet*

This fact sheet provides quick, easy-to-understand instructions for eligible professionals on how to satisfactorily participate in the 2011 Physician Quality Reporting System using the Preventive Care Measures Group.

- *Physician Quality Reporting System: (Physician Quality Reporting, formerly called Physician Quality Reporting Initiative or PQRI) Reporting Periods for 2011 fact sheet*

This fact sheet explains the two reporting periods for the 2011 Physician Quality Reporting System: 12 months (January 1, 2011-December 31, 2011) and 6 months (July 1, 2011-December 31, 2011).

To access all available Physician Quality Reporting System educational resources, please visit *http://www.cms.gov/PQRS* and select the *Educational Resources* tab. Once on the Educational Resources page, scroll down to the *Downloads* section select the publication title.

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

Source: CMS PERL 201107-01

Bone Mass Measurement brochure revised

The *Bone Mass Measurement* brochure is designed to provide education on the bone mass measurement benefit, and includes information on methods of bone measurement (bone density), coverage information, and risk factors. This brochure has been updated and is now available in downloadable format, free of charge, from the *Medicare Learning Network* at *http://www.CMS.gov/MLNproducts/downloads/bone_mass.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 201107-39

Physician Quality Reporting System and eRx incentive program fact sheets available

A series of fact sheets relating to the *Physician Quality Reporting System and the Electronic Prescribing (eRx) Incentive Program* are now available in downloadable format from the *Medicare Learning Network*:

- The *2011 Physician Quality Reporting System Made Simple for Reporting the Preventive Care Measures Group* fact sheet is designed to provide information to eligible professionals regarding how to report the preventive care measures group, and includes information on how to start using the measures group, as well as some examples of situations and solutions; download at *http://www.CMS.gov/MLNProducts/downloads/PQRS_fact_sheet.pdf*.
- The *Physician Quality Reporting System Satisfactorily Reporting 2011 Measures: Claims and Registry* fact sheet is designed to provide information to eligible professionals and their billing staff regarding some preparatory steps that need to be taken prior to reporting, should they choose to participate in Physician Quality Reporting, and includes guidance on getting started, tips for Physician Quality Reporting, Claims-Based Reporting of Individual Measures, and Common Reporting Errors Associated with Claims-based Reporting; download at *http://www.CMS.gov/MLNProducts/downloads/PQRS_claimreg_fact_sheet.pdf*.
- The *Physician Quality Reporting System (Physician Quality Reporting, formerly called Physician Quality Reporting Initiative or PQRI) Reporting Periods* for 2011 fact sheet is designed to provide information to eligible professionals regarding the PQRI 2011 reporting periods, and includes information on Physician Quality Reporting Resources and the Four 6-Month Reporting Period Options; download at *http://www.CMS.gov/MLNProducts/downloads/PQRS_RptPeriod_fact_sheet.pdf*.
- The *2011 Electronic Prescribing (eRx) Incentive Program Made Simple* fact sheet is designed to provide information to eligible professionals regarding the steps necessary to qualify for the 2011 eRx incentive, and includes information on qualifying for a 2011 eRx Incentive by reporting the eRx measure, what is considered a qualified eRx system, and other resources available; download at *http://www.CMS.gov/MLNProducts/downloads/eRx_fact_sheet.pdf*.
- The *2011 Electronic Prescribing (eRx) Incentive Program Made Simple Quick Reference Chart* provides information regarding questions to answer before reporting the eRx measure; download at *http://www.CMS.gov/MLNProducts/downloads/eRx_quick_reference.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 201107-23

2011 eRx educational resources are now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that two new educational resources on the 2011 Electronic Prescribing Incentive (eRx) Program are now available on the CMS website.

- *2011 Electronic Prescribing Incentive Program Made Simple Fact Sheet*

  This fact sheet provides step-by-step advice for participating in the 2011 eRx incentive program.

- *2011 Electronic Prescribing (eRx) Incentive Program Made Simple Quick Reference Chart*

  This resource provides a quick reference to assist with participating in the 2011 eRx incentive program.

To access all available eRx program educational resources, please visit *www.cms.gov/ERxIncentive* on the CMS website and click on the *Educational Resources* tab. Once on the *Educational Resources* page, scroll down to the *Downloads* section select the publication title.

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

Source: CMS PERL 201107-02

New podcasts released on avoiding Medicare billing errors

The *Medicare Learning Network*® has released the next in a series of podcasts designed to provide education to fee-for-service (FFS) providers on how to avoid common billing errors and other improper activities when dealing with the Medicare program:

Power Mobility Device Face-to-Face Examination Checklist discusses the documentation requirements for the face-to-face examination that occurs before ordering a power mobility device for Medicare beneficiaries.

Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements discusses the documentation and coverage requirements needed to submit Medicare claims for oxygen therapy supplies.

To download these and other MLN podcasts, please visit the *MLN Multimedia Web page* and select the topic of the podcast. Also visit the *MLN Provider Compliance Web page*, which contains educational FFS provider materials to help providers understand – and avoid – common billing errors and other improper activities identified through claim review 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 201107-18

'Rehabilitation Therapy Information Resource for Medicare' fact sheet revised

The "Rehabilitation Therapy Information Resource for Medicare" fact sheet has been revised and is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf*. This fact sheet is designed to provide education on rehabilitation therapy services and includes information on coverage requirements, billing and payment information, and a list of contacts and resources.

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

Source: CMS PERL 201107-18

Now available – presentation materials from May 18 ICD-10 national provider call

The Centers for Medicare & Medicaid Services (CMS) has released four podcasts and a video slideshow presentation of the May 18, 2011, national provider call on "CMS ICD-10 Conversion Activities, Including a Lab Case Study."

Did you miss the May 18 ICD-10 national provider call? The entire presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio and captioning.
Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone.

- Podcast 1of 4: Welcome and ICD-10 Overview
- Podcast 2 of 4: Case Study on Translating the Lab NCDs
- Podcast 3 of 4: ICD-10 Updates from CMS Subject Matter Experts
- Podcast 4 of 4: Question and Answer Session

The podcasts, slideshow presentation, and written transcripts are now available on the CMS website at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998*.

The four audio podcasts with corresponding written transcripts, as well as the full written transcript of the call can be accessed by scrolling to the "Downloads" section at the bottom of the page. To access the video slideshow presentation, select the link in the "Related Links Outside CMS" section of the Web page.

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

Source: CMS PERL 201107-20

New *Medicare Ambulance Services* booklet

A new publication titled *Medicare Ambulance Services* (released May 2011), which is designed to provide education on Medicare ambulance services, is now available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/Medicare_Ambulance_Services_ICN903194.pdf*. This booklet includes information about the ambulance service benefit, ambulance transports, ground and air ambulance providers and suppliers, ground and air ambulance vehicles and personnel requirements, covered destinations, ambulance transport coverage requirements, and ambulance services payments.

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

Source: CMS PERL 201107-23

Medicare Learning Network provider exhibit program

Would you like to have the Centers for Medicare & Medicaid Services (CMS) present at your next national and/or regional provider association meeting or conference? If so, visit the brand new *Medicare Learning Network* provider exhibit program Web page to contact us directly. We can provide your conference attendees with access to relevant MLN educational products and resources that have been developed especially for their use; your members/attendees will also be provided with an opportunity to provide feedback and exchange ideas with CMS on the relevance of our MLN program materials. For more information on the exhibit program selection process and the current schedule, please visit the MLN provider exhibit program Web page at *http://www.CMS.gov/MLN-Provider-Exhibit-Program*.

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

Source: CMS PERL 201107-23

DMEPOS fact sheets and booklet available in hard copy

Basics of DMEPOS Accreditation fact sheet

The *Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation* fact sheet is now available in hard copy format from the *Medicare Learning Network*; this fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. To place your order, visit the MLN Product Ordering page at *http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*.

DMEPOS Quality Standards fact sheet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards* fact sheet is now available in a hard copy format from the *Medicare Learning Network*; this fact sheet is designed to provide education on DMEPOS quality standards for Medicare-deemed Accreditation Organizations (AOs) for DMEPOS suppliers. To place your, visit the MLN Product Ordering page at *http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*.

DMEPOS New Information for Pharmacies booklet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies* booklet is now available in hard copy format from the *Medicare Learning Network*; this booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by CMS-approved independent national Accreditation Organization (AO) or must obtain an accreditation exemption. To place your order, visit the MLN Product Ordering page at *http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*.

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

Source: CMS PERL 201107-39

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:
1-888-664-4112

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:
1-888-664-4112

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