Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers October 2011

In this issue

2012 ICD-10-PCS GEMs files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2012 ICD-10 procedure coding system (PCS) general equivalence mappings (GEMs) files to the CMS website. These files are available on the 2012 ICD-10-PCS and GEMs Web page at *http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp*. To access the files, scroll to the bottom of the page to the "Downloads" section.

Also available on the 2012 ICD-10 PCS and GEMs Web page:

- Official ICD-10-PCS coding guidelines
- 2012 version – what's new
- Code tables and index
- Code descriptions – long and abbreviated titles
- Development of the ICD-10-PCS
- ICD-10-PCS reference manual and slides
- Addendum

Coming December 2011 – the 2012 ICD-10-CM (diagnosis) files, the diagnosis GEMs, and the reimbursement mappings

Is your organization preparing for a smooth transition to ICD-10 on October 1, 2013?

The CMS ICD-10 website at *www.cms.gov/icd10* is a valuable resource to help you prepare for the U.S. health care industry's change from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding. Bookmark this website and check back frequently for the latest news, resources, compliance timelines, and teleconference information, or get notification of website updates by signing up for the *CMS ICD-10 industry email updates* mailing list.

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

Source: CMS PERL 201109-66

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/*

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.

Ambulance

Ambulance inflation factor for calendar year 2012

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What you need to know

Change request (CR) 7546, from which this article is taken, updates the Medicare Claims Processing Manual by providing the ambulance inflation factor (AIF) for calendar year (CY) 2012 so that Medicare carriers, FIs, and A/B MACs can accurately determine the payment amounts for ambulance services. The AIF for CY 2012 is 2.4 percent. You should ensure that your billing staffs are aware of this 2012 AIF.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to pay for the claims that you submit for ambulance services. Specifically, this section of the Act provides for a yearly payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the prior year.

On March 23, 2010, Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to require that specific prospective payment system and fee schedule update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period). The MFP for CY 2012 is 1.2 percent and the CPI-U for 2012 is 3.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2012 is 2.4 percent.

Note: The Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

You may find the official instruction, CR 7546, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.gov/Transmittals/downloads/R2310CP.pdf*. You will find the updated *Medicare Claims Processing Manual*, Chapter 15 (Ambulance), Section 20.4 (Ambulance Inflation Factor [AIF]) as an attachment to that CR. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7546
Related Change Request (CR) #: CR 7546
Related CR Release Date: September 23, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2310CP
Implementation Date: January 3, 2012

Updates to the Internet-Only Manual Publication 100-04, Chapter 15 – Ambulance to include MMEA provisions

Provider types affected

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

What you need to know

Change request (CR) 7558 updates Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual* to include the correct extension dates per the Medicare and Medicaid Extenders Act of 2010 (MMEA). CR 7558 instructs contractors to ensure that they are in compliance with the instructions found in Chapter 15 of the *Medicare Claims Processing Manual*.

The MMEA of 2010 extends the increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by 3 percent and for covered ground ambulance transports which originated in urban areas by 2 percent through December 31, 2011. **The MMEA of 2010 also extends the "super-rural" bonus an additional year, through December 31, 2011.**

Background

Urban and Rural Ambulance Payment Extensions

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by three percent and for covered ground ambulance transports which originated in urban areas by two percent. These increases were only applicable for claims with dates of service July 1, 2008, through December 31, 2009. The Patient Protection and Affordable Care Act of 2010 reinstated these provisions to on or after January 1, 2010.

Subsequently, the MMEA again extended the payment add-ons through December 31, 2011.

"Super-Rural" Ambulance Payment Extension

In addition, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) specified that, for services furnished during the period July 1, 2004, through December 31, 2009, the payment amount for the ground ambulance base rate was increased where the ambulance transport originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) were required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase was based on the Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile of population arrayed by density. CMS determined that the amount of this increase was equal to 22.6 percent. The Patient Protection and Affordable Care Act of 2010 reinstated this provision for claims with dates of service on or after January 1, 2010, and before January 1, 2011, using the percentage increase that was applicable under this provision for ambulance services during 2009.

Subsequently, the MMEA again extended the rural bonus through December 31, 2011.

Additional information

The official instruction, CR 7558, issued to your A/B MAC, FI, or carrier regarding this change may be viewed *at http://www.cms.gov/Transmittals/downloads/R2318CP.pdf*. If you have any questions, please contact your A/B MAC, FI, or carrier at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

To review the CMS one-stop resource focused on the informational needs and interests of Medicare Fee-for-Service (FFS) ambulance suppliers, you may go to *http://www.cms.gov/AmbulanceFeeSchedule/*.

An ambulance fact sheet is also available at *http://cms.gov/mlnproducts/downloads/ambulancefeesched_508.pdf*.

MLN Matters® Number: MM7558
Related Change Request (CR) #:7558
Related CR Release Date: October 13, 2011
Effective Date: January 18, 2012
Related CR Transmittal #: R2318CP
Implementation Date: January 18, 2012

Drugs and Biologicals

2011-2012 influenza vaccine prices are now available

Remember – influenza vaccine plus its administration are covered Part B benefits. The Centers for Medicare & Medicaid Services (CMS) has posted the 2011-2012 seasonal influenza vaccine payment limits at: *http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp*.

Note that influenza vaccine is not a Part D-covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, visit *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 201109-65

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

Note: This article was revised on September 26, 2011, to reflect the revised change request (CR) 7397 issued on September 23. 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 August 2011 *Medicare B Connection*, pages 10-11.

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.

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.

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Pharmacy.... (continued)

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/R2312CP.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: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2312CP
Implementation Date: January 1, 2012

Durable Medical Equipment

Are you licensed for DMEPOS competitive bidding?

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 2 and national mail-order competitions are coming soon. If you plan to bid, take action now to make sure you have all required licensures for the competitive bidding areas and product categories for which you plan to bid. You must have current versions of all required licenses on file with the national supplier clearinghouse (NSC) at the time of bidding or we can reject your bid.

The NSC has recently updated its DMEPOS licensure database. This database contains the licensure requirements for each state and territory and can assist you in verifying that you meet current licensure requirements. The updated database contains a search tool that is more interactive and is arranged by product specialty rather than supplier type. The database also contains contact information for licensing agencies in each state and territory.

Licensure requirements vary from state to state and locality to locality. The NSC licensure directory provides a good starting point to help you identify the licenses you need. State licensure requirements change periodically and have many exceptions, so the NSC's database serves only as a guide. It remains your responsibility to ensure you are in compliance with the most current state and federal laws and regulations.

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DMEPOS.... (continued)

The new and improved NSC licensure database can found on the NSC website at *http://www.PalmettoGBA.com/NSC* (select the "Licensure Database" in the Self Service Tools section of the home page). You can verify the licenses you currently have on file with the NSC via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) at *https://pecos.cms.hhs.gov/pecos/login.do*.

For more information about the competitive bidding program, including a fact sheet about the licensure requirements for bidding suppliers, please visit the competitive bidding implementation contractor website at *www.DMECompetitiveBid.com*.

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

Source: CMS PERL 201110-06

Get ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 2 and the national mail-order competitions are coming soon.

Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

- Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:
- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011, version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website (*www.cms.gov/MEDICAREPROVIDERSUPENROLL/*) or reviewing the PECOS fact sheet at *www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website (*www.palmettogba.com/nsc*) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

- **Get licensed**: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a competitive bidding area (CBA), you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is very important that you make sure that current versions of all required licenses are in your enrollment file with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

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Competitive.... (continued)

- **Get accredited**: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS website: *www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website at *www.dmecompetitivebid.com* to subscribe to email updates and for the latest information on the DMEPOS competitive bidding 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 201110-01

Evaluation and Management

Clarification of evaluation and management payment policy

Provider types affected

Physicians, non-physician practitioners (NPP), and hospices billing fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, and A/B Medicare administrative contractors (A/B MAC) for certain services to Medicare beneficiaries are affected by this article.

What you need to know

This article, based on change request (CR) 7405, alerts physicians, NPPs and hospices that the Centers for Medicare & Medicaid Services (CMS) recognized the newly created *Current Procedural Terminology* (*CPT*) subsequent observation care codes (*99224-99226*). The article also clarifies the use of evaluation and management (E/M) codes by providers for services in various settings.

Medicare contractors will not search their files to adjust claims already processed, but will adjust claims brought to their attention. Be sure your billing staffs are aware of these changes.

Background

In the calendar year (CY) 2010 physician fee schedule (PFS) final rule with comment period (CMS-1413-FC), CMS eliminated the payment of all *CPT* consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS) G-codes.

In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created *CPT* subsequent observation care codes (*99224-99226*).

All references to billing *CPT* consultation codes in the *Medicare Benefit Policy Manual*, Chapter 15, and the *Medicare Claims Processing Manual*, Chapter 12, are revised, as a result of CR 7405, to reflect the current policy on reporting E/M services that would otherwise be described by *CPT* consultation codes.

References to billing observation care codes in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6, are also revised to account for the new subsequent observation care codes (*99224-99226*).

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E/M.... (continued)

Key points of CR 7405

Consultation codes no longer recognized

Effective January 1, 2010, *CPT* consultation codes were no longer recognized for Medicare Part B payment. A previous article, MM6740, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, informed you that you must code patient evaluation and management visits with E/M codes that represent where the visit occurred and that identify the complexity of the visit performed. (MM6740, Revisions to Consultation Services Payment Policy, is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6740.pdf*.)

- CMS instructed physicians (and qualified NPPs where permitted) billing under the physician fee service (PFS) to use other applicable E/M codes to report the services that could be described by *CPT* consultation codes.
- CMS also provided that, in the inpatient hospital setting, physicians (and qualified NPPs where permitted) who perform an initial E/M service may bill the initial hospital care codes (*99221-99223*).

Reporting initial hospital care codes

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with *CPT* consultation codes, for which the minimum key component work and/or medical necessity requirements for *CPT* codes *99221-99223* are not documented.

- Physicians may bill initial hospital care service codes (*99221-99223*), for services that were reported with *CPT* consultation codes (*99241-99255*) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements. Physicians must meet all the requirements of the initial hospital care codes, including "a detailed or comprehensive history" and "a detailed or comprehensive examination" to report *CPT* code *99221*, which are greater than the requirements for consultation codes *99251* and *99252*.

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with CPT consultation codes

- In situations where the minimum key component work and/or medical necessity requirements for initial hospital care services are not met, subsequent hospital care *CPT* codes (*99231* and *99232*) could potentially be reported for an E/M service that could be described by *CPT* consultation code *99251* or *99252*.
- Subsequent hospital care *CPT* codes *99231* and *99232*, respectively, require "a problem focused interval history" and "an expanded problem focused interval history." An E/M service that could be described by *CPT* consultation code *99251* or *99252* could potentially meet the component work and medical necessity requirements to report *99231* or *99232*. Physicians may report a subsequent hospital care *CPT* code for services that were reported as *CPT* consultation codes (*99241-99255*) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.
- Reporting *CPT* code *99499* (*Unlisted evaluation and management service*) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting *CPT* code *99499* requires submission of medical records and contractor manual medical review of the service prior to payment. Contractors shall expect reporting under these circumstances to be unusual.

Medicare contractors have been advised to expect changes to physician billing practices accordingly. Contractors will not find fault with providers who report subsequent hospital care codes (*99231* and *99232*) in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Billing visits provided in skilled nursing facilities and nursing facilities

The general policy of billing the most appropriate visit code, following the elimination of payments for consultation codes, will also apply to billing initial visits provided in skilled nursing facilities (SNFs) and nursing facilities (NFs) by physicians and NPPs who are not providing the federally mandated initial visit. If a physician or NPP is furnishing that practitioner's first E/M service for a Medicare beneficiary in a SNF or NF during the patient's facility stay, even if that service is provided prior to the federally mandated visit, the practitioner may bill the most appropriate E/M code that reflects the services the practitioner furnished, whether that code be an initial nursing facility care code (*CPT* codes *99304-99306*) or a subsequent nursing facility care code (*CPT* codes *99307-99310*), when documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code.

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E/M.... (continued)

CPT subsequent observation care codes

In CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created *CPT* subsequent observation care codes (*99224-99226*).

- For the new subsequent observation care codes, the current policy for initial observation care also applies to subsequent observation care.
- Payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date.
- All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
- In the rare circumstance when a patient receives observation services for more than two calendar dates, the physician will bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

Additional information

The official instruction, CR 7405, was issued to your FI, RHHI, carrier and A/B MAC via two transmittals. The first updates the *Medicare Benefit Policy Manual* and is at *http://www.cms.gov/Transmittals/downloads/R147BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and is at *http://www.cms.gov/Transmittals/downloads/R2282CP.pdf*. If you have any questions, please contact your FI, RHHI, 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: MM7405
Related Change Request (CR) #: 7405
Related CR Release Date: August 26, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R147BP and R2282CP
Implementation Date: November 28, 2011

Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

Important update regarding 5010/D.0 implementation – action needed now

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), home health and Hospice MACs (HH+H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

You and your billing and software vendors must be ready to begin processing the Health Insurance Portability and Accountability Act (HIPAA), versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 1, 2012, all electronic claims, eligibility and claim status inquiries, must use versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

Caution – what you need to know

You must comply with this important deadline to avoid delays in payments for Medicare fee-for-service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Go – what you need to do

Contact your MACs to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background

HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to version 5010 by January 1, 2012. Any electronic transaction for which a standard has been adopted must be submitted using version 5010 on or after January 1, 2012. Electronic transactions that do not use version 5010 are not compliant with HIPAA and will be rejected.

To allow time for testing, CMS began accepting electronic transactions using either version 4010/4010A or version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with versions 5010 and D.0.

Note: HIPAA standards, including the ASC X12 version 5010 and version D.0 standards are national standards and apply to your transactions with all payers, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well.

continued on next page

Important....(continued)

Are you at risk of missing the deadline?

If you can answer NO to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your version 4010 transactions to version 5010 (if not converting your older software)?
3. Have you identified changes to data reporting requirements?
4. Have you started to test with your trading partners, which began on January 1, 2011?
5. Have you started testing with your MAC, which is required before being able to submit bills with the version 5010?
6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional information

MLN Matters® article MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7466.pdf*.

The *Medicare Learning Network*® (*MLN*) fact sheet, *Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0*, is available at *http://www.cms.gov/Versions5010andD0/downloads/w5010TransitionFctSht.pdf*.

MLN Matters® special edition article SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at *http://www.cms.gov/MLNMattersArticles/Downloads/SE1106.pdf*.

Additional educational resources about HIPAA 5010 & D.0 are available at *http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp*.

If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, and DME MACs) at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1131
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

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Crossover company name not being displayed on electronic remittance advice

The Centers for Medicare & Medicaid Services (CMS) has determined that Medicare Part B electronic remittance advices (ERAs) in the 4010A1 format issued October 3, 2011, through October 7, 2011, are not displaying the crossover company name and accompanying 5-byte Coordination of Benefits Agreement (COBA) ID. To identify that these claims have been automatically crossed over to a supplemental payer, look for remittance advice remark code (RARC) MA18 and/or N89. RARC MA18 alerts providers that the claims information is being forwarded to the patient's supplemental payer, while RARC N89 alerts providers that claim information is being forwarded to multiple supplemental payers. If you see RARC MA18 and/or N89, the patient's claim has automatically been crossed over, even though the crossover company name and COBA ID is not being displayed.

Suppliers that receive the ERA from durable medical equipment Medicare administrative contractors (DME MACs) are not affected since this was a multi-carrier system issue. The problem is now resolved via an emergency change. CMS apologizes for any inconvenience you may experience related to this issue.

Source: CMS PERL 201110-13

Version 5010 level II compliance: Do you know what to do?

Make sure you know how to meet version 5010 level II compliance

The version 5010 compliance deadline is less than 90 days away.

All entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the version 5010 transaction standards by December 31, 2011. In order to meet this compliance deadline, you need to conduct both level I internal testing, and level II external testing of transactions.

Level I internal testing

Level I internal testing allows you to identify and address any potential issues that may arise in advance of testing with external business partners. If you have not yet done so, take action now to complete your internal testing as soon as possible. By now, you should have completed level I internal testing, and begun level II external testing.

Level II external testing

For level II external testing, you should identify the business partners you currently conduct transactions with, and create a schedule and timeline for external testing with each partner. If you trade with a large number of business partners, identify priority partners to conduct testing with first.

To meet level II compliance, business partners that should be included in external testing include:

- Billing services
- Clearinghouses
- Pharmacies
- Entities responsible for coverage and benefit determinations
- Payers

To ensure a smooth transition during level II external testing, you should first test the transactions you currently use on a daily basis, such as:

- Claims
- Eligibility determinations
- Remittances
- Referral authorizations

After testing your daily transactions, you are ready to test all remaining transactions to ensure that you are fully compliant for level II external testing.

Keep up to date on version 5010 and ICD-10
Please visit the *ICD-10 website* for the latest news and resources to help you prepare, and to download and share the implementation *widget* today.

Source: CMS PERL 201110-14

Claim adjustment reason code, remittance advice remark code, and Medicare Remit Easy Print and PC Print update

Provider types affected

Physicians, providers and suppliers who bill Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare carriers, A/B Medicare administrative contractors [A/B MACs] and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries are affected.

Provider action needed

Change request (CR) 7514, from which this article is taken, announces the latest update of claim adjustment reason codes (CARC) and remittance advice remark codes (RARCs) that are effective on October 1, 2011, for Medicare. It also instructs certain Medicare contractors to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits (COB) transactions. A national code maintenance committee maintains the Healthcare CARCs. The CARC list is updated three times a year in early

continued on next page

CARC ...(continued)

March, July, and November. The Centers for Medicare & Medicaid Services (CMS) maintains the RARC list, which is used by all payers. The RARC list is also updated three times a year in early March, July, and November.

Both code lists are posted on the Washington Publishing Company (WPC) website, available at *http://www.wpc-edi.com/Codes*.

The lists at the end of this article summarize the latest changes to these code lists, as announced in CR 7514.

Additional information

If you use the MREP and/or PC Print software, be sure to obtain an updated copy once it is available.

The official instruction, CR 7514, 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/R2304CP.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*.

CR 7514 changes
New codes – CARC

Code	Current narrative	Effective date
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	6/5/2011

Modified codes – CARC
None

Deactivated codes – CARC
None

New codes – RARC

Code	Current narrative	Medicare initiated
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.	Yes
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.	Yes
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.	Yes

Modified codes – RARC
None

Deactivated codes – RARC
None

MLN Matters® Number: MM7514
Related Change Request (CR) #: 7514
Related CR Release Date: September 15, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2304CP
Implementation Date: October 3, 2011

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article, based on change request (CR) 7585, explains that the claim status category and claim status codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October, in conjunction with the Accredited Standards Committee (ASC) X12 meetings.

The Committee has decided to allow the industry six months for implementation of newly added or changed codes. Medicare contractors will begin using the current codes posted at *http://www.wpc-edi.com/codes*, on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All providers are reminded to ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction, CR 7585, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2314CP.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*.

MLN Matters® Number: MM7585
Related Change Request (CR) #: 7585
Related CR Release Date: September 30, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2314CP
Implementation Date: January 3, 2012

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Less than 90 days left until full 5010 implementation

Version 5010 testing week shows promising results

The Centers for Medicare & Medicaid Services (CMS) version 5010 team held its second national testing event the week of Monday, August 22, 2011, to Friday, August 26, 2011. During national testing week, 1252 Medicare fee-for-service (FFS) trading partners conducted testing with the Medicare administrative contractors using the version 5010 format that all covered entities are required to use beginning Sunday, January 1, 2012.

Results

These 1,252 trading partners submitted a total of 67,782 test files and no significant error scenarios were reported. Additionally, 74 trading partners responded to a follow-up survey about national testing week that found that:

- 45 percent of those surveyed responded that they were testing the 837I with Medicare;
- 72 percent responded they were testing the 837P with Medicare;
- 43 percent responded they were testing the 835 with Medicare;
- 24 percent responded they were testing the 276/277 with Medicare; and
- 54 percent responded they were exchanging test files with payers other than Medicare.

Additional results show that transition to production is progressing. Twenty-six percent of trading partners stated they were currently in production status, with an additional 42 percent stating that they expect to be in production status within the next month. Most respondents (72 percent) stated that they were able to receive and process a 277CA while testing.

More information

Medicare FFS providers should take advantage of the many resources we have provided on the 5010-dedicated website at *http://www.CMS.gov/Versions5010andD0*.

5010/D.0 implementation items

The HIPAA 5010 compliance date is fast approaching. There are only 90 days left until full implementation on Sunday, January 1, 2012. Don't wait. Contact your local Medicare administrative contractor and test now to avoid possible delays in payment due to the end-of-year rush in 5010 testing. Testing now will allow time for any needed corrections prior to Sunday, January 1 – the date when only 5010 transactions will be accepted.

Reminders

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

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

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?

5010/D.0 implementation calendar

Upcoming events

Wednesday, November 9 – CMS-hosted 5010 national provider call – HIPAA 5010 status update

Wednesday, December 7 – CMS-hosted 5010 national provider call – question and answer session

Saturday, December 31 – end of the transition year; beginning of 5010 production environment

Past events

For a complete list of past 5010 national provider calls, please visit the *5010 national provider calls section of our versions 5010 & D.0 website*.

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

Source: CMS PERL 201110-02, 201109-69

Full 5010 implementation is coming soon

The HIPAA 5010 compliance date is fast-approaching. There are less than 100 days left until full implementation on January 1, 2012.

As of January 1, 2012, version 5010 will be required for all HIPAA standard transactions. This means:

- Beginning January 1, 2012, HIPAA version 4010A1 will no longer be accepted by Medicare.
- All trading partners must operate in HIPAA version 5010.

It is essential to begin the transition now to prevent a disruption to your claims processing and cash flow.

If you have not done so already, the Centers for Medicare & Medicaid Services (CMS) strongly encourages you to begin exchanging version 5010 transactions with your Medicare administrative contractor (MAC) now to ensure compliance with the January 1, 2012, impact date.

As a reminder, CMS offers free billing software that is version 5010 compliant. Please contact your MAC, fiscal intermediary (FI) or carrier to obtain the latest version of PC-Ace Pro32. CMS also provides the Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 - 835 remittance advices. Please visit *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp* to view this software.

More information

Medicare fee-for-service (FFS) providers should take advantage of the many resources we have provided on the 5010 dedicated website located at *https://www.cms.gov/Versions5010andD0/*.

Don't wait! Test now to avoid possible delays in payment due to the end-of-year rush in 5010 testing. Testing now will allow time for any needed corrections prior to January 1, 2012, the date when only 5010 transactions will be accepted.

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

Source: CMS PERL 201109-55

New fact sheet available on version 5010 testing readiness

All covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the version 5010 transaction standards on January 1, 2012. A critical step to reaching this milestone is testing version 5010 transactions prior to going live. With less than four months until the transition, it is time to take action, especially on external (Level II) testing. The Centers for Medicare & Medicaid Services (CMS) has posted a new *fact sheet* to help you better understand testing and the steps involved.

External testing with business partners in the new version 5010 format will ensure that you are able to send and receive compliant transactions prior to the deadline. You should begin testing as soon as possible if you have not already done so. Waiting until the last minute may result in long testing queues, so plan ahead to avoid the rush.

Here are some suggested steps to take now:

- Identify the partners you currently conduct transactions with
- Create a schedule and timeline for external testing with each partner
- Identify priority partners to conduct testing with if you trade with a large number of business partners

Keep up-to-date on version 5010.

Please visit the 5010 website located at *https://www.CMS.gov/Versions5010andD0/* for the latest news and resources to help you prepare today.

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

Source: CMS PERL 201109-53

Incentive Programs

Deadline to request a Medicare eRx incentive program hardship exemption for the 2012 eRx payment adjustment is November 1, 2011

The Centers for Medicare & Medicaid Services (CMS) would like to remind eligible professionals and group practices participating in the Medicare electronic prescribing (eRx) incentive program that the deadline to request a hardship exemption for the 2012 eRx payment adjustment is November 1, 2011.

Eligible professionals and group practices should determine if they are subject to the 2012 eRx payment adjustment by reviewing the *MLN Article SE1107*. If you believe that you may be subject to the 2012 eRx payment adjustment, you should determine if you meet any of the hardship exemption categories specified by CMS in the 2011 Medicare electronic prescribing (eRx) incentive program final rule.

In addition, a *Quick Reference Guide* is available to help you understand the changes that the eRx final rule made to the 2011 Medicare eRx incentive program. As a result of changes to the program, eligible professionals and group practices have until November 1, 2011, to submit a significant hardship exemption request and rationale.

Please note, to be considered for an exemption under the significant hardship exemption category "Eligible professionals who register to participate in the Medicare or Medicaid electronic health record (EHR) incentive programs and adopt certified EHR technology," an eligible professional must:

1. Have registered for either the Medicare or Medicaid EHR incentive program (for instructions on how to register for one of the EHR incentive programs, we refer readers to the registration and attestation page of the EHR incentive programs section of the CMS website at *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp*; and
2. Provide identifying information as to the certified EHR technology (as defined at 42 CFR 495.4 and 45 CFR 170.102) that has been adopted for use no later than October 1, 2011. Please note that, in order to qualify for an exemption to the 2012 eRx payment adjustment under this significant hardship exemption category, it is not necessary that an eligible professional receive an incentive payment under the Medicare or Medicaid EHR incentive program.

Eligible professionals wishing to register for the Medicaid EHR incentive program in states that have not yet launched their respective programs may initiate the registration process at the CMS registration and attestation system, and obtain a registration number but will not be able to successfully complete registration. If a state has not launched its Medicaid EHR incentive program, the state name will not appear in the drop-down menu for eligible professionals to choose from. However, a registration number is assigned even if registration is not successfully completed.

In order to initiate registration for the Medicaid EHR incentive program, please visit *https://ehrincentives.cms.gov/hitech/login.action* and follow the instructions to begin the registration process. Obtaining a CMS EHR incentive programs registration number, even if the registration is not successfully completed, suffices for the purposes of applying for a significant hardship exemption for the 2012 Medicare eRx payment adjustment.

To request an exemption, individual eligible professionals must submit their hardship exemption requests through the *Quality Communications Support Page* and group practices participating under the group practice reporting option (GPRO) must submit hardship exemption requests via a letter to CMS.

Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

For additional information and resources, please visit *www.cms.gov/erxincentive*.

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

Source: CMS PERL 201109-67

Materials from 'Medicare and Medicaid EHR Incentive Programs: Registration and Attestation for Eligible Professionals' call available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on **Friday, September 9**, 2011, on the topic of *"Registration and Attestation for Medicare and Medicaid EHR Incentive Programs for Eligible Professionals"*, including:

- Path to payment
- Highlights of registration and attestation processes
- Third party proxy
- Troubleshooting
- Helpful resources
- Question and answer session

The presentation, transcript, and audio recording from this call and other selected calls can now be found under the "Presentations for Providers" section on the *Educational Materials page* of the CMS electronic health record (EHR) website. Please refer to the transcript for clarifications to the audio recording for the Friday, September 9 call.

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

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

Source: CMS PERL 201110-08

Materials from 'Medicare & Medicaid EHR Incentive Program: Understanding Meaningful Use' national provider call now available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on **Thursday, August 18**, to discuss the meaningful use requirements of the electronic health record (EHR) incentive programs. The presentation, call transcript, and the audio recording of the call are now available. Don't miss this opportunity to hear from CMS experts on this important topic.

The agenda included:

- 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
  1. *Stage 1 EHR Meaningful Use Specification Sheets for Eligible Professionals*
  2. *Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals*
- Question and answer session

All materials from this call can be found on the CMS EHR website on the *Educational Materials* page at *http://www.CMS.gov/EHRIncentivePrograms/Downloads/UnderstandingMeaningfulUse.zip*.

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

Source: CMS PERL 201109-47

Get motivated by Medicare …

Find out about Provider Incentive Programs

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

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

Medicare EHR incentive program: October 3 was the last day for eligible professionals to begin 90-day reporting period for 2011

The last day that eligible professionals (EPs) could've began their 90-day reporting period in calendar year (CY) 2011 for the Medicare electronic health record (EHR) incentive program was Monday, October 3, 2011. For EPs, this means they must've began their consecutive 90-day reporting period by Monday, October 3, 2011, in order to attest to meeting meaningful use and be eligible to receive an incentive payment for CY 2011.

For EPs who have already completed their reporting period, Centers for Medicare & Medicaid Services (CMS) has a number of tools available to help prepare for attestation. EPs can use the *CMS Eligible Professional Attestation Worksheet* to record their meaningful use measures to have as a reference when attesting for the Medicare EHR incentive program in the *Web-based Registration and Attestation System* registration and attestation system. The *Meaningful Use Attestation Calculator* and *Attestation User Guide for Eligible Professionals* can also help EPs to successfully attest to meeting meaningful use.

Looking ahead
Take a look at all of the other important dates that are coming up by visiting the *CMS Medicare and Medicaid EHR Incentive Programs Milestone Timeline*, or reviewing the "Important Dates" section of the *EHR Incentive Programs' Overview* page.

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

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

Source: CMS PERL 201109-60

New information about the PCIP's special incentive remittance

Payments under the primary care incentive payment program (PCIP) are often electronic, followed-up with a paper report called the special incentive remittance. The remittance is detailed, identifying all of the PCIP-eligible services for the previous quarter from which the Centers for Medicare & Medicaid Services (CMS) calculated the PCIP bonus payment. In 2012, the remittance will be modified to include a summary statement, sorted by practitioner and incentive. Stay tuned for an upcoming change request (CR) for more information.

Source: CMS PERL 201109-51

Contact FCSO if you feel you've been incorrectly identified as a PCIP practitioner

If you feel that you have been incorrectly identified as a Primary Care Incentive Payment Program (PCIP) eligible practitioner, you may contact First Coast Service Options (FCSO) and request a review of your prior claims history that resulted in the eligibility determination. If it is determined that an error was made in your claims history, FCSO will accept the return of your PCIP payment. Refer to *MLN Matters* article MM7060 at *http://www.CMS.gov/MLNMattersArticles/downloads/MM7060.pdf* for a list of eligibility requirements.

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

Source: CMS PERL 201109-61

Summary information regarding the Medicare Primary Care Incentive Payment Program

Note: This article was revised on September 20, 2011, to clarify A1 in the frequently asked questions (FAQ) section and to add additional FAQs Q21 and Q22. In addition, information has been added to the *Additional information* section. All other information is unchanged. This information was previously published in the March 2011 *Medicare B Update!* pages 16-18.

Provider types affected

Physicians and non-physician practitioners (NPPs), who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for primary care services rendered to Medicare beneficiaries, are affected by this information.

What you need to know

Stop – impact to you

The Affordable Care Act provides for a 10 percent Medicare incentive payment to eligible physicians and NPPs for specified primary care services effective for services furnished on or after January 1, 2011, and before January 1, 2016. Payments will be made on a quarterly basis.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) published several recent articles informing you about Section 5501(a) of The Affordable Care Act, which provides for an incentive payment for primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care physician or NPP. These articles explain how the program would pay the incentive payment to eligible primary care physicians and NPPs, including newly enrolled physicians and NPPs, who furnish primary care services in various settings. You may review these articles, which are listed in the *Additional information* section.

Go – what you need to do

The *Background* section of this article provides answers to common questions for physicians and NPPs on the Primary Care Incentive Payment Program (PCIP).

Background

CMS has compiled the following list of questions and answers to respond to the inquiries it has received on the PCIP:

Q1. How does Section 5501(a) of the Affordable Care Act change Medicare?
A1. Beginning with services rendered on or after January 1, 2011 and continuing through December 31, 2015, Section 5501(a) of the Affordable Care Act authorizes an incentive payment of 10 percent of Medicare's program payments to be paid to qualifying primary care physicians and NPPs who furnish specified primary care services. (Please note: coinsurance, copayments, and deductibles are not included in the calculation of PCIP incentive payments).

Q2. Which Medicare specialty designations may potentially qualify as primary care physicians or NPPs?
A2. A potentially qualified primary care physician or NPP, as defined in Section 1833 (x) of the Social Security Act, is a physician with a Medicare specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine or an NPP with a specialty designation of nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).

Q3. How can I confirm my primary specialty designation in Medicare?
A3. You may contact your Medicare claims processing contractor to confirm your primary Medicare specialty designation. Medicare allows two specialty designations upon enrollment' however, PCIP payment eligibility is only determined on the primary specialty designation.

Q4. What are the additional qualifying criteria for the primary care incentive payment program?
A4. Physicians and NPPs of a potentially qualifying specialty whose primary care percentage from historical claims data for the specified period, calculated as primary care allowed charges divided by the total physician fee schedule (PFS) allowed charges excluding hospital inpatient and emergency department visits, and then multiplied by 100, exceeds 60 percent will be eligible for the PCIP.

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PCIP....(continued)

For established physicians and NPPs enrolled in the Medicare program two years prior to the PCIP payment year, the primary care percentage is calculated based on claims data from two years prior to the PCIP payment year. Medicare annually identifies the national provider identification numbers (NPIs) of qualified primary care physician and non-physician practitioners for each PCIP payment year.

Q5. What are the specific primary care services that are eligible for incentive payments?
A5. The specific services are defined by the following *Current Procedural Terminology* (*CPT*) codes:

- *99201* through *99215* (office and other outpatient visits)
- *99304* through *99340* (nursing facility, domiciliary, rest home, or custodial care)
- *99341* through *99350* (home services)

Only the services reflected in the *CPT* ranges above will be eligible for primary care incentive payments.

Q6. What if I am a physician or NPP newly enrolled in Medicare and do not have claims data from two years prior to the PCIP payment year?
A6. For newly enrolled Medicare practitioners who do not have claims data from two years prior to the PCIP payment year upon which an eligibility determination can be made, Medicare will make PCIP eligibility determinations based upon the claims data from the year before the PCIP payment year. There is no minimum amount of claims data required from that year and eligibility determination will be made based on the claims data available, with no minimum time period.

Due to the lag-time in processing claims, PCIP eligibility for new physicians and NPPs will be determined after the close of the third quarter of the PCIP payment year and a single cumulative PCIP payment for all eligible primary care services furnished in the PCIP payment year by that newly enrolled, eligible primary care physician or NPP will be made after the close of the fourth quarter of the PCIP payment year. For specific implementation instructions for this provision, see *MLN Matters*® article MM7267 referenced in the *Additional information* section.

Q7. How can I verify my percentage of primary care services from the claims data year used for eligibility determination (for example, CY 2009 data for the CY 2011 PCIP payment year)?
A7. You may contact your Medicare claim processing contractor to confirm your percentage of primary care services for CY 2009.

Q8. Do I need to enroll in the PCIP program to participate?
A8. No, there is no enrollment process for participation in the PCIP. The NPIs of qualified primary care physicians and NPPs are identified by CMS based on an analysis of historical Medicare claims.

Q9. How can I confirm that I am eligible for the PCIP?
A9. In the beginning of the PCIP payment year, each Medicare claims processing contractor is provided a national PCIP eligibility file that identifies the NPIs of all eligible primary care physicians and NPPs. If your NPI is on the list, you are automatically eligible for PCIP payments in the applicable PCIP payment year. This file may be viewed on your Medicare contractor's website.

Q10. If I qualify for the PCIP payments in calendar year (CY) 2011, will I have to qualify again for the remaining PCIP payment years?
Q10. Yes, each physician or NPP must re-qualify for each PCIP payment year. Eligibility for established physicians and NPPs is determined using claims data from the most recent full calendar year (CY) of data available. For example, CY 2011 PCIP payment year eligibility was determined based on PFS claims from CY 2009.

Q11. What if I have changed Medicare claims processing contractors in the past two years?
A11. Medicare combines claims data for each NPI across all contractors and sites of services (for example, CAH and office) in the development of the national PCIP eligibility file. Each claims processing contractor handling claims in the PCIP payment year for an eligible NPI will make PCIP payments based on the eligible primary care services processed by that contractor and attributed to the eligible NPI in the PCIP payment year.

Q12. Whom may I contact if I have questions regarding my PCIP eligibility status?
A12. If you have questions regarding PCIP eligibility, you may contact your Medicare claims processing contractor contact center support. They will be able to confirm your primary Medicare specialty designation and your percentage of primary care services in the claims year used for eligibility determination (for example, CY 2009 for the CY 2011 PCIP payment year). You may contact your carrier or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Q13. Do I need to identify PCIP participation on submitted claims?
A13. No, services eligible for PCIP payment are identified based on the qualifying physician's or NPP's NPI on the claim and the CPT codes for eligible primary care services.

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PCIP....(continued)

Q14. What if I am part of a physician group?
A14. If you are part of physician group, you are still eligible for primary care incentive payments if you qualify based on your own specialty and primary care percentage. The rendering eligible primary care physician's or NPP's NPI and the primary care services on the claim identify the services as eligible for PCIP payment.

Q15. What if I am a qualifying physician or NPP who has reassigned my Medicare billing rights to a critical access hospital (CAH)?
A15. Primary care incentive payments will be made to CAHs of behalf of qualifying primary care physicians and NPPs. The rendering physician or NPP is identified on the CAH claim by the NPI in the "other provider" field and the eligible primary care services are identified by the *CPT* codes.

Q16. How often will PCIP payments be made?
A16. Primary care incentive payments will be made quarterly.

Q17. Will this incentive payment be coordinated with other bonus payments?
A17. Yes, PCIP payment will be made in addition to Medicare payment under other bonus programs such as the Medicare health professional shortage area (HPSA) physician bonus program. Incentive payments will be made with a "special incentive remittance" so that eligible physicians and NPPs may identify which incentives were paid for specific services furnished.

Q18. Will I receive a written notice from Medicare if I become eligible for the PCIP payment in future payment years?
Q18. No, each PCIP payment year Medicare will provide a national PCIP eligibility file for contractors to post to their websites. Physicians and NPPs will continue to confirm PCIP eligibility for each payment year via this data file.

Q19. Will I receive written notice from Medicare if I become ineligible for the PCIP payment in future PCIP payment years?
Q19. No, if you become ineligible for future PCIP payment years, you will not be contacted by Medicare.

Q20. What if I have other questions regarding my PCIP eligibility status?
A20. Physicians and NPPs should contact their claims processing contractor with any questions regarding their eligibility for the PCIP.

Q21. Will my PCIP payment include a remittance statement?
A21. Yes, the PCIP is often an electronic payment, followed up with a paper report called the Special Incentive Remittance. The remittance is detailed, identifying all of the PCIP eligible services furnished by the PCIP identified practitioner for the previous quarter from which the CMS calculated the PCIP bonus payment for that practitioner. Currently the remittance does not include a summary statement that accumulates PCIP payments for each practitioner. However, no earlier than April 2012 the remittance will be modified to include a summary of total PCIP bonus by practitioner.

Q22. What if I feel that I have been incorrectly qualified as an eligible PCIP practitioner?
A22. If you feel that you have been incorrectly qualified as a PCIP eligible practitioner, you may contact your Medicare claim processing contractor and request that the contractor review your prior period claims history that resulted in an eligibility determination. If it is determined that an error was made in your claims history, your contractor may accept the return of your PCIP payment.

Additional information

MLN Matters® article MM7060 (*Incentive Payment Program for Primary Care Services, Section 5501(a) of The Affordable Care Act*) provides more detail on implementation of Section 5501(a) of The Affordable Care Act, which provides for the incentive payment for primary care services furnished on or after January 1, 2011 and before January 1, 2016, by a primary care physician or NPP. *http://www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf*

MLN Matters® article MM7267 (*Primary Care Incentive Payment Program (PCIP) Eligibility for New Providers Enrolled in Medicare*) explains that (effective July 1, 2011), the PCIP is amended to include the participation of certain newly enrolled Medicare primary care physicians and NPPs who do not have a prior two year claims history with which to determine eligibility. *http://www.cms.gov/MLNMattersArticles/downloads/MM7267.pdf*

MLN Matters® article MM7115 (*Incentive Payment Program for Primary Care Services, Section 5501(a) of The Patient Protection and Affordable Care Act, Payment to a Critical Access Hospital (CAH) Paid Under the Optional Method*) explains that PCIP payments may be made to certain critical access hospitals. *http://www.cms.gov/MLNMattersArticles/downloads/MM7115.pdf*

PCIP....(continued)

New information about the PCIP's Special Incentive Remittance

The PCIP is often an electronic payment, followed-up with a paper report called the Special Incentive Remittance. The remittance is detailed, identifying all of the PCIP-eligible services for the previous quarter from which CMS calculated the PCIP bonus payment. In 2012, the remittance will be modified to include a summary statement, sorted by practitioner and incentive. Stay tuned for an upcoming change request (CR) for more information.

Might you have been incorrectly qualified as a PCIP program eligible practitioner?

If you feel that you have been incorrectly qualified as a PCIP eligible practitioner, you may contact your Medicare claim processing contractor and request a review of your prior claims history that resulted in an eligibility determination. If it is determined that an error was made in your claims history, your contractor may accept the return of your PCIP payment. Refer to MLN Matters article at *http://www.CMS.gov/MLNMattersArticles/downloads/MM7060.pdf* for a list of eligibility requirements.

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*.

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2010 PQRI feedback reports available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2010 Physician Quality Reporting Initiative (PQRI) feedback reports are available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (the Portal) available at QualityNet at *http://www.qualitynet.org/pqri*.

Please note the program name changed to Physician Quality Reporting System in 2011.

Taxpayer identification number (TIN) level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. Eligible professionals can request their national provider identifier (NPI)-level reports through the alternate feedback report fulfillment process, by contacting their carrier or Medicare administrative contractor (MAC) to request individual NPI-level reports or by submitting a request for their report on the new *Quality Reporting Communication Support Page*.

The following CMS resource is available to help eligible professionals understand their *2010 PQRI Feedback Report: A Guide for Understanding the 2010 PQRI Feedback Report [PDF 2MB]*

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

Source: CMS PERL 201109-68

General Information

Discontinuance of verification of foreign born status in provider enrollment

Effective immediately, providers are no longer required to provide information, which verifies the legalized status of enrollment applicants including those individuals referenced in any ownership related information. This is part of an ongoing Centers for Medicare & Medicaid Services (CMS) review of current enrollment requirements to eliminate unnecessary burden on providers as well as delays in the enrollment process. The instructions in *Program Integrity Manual* Chapter 10, Section 5.7.2 will be updated in the near future.

Source: CMS PERL 201109-62

Medicare 2012 open enrollment drug and health plan data now live – online 'Plan Finder' offers unbiased resource to review plan options

In advance of the new, earlier annual enrollment period, people with Medicare were able to begin reviewing plan benefit and cost information on Saturday, October 1, 2011. The Centers for Medicare & Medicaid Services (CMS) launched access to its popular Web-based "Medicare Plan Finder" that allows beneficiaries, their families, trusted representatives, and senior program advocates to look at all local drug and health plan options that are available for the 2012 benefit year.

The annual enrollment period begins earlier this year, on Saturday, October 15, and runs through Wednesday, December 7. People with Medicare will have seven weeks to review Medicare Advantage and Part D prescription drug coverage benefits and plan options, and choose the option that best meets their unique needs. The earlier open enrollment period also ensures that Medicare has enough time to process plan choices so that coverage begins without interruption on Sunday, January 1, 2012.

People can use the "Plan Finder" – available at *www.Medicare.gov* – by searching their home ZIP code for Medicare Advantage (Part C) and Prescription Drug (Part D) plans available in their area.

The full text of this excerpted press release may be found on the CMS website at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4104*.

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

Source: CMS PERL 201110-09

Reducing improper payments, fighting fraud, and curbing waste and abuse under the Affordable Care Act

Final rule released for the Medicaid recovery audit program

On Wednesday, September 14, 2011, the Department of Health and Human Services (HHS) released its final rule for the Medicaid recovery audit program, a key part of the Administration's initiatives to curb waste, fraud and abuse. Created by the Affordable Care Act, the Medicaid recovery audit program will help states identify and recover improper Medicaid payments. It will be largely self-funded, paying independent auditors a contingency fee out of any improper payments they recover that took place in the previous three years.

The recovery audit contractors (RACs) detect and correct past improper payments. RACs review claims after payments have been made, using both simple, automated review processes and detailed reviews that include medical records. RACs can only go three years back from the date the claim was paid, and are required to employ a staff consisting of nurses, therapists, certified coders, and a physician. Under these expansions, RACs will help identify and recover over and underpayments to providers across Medicare and Medicaid for the first time.

New resources to fight fraud

The Affordable Care Act provides an additional $350 million over 10 years and an annual inflation adjustment to ramp up anti-fraud efforts, including increasing scrutiny of claims before they've been paid, investments in sophisticated data analytics, and more "feet on the street" law enforcement agents and others to fight fraud in the health care system.

These efforts build on our recently awarded predictive modeling contract under which the Centers for Medicare & Medicaid Services (CMS) is using the kind of technology used by credit card companies to stop fraud. Since June 30 of this year CMS has been using this technology to help identify potentially fraudulent Medicare claims and uncover fraudulent providers and suppliers, flagging both for investigation and referrals to law enforcement. This new tool allows CMS for the first time to use real-time data to spot suspect claims and providers and take action to stop fraudulent payments before they are paid.

These efforts build on the many aspects of the Affordable Care Act that are currently working to bring down waste, fraud and abuse in the health care system. To learn about the many accomplishments the new tools have produced in preventing and fighting waste, fraud and abuse in these programs, see *http://www.healthcare.gov/news/factsheets/fraud09142011a.html*.

The press release is available at- *https://www.CMS.gov/apps/media/press/release.asp?Counter=4084*.

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

Source: CMS PERL 201109-50

Prohibition on balance billing qualified Medicare beneficiaries

Provider types affected

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

What you need to know

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

Refer to the *Background* and *Additional information* sections of this article for further details and resources about this guidance.

Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the state Medicaid agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background

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

Balance billing of QMBs is prohibited by federal law

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

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

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

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

QMBs and benefits

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

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the state's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and mandatory supplemental benefits.
- Regardless of whether the state Medicaid agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to improve the claim process

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

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Balance billing....(continued)

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

QMB eligibility and benefits

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

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

Additional information

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

For general Medicaid information, please visit the Medicaid Web page at *http://www.cms.gov/home/medicaid.asp*.

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Additional fields for additional documentation request letters

Provider types affected

This article is for physicians, providers, and suppliers who must respond to additional documentation request (ADR) letters from Medicare administrative contractors (A/B MACs) or durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 7254, from which this article is taken, makes changes to the Medicare systems that allow A/B MACs and DME MACs to include, on ADR letters, information about the Electronic Submission of Medical Documentation (esMD) pilot.

Background

CR 7254, from which this article is taken, announces several changes to the Medicare systems that enable Medicare review contractors, participating in the esMD pilot, to include on ADR letters additional information necessary for Electronic Submission of Medical Documentation (esMD).

Specifically, these will allow MACs to include in each ADR:

- A statement about how providers can get more information about submitting medical documentation via the esMD mechanism
- A documentation case ID number that may facilitate tracking of submitted documents.

Additional information

You may find the official instruction, CR 7254, issued to your A/B MAC or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R958OTN.pdf*.

You may learn more about the esMD pilot by going to *http://www.cms.gov/ESMD/*. In addition, MLN Matters® article SE1110 provides more details on the esMD initiative. That article is at *http://www.cms.gov/MLNMattersArticles/downloads/SE1110.pdf*.

If you have any questions, please contact your 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: MM7254
Related Change Request (CR) #: 7254
Related CR Release Date: September 15, 2011
Effective Date: January 1, 2012, except April 1, 2012 for suppliers billing DME MACs
Related CR Transmittal #: R958OTN
Implementation Date: January 3, 2012, except April 2, 2012 for DME MACs

Implementation of Pay.gov application fee collection process through PECOS

Provider types affected

This *Medicare Learning Network* (*MLN*) *Matters*® special edition article is intended for all providers and suppliers, (except physicians and non-physician practitioners who are not required to pay an application fee), who are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information, and do so by submitting one of the following paper Medicare enrollment applications or the associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications:

CMS 855A – Medicare Enrollment Application for Institutional Providers;

CMS 855B – Medicare Enrollment Application for Clinics, Group Practices; and Certain Other Suppliers; and

CMS 855S – Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Provider action needed

Stop – impact to you

Currently, providers or suppliers use Pay.gov to make Medicare application fee payments electronically. This article announces a change to this website address to access Pay.gov.

continued on next page

PECOS....(continued)

Caution – what you need to know

The changes outlined below have no effect on the Pay.gov payment collection process. Provider and suppliers will continue to make payment for the application fees to Pay.gov. CMS is simply revising the way providers access Pay.gov to improve the efficiency of the application fee payment, collection, and accounting process.

Go – what you need to do

Use the following address to make your application fee payments: *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*. Please update any bookmarks you and your staffs may have in place to the new address.

Background

In February 2011, CMS published a final rule, CMS-6028-FC, with provisions related to the submission of application fees as part of the provider enrollment process. An application fee and/or hardship exception must be submitted with any application received from institutional providers initially enrolling in Medicare, adding a practice location, or revalidating their enrollment on or after March 25, 2011.

Changes for making Medicare application payments

Internet-based PECOS online application submitters

For those who submit applications online via the PECOS website (also referred to as PECOS Provider Interface [or PECOS PI]), you will no longer have to separately access Pay.gov first to make your application fee payments. Instead, as you proceed through the Internet-based PECOS application process, if a fee is required, you will be prompted to submit a payment. You will be automatically transferred from the Internet-based PECOS application site to the Pay.gov website where you will make your payment by ACH credit and debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction from Pay.gov and will update payment status, allowing your application to be processed.

CMS-855 paper application submitters

For providers who continue to use the CMS-855 paper enrollment application, you will now access Pay.gov using the following URL: *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*. Complete the Medicare application fee form and click the "pay now" button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt indicating the status of your payment. Please print a copy for your records. We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor.

Paper application submitters-interim procedures

Through December 31, 2011, CMS will continue to route providers and suppliers, who access Pay.gov directly using the Pay.gov form set up process, to the correct URL, *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*

After December 31, 2011, to access Pay.gov, you will be required use the URL *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*.

Additional information

More information about the enrollment process, the required fees, and the hardship exceptions process can be found in the *MLN Matters*® article MM7350, available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*. More information on revalidation may be found in SE1126, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1126.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*.

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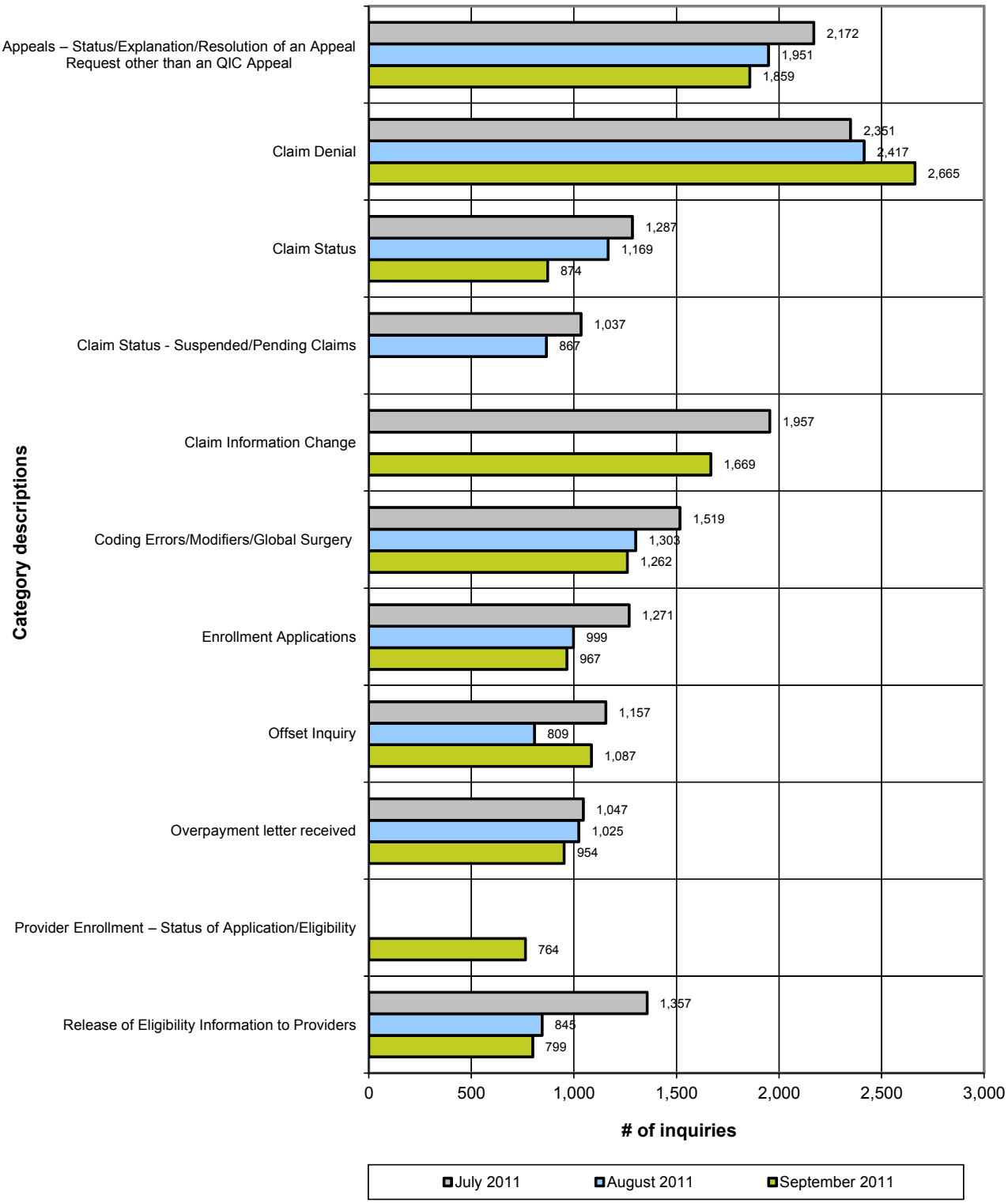
Top inquiries, denials, and return unprocessable claims

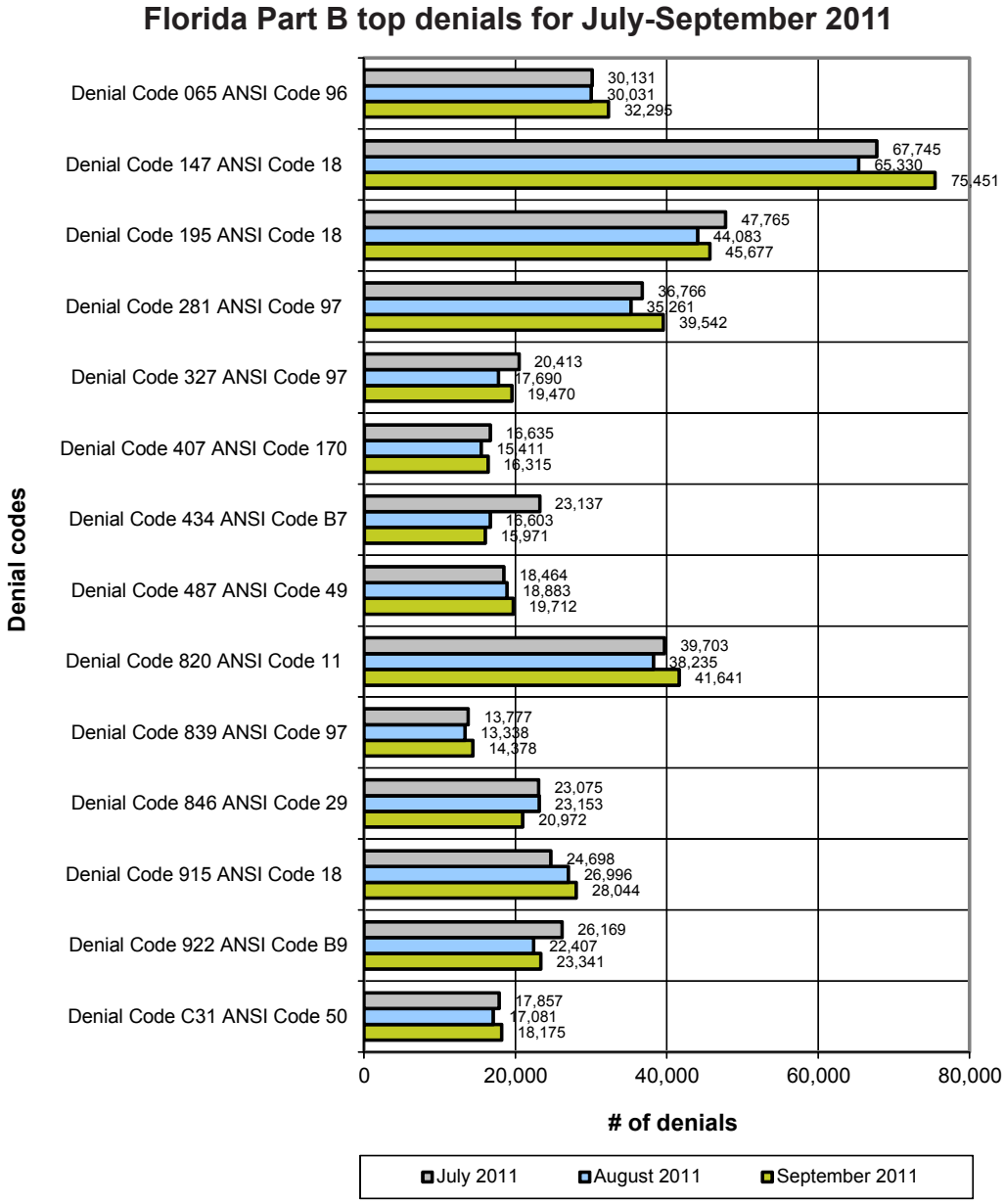
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during July-September 2011. For tips and resources to help you avoid or reduce the amount of time spent 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 July-September 2011



continued on next page

Top....(continued)



What to do when your claim is denied

Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

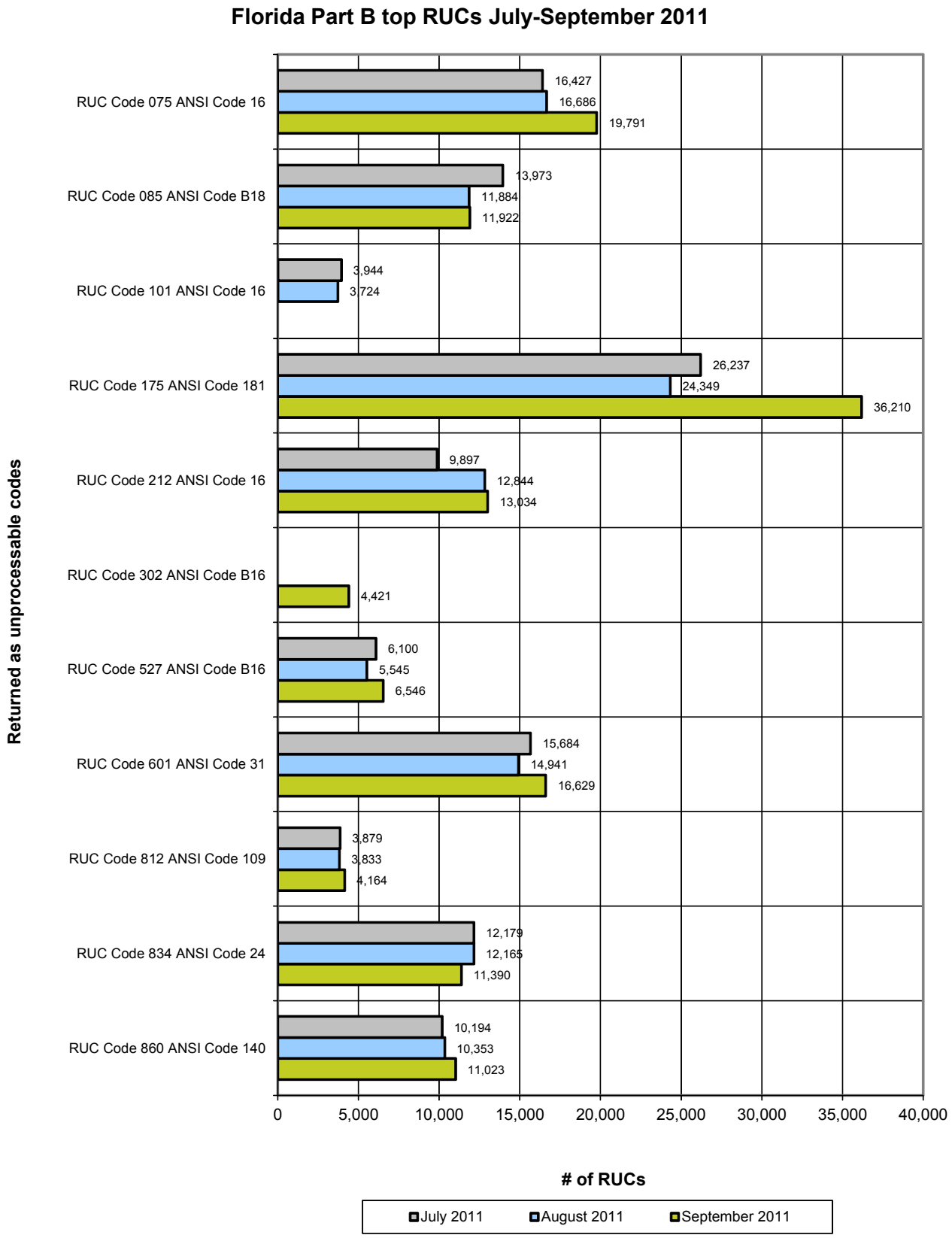
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*), and *Unprocessable FAQs* on the FCSO Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the *Top Part B claim denials* and *RUCs* tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top....(continued)

Florida Part B top return as unprocessable claims for July-September 2011



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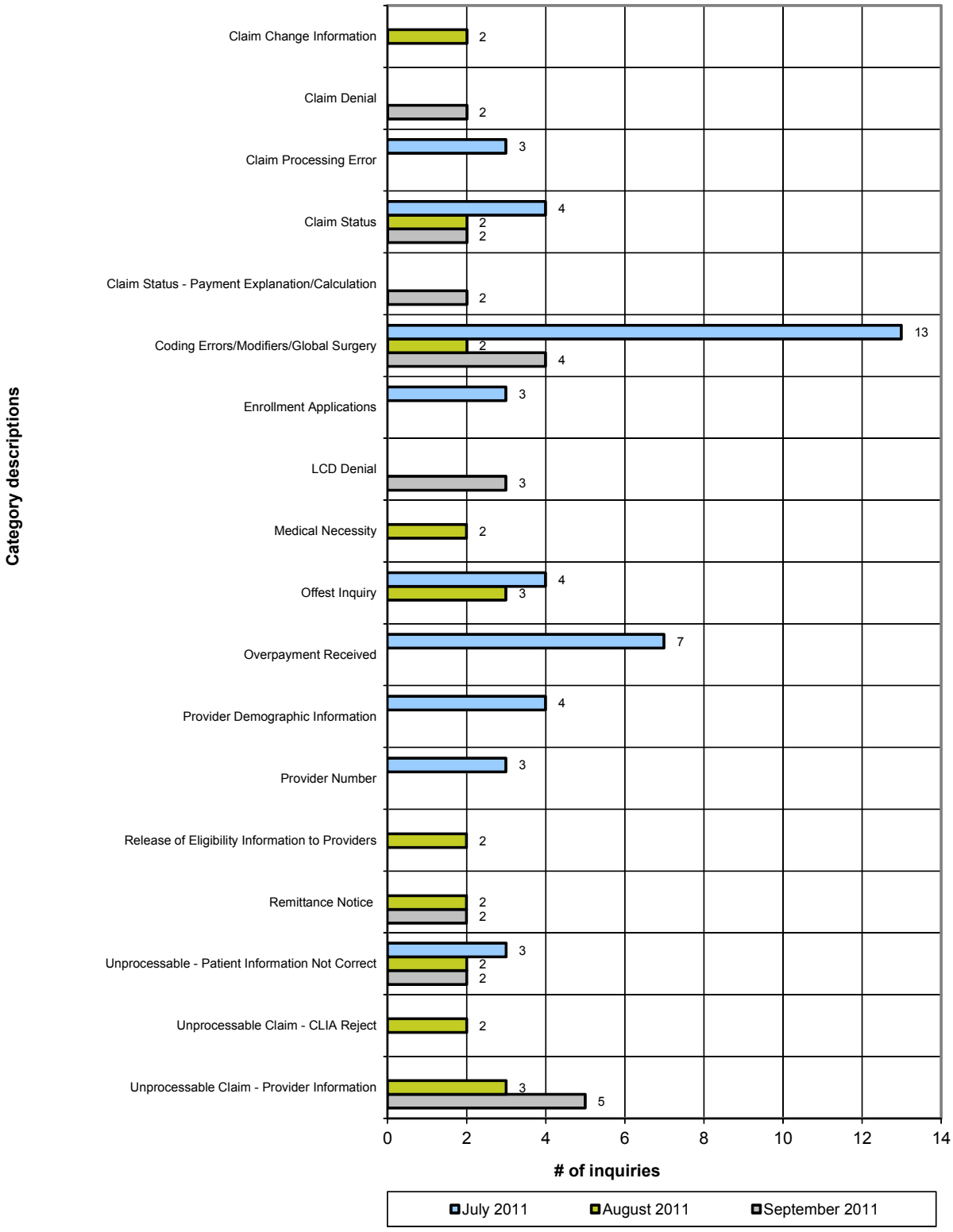
Top....(continued)

U.S. Virgin Islands Part B top inquiries for July-September 2011



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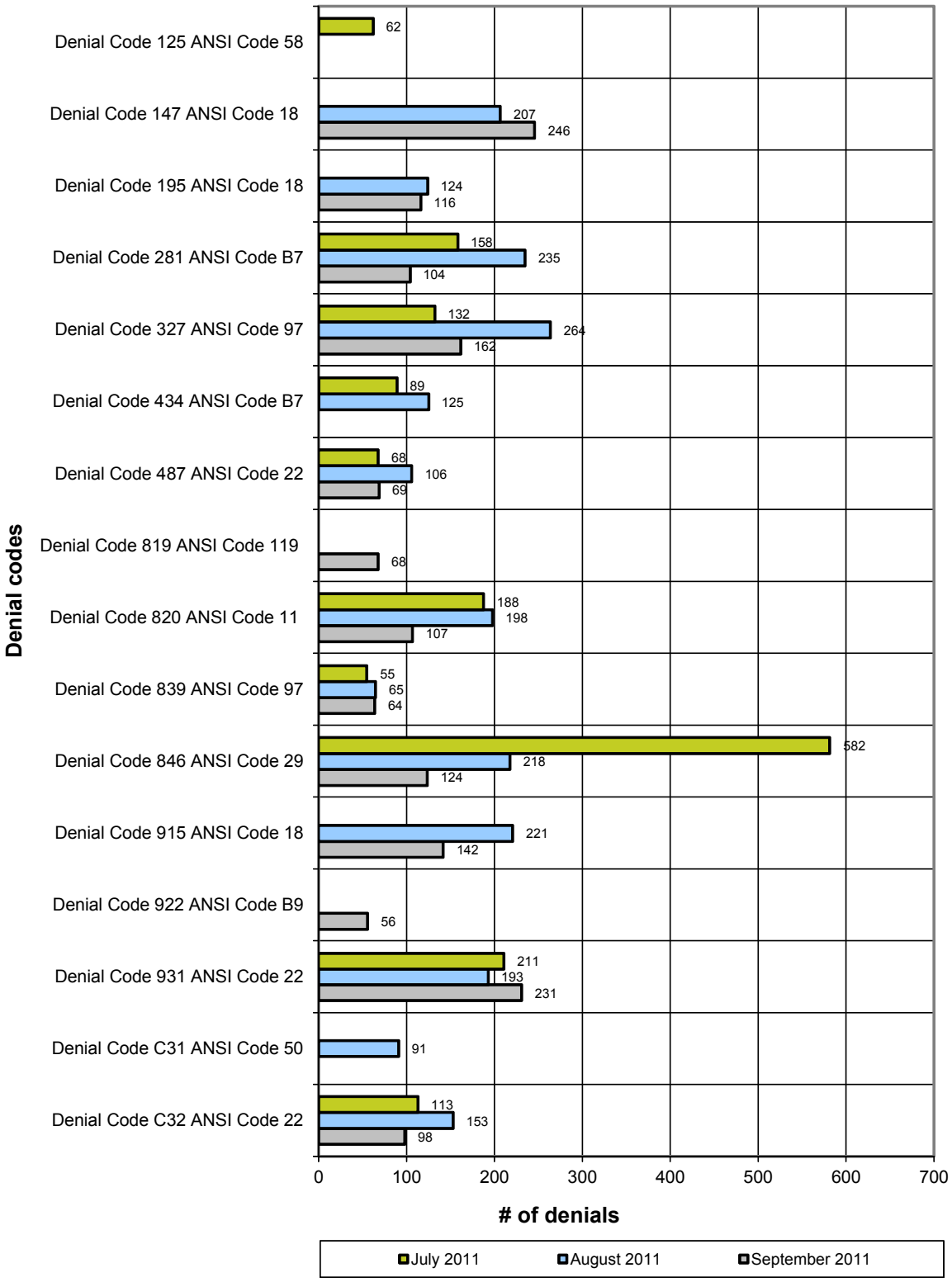
Top....(continued)

U.S. Virgin Islands Part B top denials for July-September 2011



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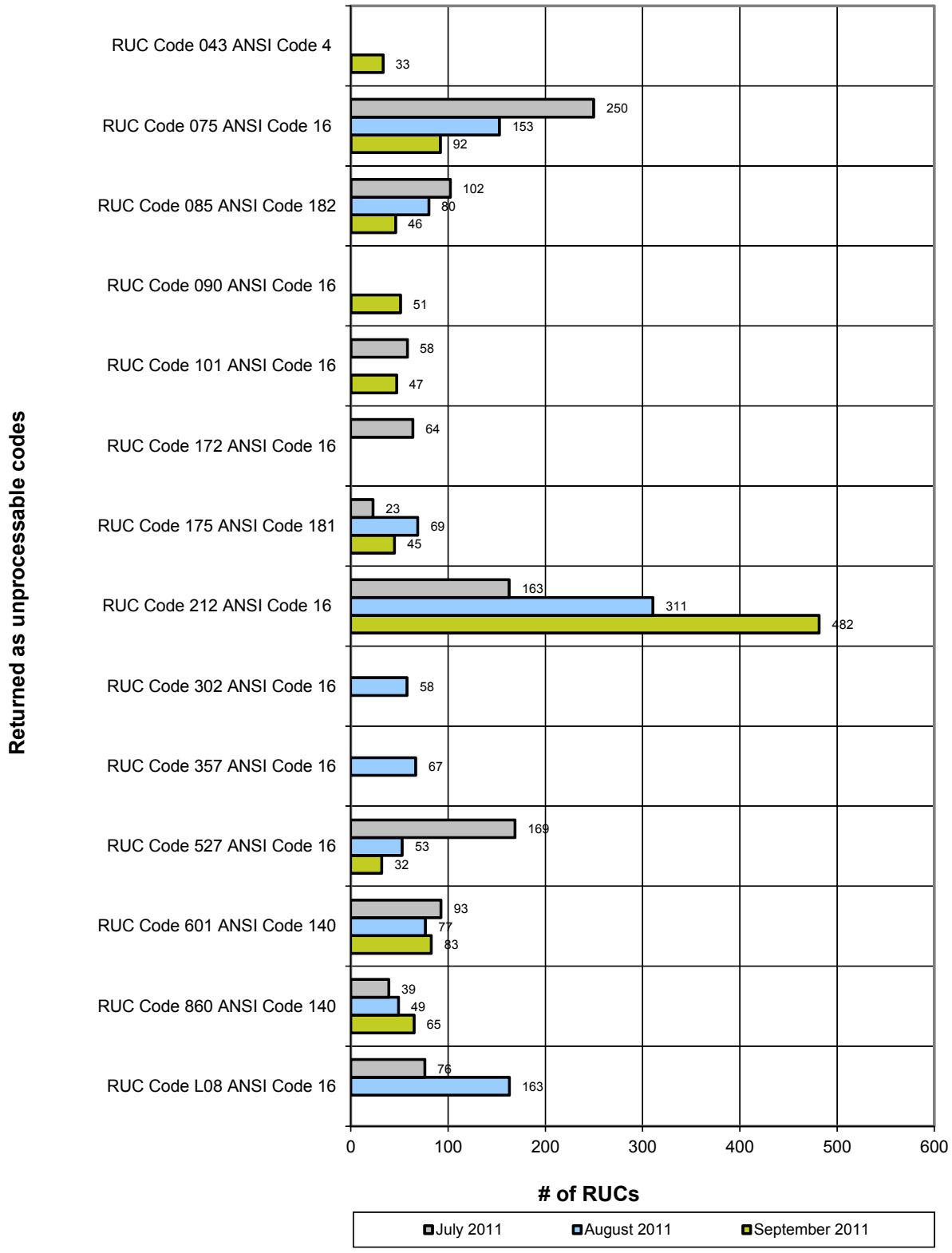
Top....(continued)

U.S. Virgin Islands Part B top return as unprocessable claims for July-September 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://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, 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

IDTF: Independent diagnostic testing facility (IDTF) – coding guidelines revision

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised on July 5, 2011. Since that time, in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 7528, dated August 19, 2011, the "Credentialing Matrix" in the LCD "Coding Guidelines" attachment has been revised to change the "Level of Physician Supervision" to a "1" for *CPT* codes *76813, 76814, 91132*, and *93025* and to change the "Level of Physician Supervision" to a "9" for *CPT* codes *92270, 92275, 92285*, and *92286*.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for claims processed **on or after October 3, 2011**, for services rendered **on or after January 1, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. 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.

64490: Paravertebral facet joint blocks – revision to the LCD

LCD ID number: L29252 (Florida)
LCD ID number: L29378 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for paravertebral facet joint blocks was most recently revised on June 14, 2011. Since that time, a revision was made under the "Limitations" section of the LCD and to the "Coding Guidelines" attachment. The verbiage was revised to clarify that the fluoroscopy is an inclusive component of *CPT* codes *64490-64495* and not paid separately.

Effective date

This LCD revision is effective for claims processed **on or after October 4, 2011**, for services rendered **on or after January 1, 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.

Additional Information

Part B 3D rendering with interpretation and reporting of imaging studies

The comprehensive data analysis department evaluated *CPT* codes *76376* (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post processing on an independent workstation*) and *CPT* code *76377* (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post processing on an independent workstation*). *CPT* codes *76376* and *76377* were identified as aberrant based on Medicare Part B extract summary system (BESS) data July –December 2010. The data revealed a carrier-to-nation ratio of 2.42 for *CPT* code *76376* and 2.05 for *CPT* code *76377*. The billing pattern identified during this analysis indicates a potential exists for improper billing and/or payment.

3D rendering is a distinct diagnostic procedure that describes a separate procedure performed with computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality. As with any service, 3D rendering must meet Medicare's reasonable and necessary threshold for coverage. The definition of medical necessity notes that a procedure must meet but not exceed the patient's medical need.

Diagnostic procedures require an order by the treating physician and the patient's medical record must support the intent to perform the diagnostic procedure as well as the medical need specific to the patient. The supervising physician for the independent diagnostic testing facility (IDTF) may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiaries treating physician. Additionally, providers may not add any procedures based on internal protocol without a written order from the treating physician.

For additional requirements for ordering and following orders for diagnostic tests please refer to the Centers for Medicare & Medicaid Services (CMS) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 80.6-80.6.4 and CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 35, Section 20.

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.

Educational Events

Upcoming provider outreach and educational events
December 2011

Bimonthly Medicare Part B ACT: Medicare changes and hot issues

When: Wednesday, December 7
Time: 11:30 a.m.-1:00 p.m.

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

Two easy ways to register

Online – Visit our provider training website at *www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

Preventive Services

Vaccinate early to protect against the flu

The Centers for Disease Control and Prevention recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no copay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don't forget to immunize yourself and your staff.

Get the flu vaccine – not the flu

Remember – influenza vaccine plus its administration are covered Part B benefits. Note that the influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *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 201109-64

CMS recognizes October as National Breast Cancer Awareness Month

Breast cancer is the most frequently diagnosed non-skin cancer in women and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Medicare provides coverage for an annual screening mammogram for all female beneficiaries aged 40 or older, as well as coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by talking with them about the importance of regular mammography screening and encouraging them to take advantage of Medicare-covered screening mammograms, as appropriate for them.

For more information

- *The Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 8)*
- *Medicare Preventive Services Quick Reference Information Chart*
- *Cancer Screenings Brochure for Physicians, Providers, Suppliers, and Other Healthcare Professionals*
- *Department of Health and Human Services*
- *National Breast Cancer Awareness Month official website*
- *The CDC's Breast Cancer Awareness website*
- *The CDC's National Breast and Cervical Cancer Early Detection Program*

Thank you for joining the Centers for Medicare & Medicaid Services (CMS) in educating beneficiaries about the importance of taking advantage of Medicare-covered screening mammograms.

Source: CMS PERL 201110-12

Expanded Benefits brochure available

The *Medicare Learning Network*® would like to remind you that the publication, *Expanded Benefits*, is available in downloadable format 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 201110-10

Diabetes-Related Services fact sheet revised

The revised *"Diabetes-Related Services" fact sheet (#006840)* is now available from the *Medicare Learning Network*. This fact sheet is designed to provide education on diabetes-related services, which includes diabetes screening tests, diabetes self-management training, medical nutrition therapy, and covered supplies and other services for beneficiaries with diabetes.

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

Source: CMS PERL 201109-46

Annual Wellness Visit brochure now available in hard copy

The publication *Annual Wellness Visit* is now available in hard copy from the *Medicare Learning Network*®. This brochure is designed to provide education on the annual wellness visit, 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. To place your order, visit the *MLN Products page*, scroll to the "Related Links Inside CMS," and select the "MLN Product Ordering Page."

Source: CMS PERL 201109-63

Other Educational Resources

New electronic MLN button for provider partners

As part of ongoing efforts to share information and updates from the Medicare Learning Network® (MLN) with providers, the MLN has developed an electronic button graphic that you are encouraged to post to your websites. The button graphic is available at *http://www.CMS.gov/MLNProducts/Downloads/MLN_Web_Button.pdf*.

By posting this button, your membership will have quick access to the *MLN General Information Web page* – and you'll be offering them the opportunity to access a variety of easy-to-understand products about Medicare changes, regulations, and new initiatives.

All of the materials are official Centers for Medicare & Medicaid Services (CMS) educational products and they're available 24/7, at absolutely no cost. Thank you in advance for joining with the MLN in offering Medicare fee-for-service providers and other health care professionals another convenient way to stay informed about Medicare program policies and regulations.

If you have any questions or concerns about how to post our button, or if you would like more information about how to work together to keep Medicare providers informed, please email CMS at *MLN@cms.hhs.gov*.

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

Source: CMS PERL 201109-63

Medicare Ambulance Services booklet released

The *Medicare Ambulance Services* booklet (ICN 903194), which is designed to provide education on Medicare ambulance services, is now available in print format from the *Medicare Learning Network*. It 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. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS" and select "MLN Product Ordering Page."

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

Source: CMS PERL 201109-46

New fast fact posted on MLN provider compliance Web page

A new fast fact has been posted to the *MLN provider compliance* Web page, which contains educational fee-for-service provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this Web page. Please bookmark this page and check back often as a new fast fact is added each month.

Source: CMS PERL 201110-10

Steps to Accessing CMS Enterprise Applications for Physician Quality Reporting System Users fact sheet revised

The revised *Steps to Accessing CMS Enterprise Applications for Physician Quality Reporting System (PQRS/PQRI) Users* fact sheet is designed to provide education on how provider organizations can access enterprise applications developed by the Centers for Medicare & Medicaid Services (CMS). These enterprise applications are hosted and managed exclusively by CMS and do not include other Internet applications developed by Medicare fiscal intermediaries, carriers, or Medicare administrative contractors (MACs). This fact sheet includes step-by-step registration instructions and a list of resources, and is available for download at *http://www.CMS.gov/MLNProducts/Downloads/2011_IACS_Fact_Sheet.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 201109-63

MLN provider exhibit program schedule

Just a reminder – the *Medicare Learning Network*® will be exhibiting at the following health care provider conferences in the coming weeks:

Gerontological Society of America 64th Annual Scientific Meeting
Friday, November 18 through Tuesday, November 22
John B Hynes Memorial Convention Center – Boston, Massachusetts
Booth #221

Source: CMS PERL 201110-10

Sign up for the *MLN Matters* Listserv

Looking for the latest new and revised *MLN Matters* articles? Subscribe to the *MLN Matters* mailing list. For more information about *MLN Matters* and how to register for this service, visit *http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf* and start receiving updates!

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

Source: CMS PERL 201110-10

Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through FCSO's PDS's portal at *https://medicare.fcso.com/reporting/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business botton line.

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)

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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
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Medicare Part A

Toll-Free:
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