

MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education websites which may be accessed at: <http://medicare.fcso.com/>.

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- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other _____



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The *Medicare B Update!* is published monthly by First Coast Service Options Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers.

Questions concerning this publication or its contents may be faxed to 1-904-361-0723.

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THE FCSO MEDICARE B UPDATE!

About the FCSO Medicare B Update!

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

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

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

Who receives the Update?

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to FCSO Medicare for processing 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 in hardcopy or CD-ROM format (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 *Update!* 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 *Update!* is arranged into distinct sections.

Following the table of contents, an administrative information section, the *Update!* content information is categorized as follows.

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

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses**, and **phone numbers**, and **websites** for Florida and the U.S. Virgin Islands.

The Medicare B Update! represents formal notice of coverage policies

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

Quarterly provider update

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

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

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS website at <http://www.cms.gov/QuarterlyProviderUpdates/>.

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

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (waiver 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 Address, Phone Numbers, and Websites section of this publication for the address in which to send written appeals requests.

Find out first: Subscribe to FCSO eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Ambulance

Manual updates – ambulance claims billing instructions and fee schedule payment rates

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

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

This article is based on change request (CR) 7018 which updates the *Medicare Claims Processing Manual* to note provisions extending several ambulance payment rate increases that were recently enacted by the Affordable Care Act of 2010. Specifically, the Affordable Care Act extends the increases of three percent for rural services and 2 percent for urban services through December 31, 2010. These increases had been initially required by the Medicare Modernization Act and were extended by the Medicare Improvements for Patients and Providers Act of 2008. CR 7018 also corrects the same manual's Chapter 15, Section 30.1.2 to specify that the correct field for reporting the ZIP code of the point-of-pickup of an ambulance trip in Item 23 of the CMS-1500, instead of item 32 as previously mentioned in that manual section.

If entities billing for ambulance services choose to submit claims in the 5010 837P electronic claim format on or after January 1, 2011, they must comply with the requirement that a diagnosis code be included on the claim. CMS will not be capable of accepting claims submitted under the 5010

version of the 837P that do not comply with this requirement. (See *MLN Matters* article SE1029, released September 24, 2010, at <http://www.cms.gov/MLNMattersArticles/downloads/SE1029.pdf> for details.) In addition, the loaded ambulance trip's destination information will be required on the 5010 837P electronic claim format. CR 7018 amends Chapter 15 to include these instructions.

Additional information

The official instruction, CR 7018, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2124CP.pdf>.

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

MLN Matters® Number: MM7018

Related Change Request (CR) #: 7018

Related CR Release Date: December 23, 2010

Effective Date: January 25, 2011

Related CR Transmittal #: R2124CP

Implementation Date: January 25, 2011

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Ambulatory Surgical Center

January 2011 update of the ambulatory surgical center payment system

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article has information for ambulatory surgical centers (ASC) submitting claims for Medicare beneficiaries to carriers and A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article is based on change request (CR) 7275, which contains the recurring update notification describing changes to and billing instructions for various payment policies implemented in the January 2011 ASC update. Be sure to inform your staff of these changes.

Background

Included in CR 7275 are updates to the Healthcare Common Procedure Coding System (HCPCS), calendar year (CY) 2011 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and CY 2011 ASC payment rates for covered surgical and ancillary services (ASCFS file). The updates are as follows:

Updated core-based statistical areas

Table 1 shows updates to three core-based statistical areas (CBSAs) recognized by CMS for ASC claims with dates of service on and after January 1, 2011.

January 2011 update of the ambulatory surgical center payment system (continued)

Table 1 – January 1, 2011 core based statistical area (CBSA) changes

County/State	2010 CBSA	2011 CBSA
Crestview-Fort Walton Beach-Destin, FL	23020	18880
North Port-Bradenton-Sarasota-Venice, FL	14600	35840
Steubenville-Weirton, OH-WV	48260	44600

Drugs and biologicals with payment based on average sales price effective January 1, 2011

Payments for separately payable drugs and biologicals based on the average sales prices (ASPs) are updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2011, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2011 outpatient prospective payment system /ambulatory surgical center (OPPS/ASC) final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2010. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2011 release of the ASC DRUG file. The updated payment rates effective January 1, 2011, for covered ancillary drugs and biologicals may be found in the January 2011 update of the ASC addendum BB available at http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp.

Payment for category 3 new technology intraocular lenses (NTIOLs); Q1003

Medicare pays an additional \$50 for specified category 3 NTIOLs (reduced spherical aberration) that are provided in association with a covered ASC surgical procedure. This current active class of NTIOLs, reported using HCPCS code Q1003, has expired for dates of service beginning on February 27, 2011. Upon expiration of this NTIOL class, Q1003 will be packaged (PI=N1) and no separate payment will be provided for the intraocular lens (IOL) in addition to the IOL insertion procedure (effective February 27, 2011).

CMS did not approve a new NTIOL class for CY 2011. Therefore, after the expiration of the category 3 NTIOL class, there are no active NTIOL classes. ASCs are reminded that Medicare beneficiaries cannot be billed for amounts above the coinsurance payment in order to mitigate any loss of the \$50 Medicare payment associated with the expiration of the category 3 NTIOL class.

New HCPCS codes for drugs and biologicals that are separately payable under the ASC payment system as of January 1, 2011

For CY 2011, thirty of the new level II HCPCS codes for reporting drugs and biologicals are separately payable to ASCs for dates of service on or after January 1, 2011. The new Level II HCPCS codes, their payment indicators, and short descriptors are displayed in Table 2 and are included in the January 2011 ASC DRUG file.

Table 2 – New level II HCPCS codes for drugs and biologicals separately payable under the ASC payment system for CY 2011

CY 2011 HCPCS code	CY 2011 payment indicator	Short descriptor
C9274	K2	Crotalidae Poly Immune Fab
C9275	K2	Hexaminolevulinate HCl
C9276	K2	Cabazitaxel injection
C9277	K2	Lumizyme, 1 mg
C9278	K2	Incobotulinumtoxin A
C9279	K2	Injection, ibuprofen
J0597	K2	C-1 esterase, berinert
J0638	K2	Canakinumab injection
J0775	K2	Collagenase, clost hist inj
J1290	K2	Ecallantide injection
J1559	K2	Hizentra injection
J1786	K2	Imuglucerase injection
J2358	K2	Olanzapine long-acting inj
J2426	K2	Paliperidone palmitate inj
J3095	K2	Televancin injection
J3262	K2	Tocilizumab injection
J3357	K2	Ustekinumab injection
J3385	K2	Velaglucerase alfa
J7184	K2	Wilate injection
J7196	K2	Antithrombin recombinant
J7309	K2	Methyl aminolevulinate, top

January 2011 update of the ambulatory surgical center payment system (continued)

CY 2011 HCPCS code	CY 2011 payment indicator	Short descriptor
J7312	K2	Dexamethasone intra implant
J7335	K2	Capsaicin 8% patch
J8562	K2	Oral fludarabine phosphate
J9302	K2	Ofatumumab injection
J9307	K2	Pralatrexate injection
J9315	K2	Romidepsin injection
J9351	K2	Topotecan injection
Q4118	K2	Matristem micromatrix
Q4121	K2	Theraskin

Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010

The payment rates for fourteen HCPCS codes were incorrect in the July 2010 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised July 2010 ASC DRUG file effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Suppliers who think they may have received an incorrect payment from July 1, 2010, through September 30, 2010, may request their Medicare contractor to adjust the previously processed claims.

Table 3 – Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010

HCPCS code	Short descriptor	Corrected payment rate
J0150	Injection adenosine 6 MG	\$13.74
J0641	Levoleucovorin injection	\$0.73
J2430	Pamidronate disodium /30 MG	\$15.61
J2850	Inj secretin synthetic human	\$26.97
J9065	Inj cladribine per 1 MG	\$24.12
J9178	Inj, epirubicin hcl, 2 mg	\$2.06
J9185	Fludarabine phosphate inj	\$112.61
J9200	Floxuridine injection	\$42.31
J9206	Irinotecan injection	\$4.23
J9208	Ifosfomide injection	\$30.95
J9209	Mesna injection	\$4.96
J9211	Idarubicin hcl injection	\$40.09
J9263	Oxaliplatin	\$4.37
J9293	Mitoxantrone hydrochl / 5 MG	\$44.07

Waiver of cost-sharing for preventive services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF) has given a grade of A or B, including copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective for services furnished on and after January 1, 2011. Further information on the implementation of waiver of cost-sharing for preventive services as prescribed by the Affordable Care Act will be included in a separate article that will be released shortly.

Payment when a device is furnished with no cost or with full or partial credit

For CY 2011, CMS updated the list of ASC covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. Medicare contractors will reduce the payment for the device implantation procedures listed in Attachment B of CR 7275. (CR 7275 is available at <http://www.cms.gov/Transmittals/downloads/R2128CP.pdf>.) ASCs must append the modifier “FB” to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment C of CR 7275 and the associated implantation procedure code is listed in Attachment B of that CR. In addition, Medicare contractors will reduce the payment for implantation procedures listed in Attachment B by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Attachment C, the ASC must append the modifier “FC” to the associated implantation procedure code if the procedure is listed in Attachment B. A single procedure code should not be submitted with both modifiers “FB” and “FC.”

More information regarding billing for procedures involving no cost/full credit and partial credit devices is available in the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 14, Section 40.8, available at <http://www.cms.gov/manuals/downloads/clm104c14.pdf>.

January 2011 update of the ambulatory surgical center payment system (continued)

Newly covered surgical procedures and ancillary service for CY 2011

Attachment C of CR 7275 lists the surgical procedures and ancillary services that are newly payable in the ASC setting as of January 1, 2011.

Additional information

The official instruction, CR 7275, issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2128CP.pdf>.

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

MLN Matters® Number: MM7275

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Related CR Release Date: December 29, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2128CP

Implementation Date: January 3, 2011

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Consolidated Billing

ESRD PPS and consolidated billing for limited Part B services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: This article was revised on November 18, 2010, to reflect the revised change request (CR) 7064, issued November 17, 2010. CR 7064 was revised to reflect a revised end-stage renal disease (ESRD) PRICER layout, the deletion of several drugs, the identification of drugs that may be eligible for the ESRD outlier payment, to provide an additional list of laboratory tests that comprise the automated multi-channel chemistry (AMCC) and to delete several laboratory tests. There were no changes in policy. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same. This information was previously published in the November 2010 *Medicare B Update!* pages 8-11.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on CR 7064 which announces the implementation of an ESRD bundled prospective payment system (PPS) effective January 1, 2011.

Caution – what you need to know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four-year phase-in

(transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Go – what you need to do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the *Background* and *Additional information* sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see <http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331>) requires the Centers for Medicare & Medicaid services (CMS) to implement an ESRD bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the

ESRD PPS and consolidated billing for limited Part B services (continued)

methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located
- Patient-level adjustments for case-mix
- An outlier adjustment (if applicable)
- Facility-level adjustments
- A training add-on (if applicable), and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B, and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using

an area wage index developed from core-based statistical areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training add-on

Facilities that are certified to furnish training services will receive a training add-on payment amount of \$33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments specific to pediatric patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

- Treatments furnished to pediatric patients:
 - Can qualify for a training add-on payment (when applicable), and
 - Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment. ESRD PPS four-year phase-in (transition) period.

The ESRD PPS provides ESRD facilities with a four-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS four-year transition period blended rate determination

Calendar year	Blended rate
2011	75 percent of the old payment methodology, and 25 percent of new PPS payment
2012	50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For calendar year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

ESRD PPS and consolidated billing for limited Part B services (continued)

The ESRD PPS base rate is \$229.63, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where:

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is \$133.79 ((229.63 X (1 - 0.41737) = \$133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments
- Outlier adjustments
- Facility-level adjustments, and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three new adjustments applicable to the adult rate

1. Comorbid adjustments: The new ESRD PPS provides for three categories of chronic comorbid conditions and three categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than four consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The three chronic comorbid categories eligible for a payment adjustment are:

- Hereditary hemolytic and sickle cell anemia
- Monoclonal gammopathy (in the absence of multiple myeloma), and
- Myelodysplastic syndrome.

The three acute comorbid categories eligible for a payment adjustment are:

- Bacterial pneumonia
- Gastrointestinal bleeding, and
- Pericarditis.

2. Onset of dialysis adjustment: An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS-2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. Low-volume facility adjustment: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The 3 years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

Change in processing home dialysis claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility, and
- Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

Consolidated billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

*ESRD PPS and consolidated billing for limited Part B services (continued)***Other billing reminders**

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the modifier AY for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign group code CO.
- All 72x claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011, are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, Section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2094CP.pdf>. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits
- Attachment 5, which contains a list of DME ESRD supply HCPCS codes that are **not** payable to DME suppliers
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing, and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

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

MLN Matters® Number: MM7064 *Revised*
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How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at <http://medicare.fcsso.com/PDS/>.

Drugs and Biologicals

Pharmacy billing for drugs provided “incident to” a physician’s service

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7109 which clarifies the Centers for Medicare & Medicaid Services (CMS) policy with respect to restrictions on pharmacies billing for drugs provided “incident to” a physician’s service. CR 7109 also clarifies the CMS policy for the local determination of payment limits for drugs that are not nationally determined.

Background

Pharmacies may bill Medicare for certain classes of drugs including:

- Immunosuppressive drugs
- Oral anti-emetic drugs
- Oral anti-cancer drugs, and
- Drugs administered through any piece of durable medical equipment (DME).

Claims for these drugs are generally submitted to the DME MAC, and the DME MAC makes payment for these drugs (when deemed to be covered and reasonable and necessary) to the pharmacy. One exception is that claims for drugs administered through implanted durable medical equipment such as an implanted infusion pump are submitted to the A/B MAC or local carrier. All bills submitted to the DME MAC must be submitted on an assigned basis by the pharmacy. (*Medicare Claims Processing Manual* (Chapter 17, Section 50.B; see <http://www.cms.gov/manuals/downloads/clm104c17.pdf>).

Pharmacies, suppliers, and providers may not bill Medicare for drugs purchased directly by beneficiaries for administration “incident to” a physician service. Medicare will deny such claims. (See the *Medicare Claims Processing*

Manual, Chapter 17, Section 50.B at

<http://www.cms.gov/manuals/downloads/clm104c17.pdf>)

Pharmacies also may not bill for drugs purchased by a physician for administration to a Medicare beneficiary. These drugs are being furnished “incident to” the physician’s service and as such must be billed by the physician. (See *Medicare Benefit Policy Manual*, Chapter 15, Section 50.3; at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>).

The payment limits for drugs and biologicals that are not included in 1) the average sales price (ASP) Medicare Part B drug pricing file or 2) the not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing except under 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.

Additional information

The official instruction, CR 7109, issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2115CP.pdf>. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7109

Related Change Request (CR) #: 7109

Related CR Release Date: December 10, 2010

Effective Date: March 14, 2011

Related CR Transmittal #: R2115CP

Implementation Date: March 14, 2011

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January 2011 average sales price drugs files are now available

The Centers for Medicare & Medicaid Services has posted the January 2011 ASP (revised 12/29/2010) and NOC pricing files and crosswalks, and updated pricing files for October 2010 and July 2010. All are available for download at: <http://www.cms.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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

Source: CMS PERLs 201101-04 & 201012-26

Durable Medical Equipment

2011 DMEPOS fee schedule update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for DMEPOS items or services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule need to be aware of this article.

Provider action needed

This article, based on change request (CR) 7248, advises you of the calendar (CY) 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

Background and key points of CR 7248

The DMEPOS fee schedule file is available for state Medicaid agencies, managed care organizations, and other interested parties at <http://www.cms.gov/DMEPOSFeeSched/>.

2011 update to labor payment rates

2011 fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011, through December 31, 2011, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	25.55	29.11	34.25	NC	13.56	20.21	27.44
AL	13.56	20.21	27.44	ND	16.90	29.05	34.25
AR	13.56	20.21	27.44	NE	13.56	20.19	38.26
AZ	16.77	20.19	33.76	NH	14.56	20.19	27.44
CA	20.81	33.19	38.68	NJ	18.30	20.19	27.44
CO	13.56	20.21	27.44	NM	13.56	20.21	27.44
CT	22.65	20.67	27.44	NV	21.61	20.19	37.40
DC	13.56	20.19	27.44	NY	24.98	20.21	27.44
DE	24.98	20.19	27.44	OH	13.56	20.19	27.44
FL	13.56	20.21	27.44	OK	13.56	20.21	27.44
GA	13.56	20.21	27.44	OR	13.56	20.19	39.46
HI	16.77	29.11	34.25	PA	14.56	20.79	27.44
IA	13.56	20.19	32.85	PR	13.56	20.21	27.44
ID	13.56	20.19	27.44	RI	16.17	20.81	27.44
IL	13.56	20.19	27.44	SC	13.56	20.21	27.44
IN	13.56	20.19	27.44	SD	15.15	20.19	36.68
KS	13.56	20.19	34.25	TN	13.56	20.21	27.44
KY	13.56	25.88	35.09	TX	13.56	20.21	27.44
LA	13.56	20.21	27.44	UT	13.60	20.19	42.73
MA	22.65	20.19	27.44	VA	13.56	20.19	27.44
MD	13.56	20.19	27.44	VI	13.56	20.21	27.44
ME	22.65	20.19	27.44	VT	14.56	20.19	27.44
MI	13.56	20.19	27.44	WA	21.61	29.62	35.18
MN	13.56	20.19	27.44	WI	13.56	20.19	27.44
MO	13.56	20.19	27.44	WV	13.56	20.19	27.44
MS	13.56	20.21	27.44	WY	18.91	26.94	38.26
MT	13.56	20.19	34.25				

2011 DMEPOS fee schedule update (continued)

HCPCS code updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and E0446 all of which have no assigned payment category
- A7020, E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category
- E1831 in the capped rental payment category (DME)
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS fee schedule update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011, through June 30, 2011. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- E0220, E0230, and E0238
- K0734, K0735, K0736, and K0737
- L3660, L3670, L3672, L3673, and L3675.

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

Factor	Category
0.502	Oxygen
0.506	Capped rental
0.507	Prosthetics and orthotics
0.643	Surgical dressings
0.700	Parenteral and enteral nutrition

Specific coding and pricing issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 fee schedule update as described in CR 3574 (Transmittal 369) which may be reviewed at <http://www.cms.gov/transmittals/Downloads/R369CP.pdf>. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the calendar year 2009
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-driven wheelchairs

In accordance with Section 3136(a)(1) of The Affordable Care Act of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. Payment amounts will be based on the lower of the supplier’s actual charge and the fee schedule amount. As part of this update, the CY 2011 rental fees for power-driven wheelchairs included in the 2011 DMEPOS fee schedule Part B file have been revised to represent 15 percent of the purchase price amount. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248, which is at <http://www.cms.gov/Transmittals/downloads/R2118CP.pdf>. This attachment identifies those codes where payment, when applicable, will be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through 13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Also, Section 3136(c)(2) of The Affordable Care Act specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. *MLN Matters*® article MM7181 at <http://www.cms.gov/MLNMattersArticles/downloads/MM7181.pdf> discusses these changes.

2011 DMEPOS fee schedule update (continued)

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10 percent of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the modifier MS, for billing maintenance and servicing, as appropriate:

K0010 Standard- Weight Frame Motorized/Power Wheelchair

K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking

K0012 Lightweight Portable Motorized/Power Wheelchair

K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair's purchase price.

CY 2011 fee schedule update factor

The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, Section 3401 of The Affordable Care Act requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U update factor is 1.1 percent. Thus, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent MFP resulting in a -0.1 percent MFP-adjusted update factor or a 0.1 percent reduction to the applicable CY 2011 DMEPOS fee schedule amounts.

2011 national monthly payment amounts for stationary oxygen equipment

CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of \$173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new oxygen generating portable equipment (OGPE) class. The revised 2011 monthly payment rate of \$173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from \$173.17 to \$173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2011 maintenance and service payment amount for certain oxygen equipment

Payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36-month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the modifier MS. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

The 2010 maintenance and servicing fee for certain oxygen equipment is based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of \$66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Social Security Act. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of \$65.93 for oxygen concentrators and transfilling equipment.

Specific billing issues

Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011, will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental DME cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Manuals/downloads/bp102c15.pdf> provides reimbursement for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary DME only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

2011 DMEPOS fee schedule update (continued)

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for ventricular assist devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type), and
- Q0479 (Power Module for Use with Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional information

The official instruction, CR 7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2118CP.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: MM7248

Related Change Request (CR) #:7248

Related CR Release Date: December 9, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2118CP

Implementation Date: January 3, 2011

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

2011 jurisdiction list for DMEPOS HCPCS codes

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Suppliers submitting claims to Medicare contractors (durable medical equipment Medicare administrative contractors [DME MACs], Part B carriers, and Medicare administrative contractors [A/B MACs]) for DMEPOS services provided to Medicare beneficiaries are affected.

Provider action needed

This article is informational and based on change request (CR) 7257 that notifies providers that the spreadsheet containing an updated list of the Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2011 jurisdiction list is an Excel® spreadsheet and is available under the coding category at <http://www.cms.gov/center/dme.asp>.

Additional information

The official instruction, CR 7257, issued to your Medicare A/B MAC, carrier and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2132CP.pdf>. The 2011 jurisdiction list is also attached to CR 7257.

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: MM7257

Related Change Request (CR) #:7257

Related CR Release Date: January 14, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2132CP

Implementation Date: February 15, 2011

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

2011 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 7257 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2011 jurisdiction list is attached to CR 7257 at <http://www.cms.gov/Transmittals/downloads/R2132CP.pdf>. **Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold.**

HCPCS	Description	Jurisdiction
A0021-A0999	Ambulance services	Local carrier
A4206-A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Non coring needle or stylet with or without catheter	Local carrier
A4213-A4215	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216-A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221-A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252-A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262-A4263	Lacrimal duct implants	Local carrier
A4264	Contraceptive implant	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266-A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281-A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300-A4301	Implantable catheter	Local carrier
A4305-A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310-A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A4360-A4434	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A4450- A4456	Tape; adhesive remover	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema bag	DME MAC
A4461- A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465- A4466	Non-elastic binder and elastic garment	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture exchanger	DME MAC
A4490- A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556- A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561- A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4566	Shoulder abduction restrainer	DME MAC
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580- A4590	Casting supplies and material	Local carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium Ion battery for non-prosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611- A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615- A4629	Oxygen and tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630- A4640	DME supplies	DME MAC
A4641- A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651- A4932	Supplies for ESRD	DME MAC
A5051- A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5102- A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5500- A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010- A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154- A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441- A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression burn mask	DME MAC
A6530- A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000- A7002	Accessories for suction pumps	DME MAC
A7003- A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040- A7041	Chest drainage supplies	Local carrier
A7042- A7043	Pleural catheter	Local carrier
A7044- A7046	Respiratory accessories	DME MAC
A7501- A7527	Tracheostomy supplies	DME MAC

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A8000- A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152- A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9273	Noncovered items or services	DME MAC
A9274- A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500- A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034- B9999	Enteral and parenteral therapy	DME MAC
D0120- D9999	Dental procedures	Local carrier
E0100- E0105	Canes	DME MAC
E0110- E0118	Crutches	DME MAC
E0130- E0159	Walkers	DME MAC
E0160- E0175	Commodes	DME MAC
E0181- E0199	Decubitus care equipment	DME MAC
E0200- E0239	Heat/cold applications	DME MAC
E0240- E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250- E0304	Hospital beds	DME MAC
E0305- E0326	Hospital bed accessories	DME MAC
E0328- E0329	Pediatric hospital beds	DME MAC
E0350- E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
E0371- E0373	Decubitus care equipment	DME MAC
E0424- E0484	Oxygen and related respiratory equipment	DME MAC
E0485- E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550- E0585	Compressors/nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602- E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610- E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618- E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621- E0636	Patient lifts	DME MAC
E0637- E0642	Standing devices/lifts	DME MAC
E0650- E0676	Pneumatic compressor and appliances	DME MAC
E0691- E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720- E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747- E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
E0769	Electrical wound treatment device	DME MAC
E0770	Functional electrical stimulator	DME MAC
E0776	IV pole	DME MAC
E0779- E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782- E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785- E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840- E0900	Traction equipment	DME MAC
E0910- E0930	Trapeze/fracture frame	DME MAC
E0935- E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942- E0945	Orthopedic devices	DME MAC
E0946- E0948	Fracture frame	DME MAC
E0950- E1298	Wheelchairs	DME MAC
E1300- E1310	Whirlpool equipment	DME MAC
E1353- E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405- E1406	Additional oxygen equipment	DME MAC
E1500- E1699	Artificial kidney machines and accessories	DME MAC
E1700- E1702	TMJ device and supplies	DME MAC
E1800- E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100- E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201- E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
E2500- E2599	Speech generating device	DME MAC
E2601- E2625	Wheelchair cushions	DME MAC
E8000- E8002	Gait trainers	DME MAC
G0008- G0329	Misc. professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337- G0365	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0378- G9147	Misc. professional services	Local carrier
J0120- J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier
J7030- J7130	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7184	Wilate injection	Local carrier
J7185- J7195	Antihemophilic factor	Local carrier
J7196- J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300- J7307	Intrauterine copper contraceptive	Local carrier
J7308- J7309	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier
J7311- J7312	Fluocinolone acetonide, intravitreal implant	Local carrier
J7321- J7325	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, implant	Local carrier
J7335	Capsaicin	Local carrier
J7500- J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604- J7699	Inhalation Solutions Implant	Local carrier if incident to a physician's. If other, DME MAC.
J7799	NOC, other than inhalation drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non-chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501- J8999	Oral anti-cancer drugs	DME MAC
J9000- J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
K0001-K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601-K0605	External infusion pump batteries	DME MAC
K0606-K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC
K0740	Repair or Nonroutine service for oxygen equipment	DME MAC
K0800-K0899	Power mobility devices	DME MAC
L0112-L2090	Orthotics	DME MAC
L2106-L2116	Orthotics	DME MAC
L2126-L4398	Orthotics	DME MAC
L4631	Orthotics	DME MAC
L5000-L5999	Lower limb prosthetics	DME MAC
L6000-L7499	Upper limb prosthetics	DME MAC
L7500-L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900	Vacuum erection system	DME MAC
L8000-L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500-L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, patient inserted	DME MAC
L8509	Voice prosthesis, inserted by a licensed health care provider	Local carrier for dates of service on or after 10/01/2010, DME MAC for dates of service prior to 10/01/2010
L8510-L8515	Voice prosthesis	DME MAC

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
L8600- L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous Orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064- M0301	Medical services	Local carrier
P2028- P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardiokymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083- Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable X-ray setup	Local carrier
Q0111- Q0115	Miscellaneous lab services	Local carrier
Q0138- Q0139	Ferumoxytol injection	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0163- Q0181	Anti-emetic	DME MAC
Q0480- Q0506	Ventricular assist devices	Local carrier
Q0510- Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1003- Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q2025	Oral anti-cancer drugs	DME MAC
Q2026- Q2027	Injectable dermal fillers (Effective July 1, 2010)	Local carrier
Q2035- Q2039	Influenza vaccine	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3025- Q3026	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001- Q4051	Splints and casts	Local carrier
Q4074	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, local carrier.
Q4082	Drug subject to Competitive Acquisition Program	Local carrier
Q4100- Q4121	Skin substitutes	Local carrier

2011 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
Q5001- Q5010	Hospice services	Local carrier
Q9951- Q9954	Imaging agents	Local carrier
Q9955- Q9957	Microspheres	Local carrier
Q9958- Q9968	Imaging agents	Local carrier
R0070- R0076	Diagnostic radiology services	Local carrier
V2020- V2025	Frames	DME MAC
V2100- V2513	Lenses	DME MAC
V2520- V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530- V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600- V2615	Low vision aids	DME MAC
V2623- V2629	Prosthetic eyes	DME MAC
V2630- V2632	Intraocular lenses	Local carrier
V2700- V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782- V2784	Lenses	DME MAC
V2785	Processing--corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787- V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008- V5299	Hearing services	Local carrier
V5336	Repair/modification of augmentative communicative system or device	DME MAC
V5362- V5364	Speech screening	Local carrier

Source: Change request 7257

Claim modifiers for use in the DMEPOS Competitive Bidding Program

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

All Medicare fee-for-service (FFS) providers and suppliers who provide durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare beneficiaries with original Medicare who reside in a Competitive Bidding Area (CBA), including: contract and non-contract suppliers; physicians and other treating practitioners providing walkers to their own patients; hospitals providing walkers to their own patients; and skilled nursing facilities (SNFs) and nursing facilities (NFs) that provide enteral nutrition to residents with a permanent residence in a CBA.

Background

Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program, beneficiaries with original Medicare who obtain competitive bidding items in designated CBAs are required to obtain these items from a contract supplier, unless an exception applies. The first phase of the program begins on January 1, 2011, in nine CBAs for nine product categories.

In order for Medicare to make payment, where appropriate, for claims subject to competitive bidding, it is important that all providers and suppliers who provide DMEPOS affected by the program use the appropriate modifiers on each claim.

Note: To ensure accurate claims processing, it is critically important for suppliers to submit each claim using the billing number/national provider identifier (NPI) of the location that furnished the item or service being billed.

Competitive bidding modifiers

New Healthcare Common Procedure Coding System (HCPCS) modifiers have been developed to facilitate implementation of various policies that apply to certain competitive bidding items. The new HCPCS modifiers used in conjunction with claims for items subject to competitive bidding are defined as follows:

- J4: DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished by a Hospital Upon Discharge.
- KG: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1.
- KK: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2.
- KU: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3.
- KW: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4.
- KY: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5.
- KL: DMEPOS Item Delivered via Mail.
- KV: DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service.
- KT: Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item.

Suppliers should submit claims for competitive bidding items using the appropriate HCPCS code and corresponding competitive bidding modifier in effect during a contract period. The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The modifiers associated with particular competitive-bid codes, such as modifiers KG, KK, or KL, are listed by competitive-bid product category on the single payment amount public use charts found under the supplier page at <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf>.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Another modifier was developed to facilitate implementation of DMEPOS fee schedule policies that apply to certain competitive bidding items that were bid prior to July 1, 2008, under the initial Round I of the DMEPOS Competitive Bidding Program. The modifier KE is defined as follows:

- KE: DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment.

How to use the modifiers

Hospitals providing walkers and related accessories to their patients on the date of discharge - modifier J4

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Please note that separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claim processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the modifier J4, to claims submitted for these items.

The modifier J4 should not be used by contract suppliers.

Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)**Modifiers for HCPCS accessory or supply codes furnished in multiple product categories – modifiers KG, KK, KU, and KW**

The modifiers KG, KK, KU, and KW are used to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 (*Wheelchair Accessory, Seat Upholstery, Replacement Only, Each*) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the modifier KG. Contract suppliers for the complex rehabilitative power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the modifier KK. Another example of the use of the modifier KG modifier is with code A4636 (*Replacement, Handgrip, Cane, Crutch, or Walker, Each*). Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the modifier KG.

All suppliers that submit claims for beneficiaries that live in a CBA, including contract, non-contract, and grandfathered suppliers, should submit claims for competitive-bid items using the above mentioned competitive bidding modifiers. Non-contract suppliers that furnish competitively bid supply or accessory items to traveling beneficiaries who live in a CBA must use the appropriate modifier KG or KK with the supply or accessory HCPCS code when submitting their claim. Also, grandfathered suppliers that furnish competitively bid accessories or supplies used in conjunction with a grandfathered item must include the appropriate modifier KG or KK when submitting claims for accessory or supply codes. The modifier KG and KK are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the modifier KU and KW are reserved for future program use.

The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public-use charts found under the supplier page at <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf>.

Purchased accessories and supplies for use with grandfathered equipment – modifier KY

Non-contract grandfathered suppliers must use the modifier KY on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the modifier KY is authorized:

- Continuous positive airway pressure devices, respiratory assistive devices, and related supplies and accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562
- Hospital beds and related accessories – E0271, E0272, E0280, and E0310, and
- Walkers and related accessories – E0154, E0156, E0157 and E0158

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single payment amounts for items included in the Round 1 Rebid of the DMEPOS Competitive Bidding Program may be found under the Single Payment Amount tab on the following website: <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/Suppliers>. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the modifier KY will be denied. Also, claims submitted with the modifier KY for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

Mail order diabetic supplies – modifier KL

Contract suppliers must use the modifier KL on all claims for diabetic supply codes that are furnished via mail order. Non-contract suppliers that furnish mail-order diabetic supplies to beneficiaries who do not live in CBAs must also continue to use the modifier KL with these codes. Suppliers that furnish mail-order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to significant penalties. For claims with dates of service prior to implementation of a national mail order competitive bidding program, the modifier KL is not used with diabetic supply codes that are not delivered to the beneficiary's residence via mail order or are obtained from a local supplier storefront. Once a national mail order competitive bidding program is implemented, the definition for mail order item will change to include all diabetic supply codes delivered to the beneficiary via any means. At this time, the modifier KL will need to be used for all diabetic supply codes except for claims for items that a beneficiary or caregiver picks up in person from a local pharmacy or supplier storefront.

Physicians and treating practitioners who furnish walkers and related accessories to their own patients but who are not contract suppliers – modifier KV

The modifier KV is to be used by physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries in a CBA. Walkers that are appropriately furnished in accordance with this exception will be paid at the single payment amount.

To be paid for walkers as a non-contract supplier, physicians and treating practitioners should use the modifier KV in

Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)

combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. On the claim billed to the durable medical equipment Medicare administrative contractor (DME MAC), the walker line item must have the same date of service as the professional service office visit billed to the Part A/Part B MAC. Physicians and treating practitioners are advised to submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.

Physicians and treating practitioners who are located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries who live in a CBA must affix the modifier KV to claims submitted for these items.

The modifier KV should not be used by contract suppliers.

Traveling beneficiaries - modifier KT

Suppliers must submit claims with the modifier KT for non-mail-order DMEPOS competitive bidding items that are furnished to beneficiaries who have traveled outside of the CBA in which they reside. If a beneficiary who lives in a CBA travels to an area that is not a CBA and obtains an item included in the competitive bidding program, the non-contract supplier must affix this modifier to the claim. Similarly, if a beneficiary who lives in a CBA travels to a different CBA and obtains an item included in the competitive bidding program from a contract supplier for that CBA, the contract supplier must use the modifier KT.

SNFs and NFs that are not contract suppliers and are not located in a CBA must also use the modifier KT on claims for enteral nutrition items furnished to residents with a permanent home address in a CBA. SNF or NF claims that meet these criteria and are submitted without the modifier KT will be denied.

Claims for mail-order competitive bidding diabetic supplies submitted with the modifier KT will be denied. Contract suppliers must submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

To determine if a beneficiary permanently resides in a CBA, a supplier should follow these two simple steps:

1. Ask the beneficiary for the ZIP code of his or her permanent residence. This is the address on file with the Social Security Administration (SSA).
2. Enter the beneficiary's ZIP code into the CBA finder tool on the home page of the Competitive Bidding Implementation Contractor (CBIC) website, found at www.dmecompetitivebid.com.

Modifier KE

Section 154(a)(2) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated a fee schedule covered item update of -9.5 percent for 2009 for items included in the Round I of the DMEPOS Competitive Bidding Program. This covered item update reduction to the fee schedule file applies to items furnished on or after January 1, 2009, in any geographical area. In order to implement the covered item update required by MIPPA, the modifier KE was added to the DMEPOS fee schedule file in 2009 to identify Round I competitively bid accessory codes that could be used with both competitively-bid and non-competitively bid base equipment. All suppliers must use the modifier KE on all Part B fee-for-service claims to identify when a Round I bid accessory item is used with a non-competitively-bid base item (an item that was not competitively bid prior to July 2008).

For example, HCPCS code E0950 (*Wheelchair Accessory, Tray, Each*) can be used with both Round I competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). All suppliers must use the modifier KE with the accessory code to identify when E0950 is used in conjunction with a non-competitively bid manual wheelchair (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). The modifier KE should not be used with competitive-bid accessory HCPCS codes that are used with any competitive-bid base item that was included in the initial Round I of the competitive bidding program prior to July 1, 2008. Therefore, in the above example, modifier KE is not valid for use with accessory code E0950 when used with standard power wheelchairs, complex rehabilitative power wheelchairs (Group 2 or Group 3), or any other item selected for competitive bidding prior to July 1, 2008.

For beneficiaries living in competitive-bid areas on or after January 1, 2011, suppliers should not use the modifier KE to identify competitively bid accessories used with base equipment that was competitively bid under the Round I Rebid Competitive Bidding Program. Rather, such claims should be submitted using the appropriate modifiers KG or KK as identified on the single payment amount public-use charts found under the supplier page at www.dmecompetitivebid.com/Palmetto/Cbic.nsf.

Below is a chart that illustrates the relationship between the competitive-bid modifiers (KG, KK, KU, and KW) and the modifier KE using competitively bid accessory code E0950:

Accessory code E0950 used with a:	Base code competitive-bid status	Claim for a beneficiary who permanently lives in a CBA	Claim for a beneficiary who permanently lives Outside a CBA*
Manual wheelchair (K0001 thru K0009) or miscellaneous power wheelchair (K0898)	non-bid	Bill with modifier KE	Bill with modifier KE

Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)

Accessory code E0950 used with a:	Base code competitive-bid status	Claim for a beneficiary who permanently lives in a CBA	Claim for a beneficiary who permanently lives Outside a CBA*
Standard power wheelchair (K0813 thru K0829)	Bid in Round 1 and the Round 1 Rebid	Bill with modifier KG	Bill without modifier KE
Complex rehabilitative group 2 power wheelchair (K0835 thru K0843)	Bid in Round 1 and the Round 1 Rebid	Bill with modifier KK	Bill without modifier KE
Complex rehabilitative group 3 power wheelchair (K0848 thru K0864)	Bid in Round 1	Bill without modifier KE, KK or KG	Bill without modifier KE

* The competitive bid modifiers (KG, KK, KU, and KW) are only used on claims for beneficiaries that live in a competitive bidding area (CBA).

Additional information

The Medicare Learning Network® (MLN) has prepared several fact sheets with information for non-contract suppliers and referral agents, including fact sheets on the hospital and physician exceptions, enteral nutrition, mail-order diabetic supplies, and traveling beneficiaries, as well as general fact sheets for non-contract suppliers and referral agents. They are all available, free of charge, at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit <http://www.cms.gov/DMEPOSCompetitiveBid>.

Information for contract suppliers may be found at the CBIC website at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home>.

Beneficiary-related information may be found at <http://www.medicare.gov>.

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End-Stage Renal Disease

CMS implements value-based purchasing for dialysis facilities Program establishes performance standards, payment penalties

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on December 29, 2010, that establishes performance standards for dialysis facilities and provide payment adjustments to individual end-stage renal disease (ESRD) facilities based on how well they meet these standards. The ESRD quality incentive program (QIP) is designed to promote high-quality dialysis services at Medicare facilities by linking CMS payments directly to facility performance on quality measures.

CMS Administrator Dr. Donald Berwick lauded the ESRD QIP as “a landmark advance for improving the quality and safety of care that Medicare beneficiaries receive while on dialysis treatment. Since most patients with ESRD are also Medicare beneficiaries, the ESRD QIP is an especially powerful tool in transforming care in America’s dialysis centers.”

Individuals are diagnosed with ESRD when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD can be cured only with a kidney transplant. ESRD patients who have not received a transplant rely on dialysis to perform the life-saving filtering function. Nearly 350,000 individuals in the United States are being treated for ESRD under Medicare, at a cost of nearly \$9 billion each year.

CMS has previously implemented programs in a variety of settings that pay for reporting of quality measures and has used its demonstration authority to test whether pay-for-performance can improve the quality of care in hospitals and physicians’ offices. The ESRD QIP takes the next step, implementing a permanent pay-for-performance program that could affect payments to all dialysis facilities. It also supports the transition of ESRD payments to a new ESRD prospective

CMS implements value-based purchasing for dialysis facilities (continued)

payment system (PPS). While the ESRD PPS will promote the efficient provision of care to patients with ESRD, the ESRD QIP will help ensure that facilities provide high quality, patient-centered care.

The ESRD QIP was mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) as a companion to the ESRD PPS. In the ESRD PPS final rule, issued July 26, 2010, and published in the August 12, 2010, *Federal Register*, CMS finalized three measures as the initial measure set during the first program year. Two of these measures are designed to assess whether patients' hemoglobin levels are maintained in an acceptable range, while the third measures the effectiveness of the dialysis treatment in removing waste products from patients' blood. The three measures were chosen because they represent important indicators of patient outcomes and quality of care.

The final rule issued today establishes the ESRD QIP performance standards, sets out the scoring methodology CMS will use to rate providers' quality of dialysis care, and establishes a sliding scale for payment adjustments based on the facility's performance. CMS will assess each dialysis facility on how well its performance meets the standard for each measure and will calculate each facility's total performance score. The maximum total performance score a facility can achieve is 30 (10 points per measure). Facilities that do not meet or exceed performance standards will be subject to a payment reduction of up to two percent depending on how far their performance deviates from the standards.

In future years CMS may add quality measures and establish additional performance standards that facilities will need to meet to receive full payment for the services they furnish to Medicare beneficiaries.

The period of performance under which facilities will be evaluated is payment year (PY) 2010, running from January 1, 2010, through December 31, 2010. CMS will give providers and facilities the opportunity to review their scores and any resulting payment adjustments prior releasing the ESRD QIP scores and payment reductions publicly. The ESRD QIP payment adjustments will apply to payments under the ESRD PPS for outpatient maintenance dialysis items and services furnished to Medicare beneficiaries by ESRD facilities between January 1, 2012, and December 31, 2012.

After ESRD facility scores and payment determinations are finalized, CMS will furnish each facility with a PY 2012 certificate noting the facility's total performance score as well as its score on each individual measure. Each facility is required to post its certificate in a prominent location in a patient care area for the duration of the payment year. CMS will furnish each facility with a new certificate annually. In addition, CMS will post on the Internet each facility's total performance score, as well as the scores that facilities earned on the individual measures.

"For over 30 years, Medicare has been monitoring quality for patients with ESRD," said Berwick. "The new ESRD QIP allows us to build up from that foundation a program that aligns payment for dialysis treatment with the outcomes that matter most to patients."

The final rule was placed on display at the *Federal Register* January 5, 2011, and may be found under "Special Filings" at: www.ofr.gov/inspection.aspx#special. For more information, please see www.cms.gov/ESRDQualityImproveInit.

Note: More information about the proposed rule, including the measures CMS proposes to use in the program, as well as CMS' proposed scoring methodology, is included in a fact sheet posted on the CMS website at: www.cms.gov/apps/media/fact_sheets.asp.

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

Source: CMS PERL 201101-03

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Reminders for those receiving monthly Medicare payments to manage ESRD patients

Resources outlined to assist eligible providers

The following reminders are for end-stage renal disease (ESRD) facilities, physicians, and practitioners who receive monthly Medicare payments to manage ESRD patients (MCPs) that pertain to the Centers for Medicare & Medicaid Services' (CMS's) requirements for ESRD beneficiaries to access ESRD-related drugs effective January 1, 2011. These requirements will ensure that patients receive their medications and that appropriate payment is made for their medications.

- ESRD facilities must instruct patients to obtain their ESRD-related medications from ESRD facilities' contracted pharmacies to ensure that pharmacies receive payment from the ESRD facilities and patients receive their medications with no financial obligation.
- ESRD facilities must instruct physicians and practitioners who receive monthly Medicare payments to manage ESRD patients (MCPs) to direct their patients to use ESRD facility-contracted pharmacies to ensure that pharmacies receive payment from the ESRD facilities and patients receive their medications.
- MCPs must indicate on an ESRD patient's prescription if prescribed medications are not ESRD-related to ensure that payment for these non-ESRD-related medications can be made under Part D. ESRD patients may obtain covered Part D, non-ESRD related prescription drugs from a network pharmacy or an out-of-network pharmacy in accordance with Part D rules.

Reminders for those receiving monthly Medicare payments to manage ESRD patients (continued)

- ESRD facilities must indicate on the ESRD claims, each ESRD-related drug (except for composite rate drugs) furnished to an ESRD patient either directly or through a prescription filled by a pharmacy.
- ESRD facilities must use the AY modifier on the ESRD claims for each non-ESRD-related drug furnished to an ESRD patient.
- ESRD facilities must instruct home dialysis patients currently under Method II, about any changes in the arrangements for ESRD-related home dialysis supplies on and after January 1, 2011.
- ESRD facilities must instruct home dialysis patients currently under Method II, that patients no longer have any financial obligation to suppliers for ESRD-related supplies on and after January 1, 2011.

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

Source: CMS PERL 201012-38

Laboratory/Pathology

Changes to the laboratory national coverage determination edit software for April 2011

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7290, which announces the changes that will be included in the April 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs).

The change that is effective for dates of service on and after April 1, 2011, is as follows:

For blood counts

ICD-9-CM code V49.87 will be added to the list of "Do Not Support Medical Necessity" ICD-9-CM codes for the blood counts (190.15) NCD.

Please ensure that your billing staffs are aware of these changes.

Background

NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at <http://www.cms.gov/manuals/downloads/clm104c16.pdf>. The laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

Additional information

The official instruction, CR 7290, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2133CP.pdf>.

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

MLN Matters® Number: MM7290

Related Change Request (CR) #: 7290

Related CR Release Date: January 14, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2133CP

Implementation Date: April 4, 2011

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Surgery

Payment for 510k post-approval extension studies using 510k-cleared embolic protection devices during carotid artery stenting procedures

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, hospitals, or other providers who submit claims to Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing carotid artery stenting (CAS) procedures, in post approval extension studies, using 510k-cleared embolic protection devices.

What you need to know

Change request (CR) 7249, from which this article is taken, announces that, effective October 22, 2010, the Centers for Medicare & Medicaid Services (CMS) has determined that all 510k post-approval extension studies must be reviewed by the Food and Drug Administration (FDA) via its pre-investigational device exemption (IDE) process. It specifically discusses the coverage of proximal embolic protection devices (EPDs) used in carotid artery stenting (CAS) procedures performed in FDA-approved 510k post-approval extension studies, announcing that these patients (similar to patients covered in traditional post-approval extension studies) are eligible for coverage under the current coverage policy.

In order to receive Medicare coverage for patients participating in these 510k post-approval extension studies, you will need to follow the same billing processes as explained in the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 160.2.1 (CAS for Post-Approval Studies), except that you should report 510k-cleared devices with a pre-IDE number beginning with an “I”, instead of an IDE number beginning with a “P” (post-market approval). You may find this manual section at <http://www.cms.gov/manuals/downloads/clm104c32.pdf>.

You should make sure that your billing staffs are aware of these coverage changes.

Background

In 2004, CMS gave Medicare contractors instructions on processing claims for CAS procedures performed in FDA-approved post-approval studies. (Please refer to *MLN Matters*® article MM3489, released on October 15, 2004, entitled Percutaneous Transluminal Angioplasty (PTA), which you may find at <http://www.cms.gov/MLN MattersArticles/downloads/MM3489.pdf>).

As these post-approval studies began to end, CMS received requests to extend coverage for them. On May 12, 2006, CMS released CR 5088 which updated the *Medicare Claims Processing Manual* and explained that patients participating in post-approval extension studies are also included in the covered population of patients participating in FDA-approved post-approval studies. CR 5088 also provided claims processing instructions specific to post approval extension studies. Please refer to *MLN Matters*® article MM5088 entitled Payment for Carotid Artery Stenting (CAS) Post Approval Extension Studies, which you may find at <http://www.cms.gov/MLN MattersArticles/downloads/MM5088.pdf> and to the *Medicare National Coverage Determinations [NCD] Manual*, Chapter 1 [Coverage Determinations], Section 20.7 (Percutaneous Transluminal Angioplasty [PTA]), which is available at http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf.

Coverage of proximal embolic protection devices in carotid artery stenting procedures

Recently, the FDA issued 510k approvals for proximal EPDs used in CAS procedures. However, while the NCD requires use of an EPD, the 510k process (unlike traditional FDA marketing approval requirements) does not involve a post-approval study requirement; and CMS received requests to include, under the current coverage policy, patients participating in studies that followed FDA 510k approval of these devices.

In response, effective October 22, 2010, CMS determined that patients in these studies (similar to patients covered in traditional post-approval extension studies as discussed above) are eligible for coverage under the current coverage policy referenced in Section 20.7 in the *NCD Manual* previously referenced.

Moreover, while the FDA does not require devices approved through the 510k process to undergo further study following clearance (as such, these studies are neither required by, nor subject to, FDA approval), CMS has determined that the FDA must review all 510k post-approval extension studies through its pre-IDE process. As a result of this process, each study is assigned, and identified by, a single, 6-digit number preceded by the letter ‘I’ (i.e., I123456). (For example, the FREEDOM study, examining the 510k-cleared Gore Flow Reversal System, was assigned I090962, and must be identified as such on all claims.)

Notification process

Following this review process, the FDA will issue CMS an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. CMS, upon receipt of this letter and review of the 510k post-approval extension study protocol, will issue a letter to the study sponsor indicating that Medicare will cover the study under review.

*Payment for 510k post-approval extension studies using 510k-cleared embolic protection ... (continued)***Billing**

Your carrier, FI, or A/B MAC will follow the same procedures for processing post-approval study devices that are currently in place for category B IDEs. In order to receive Medicare coverage for patients participating in 510k post-approval extension studies, you will need to submit both the FDA acknowledgement letter and the CMS letter providing coverage for the extension study to your contractor, and any other materials they might require for FDA-approved post-approval studies or post-approval extension studies. Further, you should follow the process (as established in CR 3489) for informing them of the patients' participation in the studies, utilizing the most current and appropriate codes when submitting your claims. This process is as follows:

For billing carriers

- Place the IDE number (that begins with an "I") in either item 23 of the CMS-1500 paper claim format or in the 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837p claim format
- Use the modifier Q0, instead of QA
- Use the most current ICD-9-CM procedure codes
- Use the most current ICD-9-CM diagnostic codes

For billing FIs

- Use the most current ICD-9-CM procedure codes
- Place no more than one IDE number (that begins with an "I") in form locator 43 of the CMS-1450 or in 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837i
- Use revenue code 0624 for post-approval study devices in form locator 42 of the CMS-1450 paper claim form or 2400 Institutional Service Line SV201 Segment, data element 234 of the 837i
- Use the most current ICD-9-CM diagnostic codes

You should also be aware that your contractor is not required to mass-adjust claims for dates of service between the October 22, 2010, effective date and this CR's implementation date, but they may adjust claims that you bring to their attention.

Additional information

You may find more information about payment for 510k post-approval extension studies using 510k-cleared EPDs during CAS procedures by going to CR 7249, located at <http://www.cms.hhs.gov/Transmittals/downloads/R2113CP.pdf>.

You will find the updated *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 160.4 (510k Post-Approval Studies using 510k-Cleared Embolic Protection Devices during Carotid Artery Stenting (CAS) Procedures) as an attachment to that CR.

If you have 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: MM7249

Related Change Request (CR) #: 7249

Related CR Release Date: December 10, 2010

Effective Date: October 22, 2010

Related CR Transmittal #: R2113CP

Implementation Date: January 12, 2011

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Place of service indicator revised for HCPCS codes G0339 and G0340

The pricing indicator code on the alpha-numeric Healthcare Common Procedure Coding System (HCPCS) file has been changed from "00" (Service not separately priced by Part B) to "13" (Price established by carriers) for HCPCS codes G0339 and G0340. This change is effective for services furnished in calendar year (CY) 2006-CY 2010.

Source: JSM 11066

Therapy Services

Multiple procedure payment reduction for selected therapy services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: This article was revised on December 22, 2010, to reflect changes made to change request (CR) 7050 on December 21, 2010. The CR 7050 was revised based on policy changes required by the Physician Payment and Therapy Relief Act of 2010, which changed the multiple payment procedure reduction for therapy services in the office setting or a non-institutional setting to 20 percent, instead of 25 percent. The CR release date, transmittal number, and Web address for accessing CR 7050 were also revised. All other information remains the same. This information was previously published in the November 2010 *Medicare B Update!* pages 18-19.

Provider types affected

Physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs] for therapy services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule [MPFS]).

Provider action needed

This article is based on change request (CR) 7050, which announces that Medicare is applying a new multiple procedure payment reduction (MPPR) to the practice expense (PE) component of payment of select therapy services paid under the MPFS. Make sure your billing staff is aware of these payment reductions.

Background

Section 3134 of The Affordable Care Act added section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.

For therapy services furnished by a group practice or “incident to” a physician’s service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

The reduction applies to the HCPCS codes contained on the list of “always therapy” services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR 7050 as Attachment 1. CR 7050 is available at <http://www.cms.gov/Transmittals/downloads/R826OTN.pdf>. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example based on the 75 percent reduction for institutional settings:

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed Total Payment	Proposed Payment Calculation
Work	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	no reduction
PE	\$10.00	\$10.00	\$8.00	\$28.00	\$23.50	\$10 + (.75 x \$10) + (.75 x \$8)
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	no reduction
Total	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	\$18 + (\$18-\$10) + (.75 x \$10) + (\$20-\$8) + (.75 x \$8)

Where claims are impacted by the MPPR, Medicare will return a claim adjustment reason code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a group code of contractual obligation (CO).

*Multiple procedure payment reduction for selected therapy services (continued)***Additional information**

The official instruction, CR 7050, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R826OTN.pdf>. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7050 *Revised*
 Related Change Request (CR) #: 7050
 Related CR Release Date: December 21, 2010
 Effective Date: January 1, 2011
 Related CR Transmittal #: R826OTN
 Implementation Date: January 3, 2011

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General Coverage

Emergency update to the CY 2011 Medicare physician fee schedule database

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], durable medical equipment Medicare administrative contractors [DME/MACs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS final rule. This CR also reinstates three durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background

Payment files were issued based upon the calendar year (CY) 2011 MPFS final rule, issued on November 2, 2010, and published in the *Federal Register* on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS final rule correction notice, issued in December 30, 2010, ([http://www.ofr.gov/\(X\(1\)S\(zj23h5e5vs3xn5y2yjsecx03\)\)/inspection.aspx?AspxAutoDetectCookieSupport=1](http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1)) to be published in the *Federal Register* on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare physician fee schedule revisions and updates

Some physician work, practice expense (PE) and malpractice (MP) relative value units (RVUs) published in the CY 2011 MPFS final rule have been revised to align their values with the CY 2011 MPFS final rule policies. These changes are discussed in the CY 2011 MPFS final rule correction notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS final rule correction notice public use data files located at <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at <http://www.cms.gov/Transmittals/downloads/R828OTN.pdf>.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS final rule has been revised. This CF will be published in the CY 2011 MPFS final rule correction notice. Legislative changes subsequent to issuance of the CY 2011 MPFS final rule have led to the further revision of the values published in the CY 2011 MPFS final rule correction notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent multiple procedure payment reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Security Act. This change is detailed in recently released CR 7050. CMS published *MLN Matters*® article 7050, related to CR 7050, which may be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/MM7050.pdf>. This Act also made the therapy MPPR not budget neutral under the physician fee schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

Medicare and Medicaid Extenders Act (MMEA) of 2010

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare fee-for-service program policies. A summary of MPFS-related provisions follows.

- **Physician payment update**

Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare economic index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is \$33.9764.

The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 conversion factor		\$36.8729
MMEA "Zero Percent Update"	0.0 percent (1.000)	
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)	
CY 2011 Conversion Factor		\$33.9764

The revised CY 2011 MPFS payment files will reflect this conversion factor.

- **Extension of Medicare physician work geographic adjustment floor**

Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished through December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs may also be found in the attachment to CR 7300 as noted previously.

- **Extension of MPFS mental health add-on**

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy may also be found in the attachment to CR 7300.

- **Extension of exceptions process for Medicare therapy caps**

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. Outpatient therapy service providers may continue to submit claims with the modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

- **Extension of moratorium that allowed independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients**

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary’s hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Durable medical equipment, prosthetics, orthotics, and supplies updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment (SD: Abduct restrainer canvas &web)
- L3670 Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment (SD: Acromio/clavicular canvas & web), and
- L3675 Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, and prefabricated includes fitting and adjustment (SD: Canvas vest SO).

These three “L” codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three “L” codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	\$85.06	\$118.57	\$145.25
AR	D	PO	\$85.06	\$97.17	\$145.24
AZ	D	PO	\$100.69	\$124.79	\$141.00
CA	D	PO	\$100.69	\$124.79	\$141.00
CO	D	PO	\$111.02	\$93.60	\$146.04
CT	D	PO	\$113.42	\$93.60	\$141.00
DC	D	PO	\$85.06	\$112.42	\$141.00
DE	D	PO	\$85.06	\$112.42	\$141.00
FL	D	PO	\$85.06	\$118.57	\$145.25
GA	D	PO	\$85.06	\$118.57	\$145.25
IA	D	PO	\$106.53	\$124.79	\$143.74
ID	D	PO	\$85.06	\$97.28	\$141.00
IL	D	PO	\$85.06	\$93.60	\$144.48
IN	D	PO	\$85.06	\$93.60	\$144.48
KS	D	PO	\$106.53	\$124.79	\$143.74
KY	D	PO	\$85.06	\$118.57	\$145.25
LA	D	PO	\$85.06	\$97.17	\$145.24
MA	D	PO	\$113.42	\$93.60	\$141.00
MD	D	PO	\$85.06	\$112.42	\$141.00
ME	D	PO	\$113.42	\$93.60	\$141.00
MI	D	PO	\$85.06	\$93.60	\$144.48
MN	D	PO	\$85.06	\$93.60	\$144.48
MO	D	PO	\$106.53	\$124.79	\$143.74
MS	D	PO	\$85.06	\$118.57	\$145.25
MT	D	PO	\$111.02	\$93.60	\$146.04
NC	D	PO	\$85.06	\$118.57	\$145.25
ND	D	PO	\$111.02	\$93.60	\$146.04
NE	D	PO	\$106.53	\$124.79	\$143.74

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

	JURIS	CATG	L3660	L3670	L3675
NH	D	PO	\$113.42	\$93.60	\$141.00
NJ	D	PO	\$87.06	\$110.96	\$141.00
NM	D	PO	\$85.06	\$97.17	\$145.24
NV	D	PO	\$100.69	\$124.79	\$141.00
NY	D	PO	\$87.06	\$110.96	\$141.00
OH	D	PO	\$85.06	\$93.60	\$144.48
OK	D	PO	\$85.06	\$97.17	\$145.24
OR	D	PO	\$85.06	\$97.28	\$141.00
PA	D	PO	\$85.06	\$112.42	\$141.00
RI	D	PO	\$113.42	\$93.60	\$141.00
SC	D	PO	\$85.06	\$118.57	\$145.25
SD	D	PO	\$111.02	\$93.60	\$146.04
TN	D	PO	\$85.06	\$118.57	\$145.25
TX	D	PO	\$85.06	\$97.17	\$145.24
UT	D	PO	\$111.02	\$93.60	\$146.04
VA	D	PO	\$85.06	\$112.42	\$141.00
VT	D	PO	\$113.42	\$93.60	\$141.00
WA	D	PO	\$85.06	\$97.28	\$141.00
WI	D	PO	\$85.06	\$93.60	\$144.48
WV	D	PO	\$85.06	\$112.42	\$141.00
WY	D	PO	\$111.02	\$93.60	\$146.04
AK	D	PO	\$100.22	\$148.35	\$141.00
HI	D	PO	\$107.12	\$158.62	\$141.00
PR	D	PO	\$82.83	\$105.08	\$169.21
VI	D	PO	\$87.06	\$110.96	\$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at:

<http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp>.

Additional information

The official instruction, CR 7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R828OTN.pdf>.

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

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Related Change Request (CR) #:7300

Related CR Release Date: December 29, 2010

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Summary of policies – 2011 Medicare physician fee schedule and the telehealth originating site facility fee payment amount

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Physicians and nonphysician practitioners who submit claims to fiscal intermediaries (FI), carriers, and A/B Medicare administrative contractors (MACs) are affected by this article.

What you need to know

This article is based on change request (CR) 7264, which provides a summary of the policies in the calendar year (CY) 2011 Medicare physician fee schedule and announces the telehealth originating site facility fee. Please ensure that your billing staffs are aware of these changes.

Background

The summary of changes is as follows:

Telehealth Services

Section 1834 (m) of the Social Security Act (the Act) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI). The MEI increase for CY 2011 is 0.4 percent.

For calendar year 2011, the payment amount for HCPCS code “Q3014, Telehealth originating site facility fee” is 80 percent of the lesser of the actual charge or \$24.10. The beneficiary is responsible for any unmet deductible amount or coinsurance.

For additional details regarding the expansion of telehealth services in 2011, see the article at <http://www.cms.gov/MLNMattersArticles/downloads/MM7049.pdf>.

Summary of policies in the CY 2011 MPFS

The Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians’ services for the subsequent year. Following is a summary of significant physician fee schedule issues discussed in CMS-1503-FC, Medicare Program; Payment Policies under the Physician Fee Schedule and other revisions to Part B for CY 2011.

Affordable Care Act Provisions

Elimination of deductible and coinsurance for most preventive services: Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services. Specifically, the provision waives both the deductible and coinsurance for Medicare-covered preventive services that have been recommended with a grade of A (“strongly recommends”) or B (“recommends”) by the U.S. Preventive Services Task Force, as well as the initial preventive physical examination and the new annual wellness visit. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.

Coverage of annual wellness visit (AWV) providing a personalized prevention plan:

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the “Welcome to Medicare Visit”), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV may include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual’s medical and family history
- List the individual’s current medical providers and suppliers and all prescribed medications
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Detect any cognitive impairment
- Establish or update a screening schedule for the next five to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors, and
- Furnish personalized health advice and appropriate referrals to health education or preventive services.
- CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 - Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 - Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

For more details on the AWV, see the article at <http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf>.

Incentive payments to primary care practitioners for primary care services:

The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner’s allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner’s MPFS allowed charges for a prior period as determined by the Secretary of Health and Human Services. The law also defines primary care services as limited to new and established patient office or other outpatient visits (*CPT* codes 99201-99215); nursing facility care visits, and

Summary of policies – 2011 Medicare physician fee schedule and the telehealth ... (continued)

domiciliary, rest home, or home care plan oversight services (CPT codes 99304-99340); and patient home visits (CPT codes 99341-99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in health professional shortage areas (HPSAs).

CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

For more details on this program, see the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7060.pdf>. Also, the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7115.pdf> has details on this program as they apply to critical access hospitals.

Incentive payments for major surgical procedures in health professional shortage areas: The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the MPFS – that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Further details on this program are in the *MLN Matters*[®] article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7063.pdf>.

Revisions to the practice expense geographic adjustment: As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Payment for bone density tests: The Affordable Care Act increases the payment for two dual-energy x-ray absorptiometry (DXA) CPT codes for measuring bone density for CYs 2010 and 2011. This provision requires payments for these preventive services to be based on 70 percent of their CY 2006 RVUs and the CY 2006 conversion factor, and the current year geographic adjustment.

Improved access to certified nurse-midwife services: The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after January 1, 2011.

Misvalued codes under the physician fee schedule: The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Multiple procedure payment reduction policy for therapy services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will

Summary of policies – 2011 Medicare physician fee schedule and the telehealth ... (continued)

apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under Section 1848 of the Act.

For more details, see the *MLN Matters*[®] article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7050.pdf>.

Modification of equipment utilization factor and modification of multiple procedure payment policy for advanced imaging services: The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Medicare economic index (MEI)

The MEI is an inflation index for physician practice costs that is used as part of the formula to calculate annual updates to MPFS rates. For CY 2011, CMS is rebasing and revising the MEI to use a 2006 base year in place of a 2000 base year. Prior to the rebasing for CY 2011, CMS rebased the MEI in CY 2004. In addition, the final rule with comment period announces CMS' plans to convene a technical advisory panel to review all aspects of the MEI, including inputs, input weights, price-measurement proxies, and productivity adjustment; and indicates that CMS will consider the panel's analysis and recommendations in future rulemaking.

New and revised CPT code issues

Establishment of interim final RVUs for CY 2011:

On an annual basis, the AMA RUC provides CMS with recommendations regarding physician work values for new, revised, and potentially misvalued codes. Typically, the relevant specialty society surveys physicians to gather information regarding current medical practice that is then used by the AMA RUC in developing recommendations for physician work values. CMS reviews the AMA RUC-recommended work RVUs on a code-by-code basis. CMS then decides either to accept the AMA RUC-recommended work RVUs if CMS believes the valuation is accurate, or determine an alternative value that better reflects our estimate of the physician work for the service. CMS publishes these work RVUs in the PFS final rule as interim final values, subject to public comment.

Comprehensive codes for a bundle of existing component services:

A subset of AMA RUC work RVU recommendations addressed valuing new CY 2011 CPT codes resulting from the bundling of two or more existing component services performed together 95 percent or more of the time. CMS expects this bundling of component services to continue over the next several years as the AMA RUC further recognizes the work efficiencies for services commonly furnished together. Stakeholders should expect that increased bundling of services into fewer codes will generally result in reduced MPFS payment for a comprehensive service by explicitly considering the efficiencies in work and/or PE that may occur when component services are furnished together. For CY 2011, the AMA RUC provided CMS with recommendations for several categories of new comprehensive services that historically have been reported under multiple component codes. For CY 2011 the creation of comprehensive codes for a bundle of existing component services fall into three major clinical categories: endovascular revascularization, computed tomography (CT), and diagnostic cardiac catheterization.

Additional Information

The official instruction, CR 7264, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2129CP.pdf>. If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters[®] Number: MM7264

Related Change Request (CR) #: 7264

Related CR Release Date: December 29, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2129CP

Implementation Date: January 3, 2011

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Revisions to claim processing instructions for services rendered in place of service home

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: This article was revised on January 3, 2011, to clarify that address requirements apply to paper claims that are processed on or after January 1, 2011. All other information remains the same. This information was previously published in the August 2010 *Medicare B Update!* pages 12-13.

Provider types affected

This article is for physicians and other providers who bill Medicare contractors (carriers and Medicare administrative contractors (A/B MAC)) for services provided to Medicare beneficiaries in place of service (POS) home (or any other place of service that Medicare contractors consider to be home).

What you need to know

Change request (CR) 6947, from which this article is taken, represents no change to payment policy. CR 6947 requires that you now enter the address of where services were performed, including the ZIP code, on claims for anesthesia services and every service payable under the Medicare physician fee schedule (MPFS), for services provided in all places of service, including Home. This change will be effective for claims that you submit on the 5010 version of the ANSI X12N 837 P electronic form that are processed by Medicare on or after January 1, 2011, and on the paper Form CMS-1500 for claims processed on or after January 1, 2011. (Claims submitted on the 4010A1 electronic form are not impacted by this change.) You should make sure that your billing staffs are aware of this change.

Background

Currently, you are required to submit claims for anesthesia services and for services payable under the MPFS with the address and ZIP code of where the service was performed included on the claim for services provided in all places of service (POS), except when the POS is home. In order to stay consistent with the 5010 version of the ANSI X12 N 837 P format (which is to become effective on January 1, 2011) the exception for POS home will no longer be effective.

Specifically, CR 6947 from which this article is taken, announces that effective for claims that you submit using the 5010 version of the ANSI X12N 827 P electronic claim form that are processed on or after January 1, 2011, and for paper claims that you submit on the Form CMS-1500 for claims that are processed on or after January 1, 2011; you will need to submit the address and five-digit ZIP code (or the nine-digit code when required per the CMS ZIP code file) of where the service was provided for services performed in all places of service, including POS home – 12, (and any other POS that contractors at their discretion consider to be home). Your carrier or A/B MAC will use that ZIP code to determine the correct payment locality.

Additionally, please remember that you cannot submit the CMS-1500 with more than one POS. Separate CMS-1500 claims must be submitted for each POS. Your carrier or A/B MAC will return as unprocessable such claims if you include more than one POS.

When returning these claims with more than one POS, Medicare contractors will use the following claims adjustment reason code (CARC) and remittance advice remark codes (RARCs):

- **CARC 16** – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- **RARC M77** – Missing/incomplete/invalid place of service.
- **RARC MA130** – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When returning claims for failing to include the address where the service was performed, Medicare contractors will use the following CARC and RARCs:

- **CARC 16** – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- **RARC MA114** – Missing/incomplete/invalid information on where the services were furnished.
- **RARC MA130** – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note that claims submitted on the 4010A1 version of the electronic claim form are not affected by CR 6947.

Additional information

You may find the official instruction, CR 6947, issued to your carrier or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2041CP.pdf>.

You will find the revised *Medicare Claims Processing Manual* Chapter 1 (General Billing Requirements), Sections 10.1.1 (Payment Jurisdiction Among Contractors for Services Paid Under the Physician Fee Schedule and Anesthesia Services), 10.1.1.1 (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004), and 80.3.2.1.2 (Conditional Data Element Requirements for Carriers and DMERCs) as an attachment to that CR.

Revisions to claim processing instructions for services rendered in place of service home (continued)

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

MLN Matters® Number: MM6947 *Revised*

Related Change Request (CR) #: 6947

Related CR Release Date: August 31, 2010

Effective Date: For claims processed on or after January 1, 2011

Related CR Transmittal #: R2041CP

Implementation Date: January 3, 2011

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Face validity assessment of advance beneficiary notice for complex medical record review

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

All providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare administrative contractors (A/B MACs) and durable medical equipment (DME) MACs) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6988. This CR advises contractors about the addition of Section 3.15, ABN and Complex Medical Record Review, to Chapter 3 of the *Medicare Program Integrity Manual (PIM)*. This addition directs contractors to request, as part of the additional documentation requests (ADRs), required advance beneficiary notices (ABNs) when performing a complex medical record review on all claims. Please ensure that your staffs are aware of this change.

Background

Requesting required ABNs on all claims undergoing complex medical record reviews and conducting face validity assessments of mandatory ABNs will assist in ensuring that liability is assigned appropriately in accordance with the Limitation on Liability Provisions of Section 1879 of the Social Security Act.

The instructions in the *Medicare Claims Processing Manual* Chapter 30 Section 50.6.3 address how to complete an ABN. In CR 6563, Healthcare Common Procedure Coding System (HCPCS) level II modifiers have been updated in order to distinguish between voluntary and required uses of liability notices. The *MLN Matters®* article related to CR 6563 may be viewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM6563.pdf>.

Additional information

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

The official instruction, CR 6988, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R361PI.pdf>.

MLN Matters® Number: MM6988

Related Change Request (CR) #: 6988

Related CR Release Date: December 10, 2010

Effective Date: January 12, 2011

Related CR Transmittal #: R361PI

Implementation Date: January 12, 2011

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Electronic Data Interchange

Claim adjustment reason code, remittance advice remark code update, and MREP update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

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

Provider action needed

Change request (CR) 7250, from which this article is taken, announces the latest update of remittance advice remark codes (RARC) and claim adjustment reason codes (CARCs), effective April 1, 2011. Be sure your billing staff is aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some Coordination-of-Benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November, although the Committee meets every month.

Both code lists are posted at <http://www.wpc-edi.com/Codes> on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7250.

Additional information

To see the official instruction (CR 7250) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to <http://www.cms.gov/Transmittals/downloads/R2131CP.pdf>.

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

New codes – CARC

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010

Modified codes – CARC

Code	Modified Narrative	Effective Date Per WPC Posting
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If an adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10

Claim adjustment reason code, remittance advice remark code update, and MREP update (continued)

Code	Modified Narrative	Effective Date Per WPC Posting
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	10/17/2010
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Deactivated codes – CARC

None

New codes – RARC

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

*Claim adjustment reason code, remittance advice remark code update, and MREP update (continued)***Modified codes – RARC**

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated codes – RARC

None

MLN Matters® Number: MM7250

Related Change Request (CR) #: 7250

Related CR Release Date: January 7, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2131CP

Implementation Date: April 4, 2011

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Medicare Remit Easy Print enhancement

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

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

What you need to know

The MREP software is made available to Medicare providers who may want to use the software to print their electronic remittance advice records without having to purchase software on their own. The latest enhancement to the MREP software is that, effective July 1, 2011, the software is being modified to be compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. If you wanted to use the MREP software, but have not done so because it was not compatible with your computer's operating system, this enhancement may make MREP a viable option for you.

Background

The Centers for Medicare and Medicaid Services (CMS) recently learned that the current version of MREP is not compatible with anything other than Microsoft XP (32 bit) operating system. Change request (CR) 7218 will make the MREP software compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit), operating systems. CMS expects that making the software

compatible with multiple operating systems will make it more acceptable to users and providers/suppliers for printing their electronic remittance advice (ERA) records.

Additional information

The official instruction, CR 7218 issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R811OTN.pdf>.

To learn more about this software, visit http://www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp.

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

MLN Matters® Number: MM7218

Related Change Request (CR) #: 7218

Related CR Release Date: November 12, 2010

Effective Date: July 1, 2011

Related CR Transmittal #: R811OTN

Implementation Date: July 5, 2011

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Claim status category and claim status code update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

All physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHII), carriers, Part A/B Medicare administrative contractors (MAC) and durable medical equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 7259, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the January 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at <http://www.wpc-edi.com/content/view/180/223/> on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 4, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status category codes 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 and 005010X212). CMS has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. 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

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

The official instruction, (CR 7259), issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2120CP.pdf>.

MLN Matters® Number: MM7259
 Related Change Request (CR) #: 7259
 Related CR Release Date: December 17, 2010
 Effective Date: April 1, 2011
 Related CR Transmittal #: R2120CP
 Implementation Date: April 4, 2011

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

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

Important implementation reminders

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

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

http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf

Readiness assessment: What do you need to have in place to test with your Medicare administrative contractor (MAC)?

http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf

Reminder: 5010/D.0. errata requirements and testing schedule can be found here

http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf

Reminder: Contact your MAC for their testing schedule

http://www.cms.gov/Versions5010andD0/Downloads/Reminder-Contact_MAC.pdf

Implementation calendar

January 2011

January 1: Beginning of transition year

January 11: Healthcare Information and Management Systems Society (HIMSS) 5010 industry readiness update *
<http://www.himss.org/asp/UnknownContent.asp?type=evt>

January 19: 5010 national call – errata/companion guides
<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10>

January 25-27: 4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation *
<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029>

Upcoming items

February 2011

February 20-24: HIMSS 11th Annual Conference & Exhibition *

<http://www.himss.org/ASP/eventsHome.asp>

March 2011

March 30: 5010 national call – provider testing and readiness

April 2011

TBD: MAC hosted outreach and education session – are you ready to test?

HIPAA 5010 & D.O. – implementation calendar and important reminders (continued)**May 2011**

May 2-5: 20th Annual WEDI National Conference *
<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1>
 May 25: 5010 national call – topic to be determined

June 2011

TBD: National MAC testing day (for vendors, clearinghouses, and billing services, etc)

July 2011

TBD: MAC hosted outreach and education session – troubleshooting with your MAC

August 2011

August 31: 5010 national call – MAC panel
 TBD: National MAC testing day (for providers)

October 2011

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

December 2011

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

Past items**June 2010**

June 15: 5010 national call – ICD-10/5010 national provider call
<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10>

June 30: 5010 national call – 837 institutional claim transaction
<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1236487&intNumPerPage=10>

July 2010

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

August 2010

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

September 2010

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

October 2010

October 13: 5010/D.O. errata requirements and testing schedule released
<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10>

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

November 2010

November 4: Version 5010 resource card published
http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf

November 8: WEDI 2010 fall conference *
<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C>

November 17: 5010 national call – coordination of benefits (COB)
<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241427&intNumPerPage=10>

December 2010

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

For older national call information, please visit the 5010 national calls section of CMS' versions 5010 & D.O. Web page
<http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage>

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

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Source: CMS PERL 201101-32

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Reminder: Contact your contractor for specific testing schedules for HIPAA version 5010 & D.0. transactions

Medicare fee-for-service (FFS) contractors will be ready to test the base versions of all transactions in January 2011 and the 5010/D.0. errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, visit the “Downloads” section at <http://www.cms.gov/ElectronicBillingEDITrans>. For more information on testing protocols for 2011, visit http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

Only the base versions of the transactions will be available for testing in January 2011. Errata versions will be ready for testing in April 2011. A trading partner must be tested and approved on the errata versions before being moved into production.

Background: The standards development organizations have made corrections to the 5010 and D.0. versions of certain transactions. The “errata” versions replace the base versions for HIPAA compliance. HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. The compliance date is January 2012.

Table 1. Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) version D.0. of the Telecom Standard	D.0	D.0 April 2009

Medicare FFS Timeline for 5010/D.0 Implementation

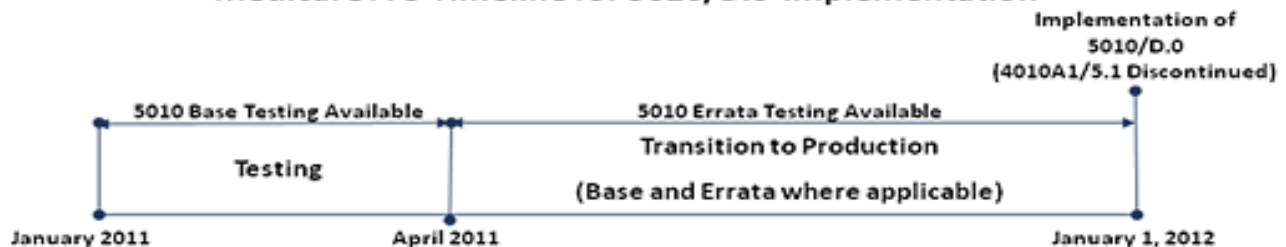


Figure 1. Medicare FFS timeline for 5010/D.0. implementation: 1) Testing on base versions to begin in January 2011, 2) Testing and transition to production on errata version to begin in April 2011, and 3) Implementation of 5010/D.0. on January 1, 2012.

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

Source: CMS PERL 201012-40

Reminder: Implementation of HIPAA version 5010 & D.0. transactions

The Centers for Medicare & Medicaid Services (CMS) would like to remind you of the following important message:

The purpose of this message is to clearly communicate the approach that Medicare fee-for-service (FFS) is taking to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) new versions of the Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP) electronic data interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0. versions of certain transactions. The errata versions replace the base versions for HIPAA compliance. Per the *Federal Register* (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at <http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf>), HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. Compliance with the errata must be achieved by the original regulation compliance date of January, 2012.

Table 1. Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) version D.0. of the Telecom Standard	D.0.	D.0. April 2009

Medicare FFS will implement the errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January 2011.

Testing

Medicare FFS contractors will be ready to test the base versions of all transactions in January 2011, and the 5010/D.0 errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. See <http://www.cms.gov/ElectronicBillingEDITrans/> under downloads, to find a Medicare FFS contractor in your state. For more information on testing protocols for 2011 see http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

Production

The errata versions will be available for Medicare FFS production in April 2011. The errata transactions must be tested before using them for production. As a result, Medicare FFS 5010/D.0 test-to-production transition will begin in April 2011.

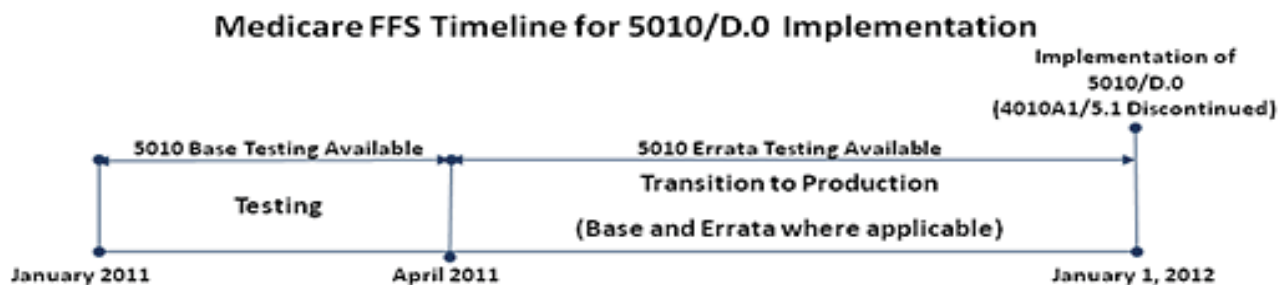


Figure 1. Medicare FFS timeline for 5010/D.0. implementation: 1) Testing on base versions to begin in January 2011, 2) Testing and transition to production on errata version to begin in April 2011, and 3) Implementation of 5010/D.0. on January 1, 2012.

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

Source: CMS PERL 201012-19

Revision request for the adopted ASC X12 version 5010

On January 1, 2012, all Health Insurance Portability and Accountability Act of 1996 (HIPAA)-covered entities are required to use the adopted ASC X12 version 5010 (version 5010) standard for electronic health care transactions, known as the ASC X12 type 3 technical reports (TR3) or implementation guides.

Even though version 5010 has not yet been implemented, the work of the standards organization is ongoing. At this time, ASC X12 is giving stakeholders an opportunity to review and comment on the version 5010 implementation guide so that modifications can be made for the next version – 6020. Stakeholder input and consensus is critical, to ensure that the standards meet the needs of all who use them, and to increase the use of electronic commerce in health care. All interested parties and stakeholders are encouraged to submit recommendations for improvements to X12.

Revision requests and recommendations should be submitted through the designated standard maintenance organization (DSMO) website, <http://www.hipaa-dsmo.org>. The deadline to submit revision requests for the ASC X12 005010 TR3 is February 4, 2011. It is imperative to have all comments submitted by this deadline for them to be considered in the development of version 6020. Please share this notification with others in your own association or network as soon as possible.

While stakeholders are encouraged to respond to X12's request and participate in the standards process to the fullest extent feasible, this notification is not an indication of the Centers for Medicare & Medicaid Services' intent to adopt version 6020 at this time.

New versions of standards must complete the standard development organization's (SDO) balloting processing, be considered and recommended by the National Committee on Vital and Health Statistics (NCVHS), and then adopted through the notice and public comment rulemaking process before they can be adopted as HIPAA standards.

For more information, please visit <http://www.x12.org/TR3ChangeRequest> or <http://www.hipaa-dsmo.org>.

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Source: CMS PERL 201012-20

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Discover the benefits of electronic remittance advice

Do you receive standard paper remittance (SPR) advices?

Currently, 96 percent of the providers in the First Coast Service Options Inc. (FCSO) jurisdiction 9 (J9) submit their claims electronically. However, FCSO's records also show that 20 percent of all the Part A remittance advices and 40 percent of all the Part B remittance advices are sent to providers as paper instead of in an easy-to-use electronic format.

Why not "go electronic"?

Here are a few benefits to receiving electronic remittance advice (ERA):

- Receive your remittances the day the claim finalizes
- Reduce costs associated with:
 - Storage and maintenance of SPRs
 - Staff time to review and file SPRs

The Centers for Medicare & Medicaid Services (CMS) provides free software for you so that you can download, view, and print duplicate copies of Part A or B electronic remittances whenever you wish. If you currently submit your claims electronically and are not set up for electronic remittance, please complete the electronic data request form, available at http://medicare.fcso.com/EDI_forms/138245.pdf, prior to downloading the free software.

How do you get this free software?

- For Part A providers, download PC-Print Software http://medicare.fcso.com/PC-print_software/
- For Part B providers, download MREP software <http://medicare.fcso.com/MREP/>.

Your time and money are valuable. Save both by downloading the software for electronic remittance advices today.

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at <http://medicare.fcso.com/PDS/>.

Incentive Programs

Registration for Medicare & Medicaid EHR incentive programs now open

The Centers for Medicare & Medicaid Services (CMS) encourages eligible professionals, eligible hospitals, and critical access hospitals to register for the Medicare and/or Medicaid EHR incentive program(s) as soon as possible. You can register before you have a certified EHR. Register even if you do not have an enrollment record in the provider enrollment, chain and ownership system (PECOS).

The registration and attestation page (http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp) on the EHR Web page now contains the following:

- Instructions to promote a smooth registration process
- User guides
- Link to the registration site

Click on the tabs to the left of this page for more general information 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 201101-13

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First payments issued under the Medicaid EHR incentive program

The first payments under the Medicaid electronic health record (EHR) incentive program were issued by Oklahoma and Kentucky on January 5. Kentucky processed payment to the University of Kentucky's teaching hospital, University of Kentucky Healthcare. The first payment, \$2.86 million, was one-third of the hospital's overall expected amount for participating in the program. Oklahoma issued payments to two physicians at the Gastorf Family Clinic of Durant, Okla. for \$21,250 each, for having adopted certified EHRs. These incentive payments for the adoption of certified EHR technology are federally-funded under the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009.

For additional information on these actions by Oklahoma and Kentucky, please visit their websites:

<http://www.okhca.org/EHR-incentive> and <http://chfs.ky.gov/dms/EHR.htm>.

For more information on the Medicare and Medicaid electronic health records incentive programs, please visit CMS' EHR website at <http://www.cms.gov/EHRIncentivePrograms/>.

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

Source: CMS PERL 201101-19

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Electronic health records incentives – registration opens

Resources outlined to assist eligible providers

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced the availability of registration for the Medicare and Medicaid electronic health record (EHR) incentive programs. CMS and ONC encouraged broad participation and outlined online and in-person resources that are in place to assist eligible professionals and eligible hospitals who wish to participate.

Beginning January 3, 2011, registration will be available for eligible health care professionals and eligible hospitals who wish to participate in the Medicare EHR incentive program. Registration in the Medicaid EHR incentive program is available in Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. In February, registration will open in California, Missouri, and North Dakota. Other states likely will launch their Medicaid EHR incentive programs during the spring and summer of 2011.

“With the start of registration, these landmark programs get underway, and patients, providers, and the nation can begin to enjoy the benefits of widespread adoption of electronic health records,” said CMS Administrator Donald Berwick, MD. “CMS has many resources available to help providers register and participate, and we look forward to working with eligible professionals and eligible hospitals to facilitate the process, beginning on January 3 and going forward.”

“It's time to get connected,” said David Blumenthal, MD, MPP, National Coordinator for Health Information

Electronic health records incentives – registration opens (continued)

Technology. “ONC and CMS have worked together over many months to prepare for the startup on January 3. ONC’s Certified HIT Product List (<http://onc-chpl.force.com/ehrcert>) includes more than 130 certified EHR systems or modules and is updated frequently. ONC also has hands-on assistance available across the country through 62 Regional Extension Centers (<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2>). We look forward to continuing to work with CMS to assist eligible providers in 2011 and future years.”

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR incentive programs. They can do so, starting January 3, 2011, at a registration site maintained by CMS.

To prepare for registration, interested providers should first familiarize themselves with the incentive programs’ requirements by visiting CMS’ official Web page for the Medicare and Medicaid EHR incentive programs (<http://www.cms.gov/ehrincentiveprograms/>). The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

CMS announced the following key dates for the Medicare and Medicaid incentive programs’ first year:

- January 3, 2011 – registration for the Medicare EHR incentive program begins.
- January 3, 2011 – states that are ready may launch their incentive programs for Medicaid providers.
- January 2011 – some state agencies begin issuing Medicaid EHR incentive payments.
- April 2011 – attestation for the Medicare EHR incentive program begins.
- May 2011 – issuing of Medicare EHR incentive payments expected to begin.
- July 3, 2011 – last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR incentive program for federal FY 2011.
- September 30, 2011 – federal FY 2011 payment year ends at midnight for eligible hospitals and critical access hospitals (CAHs).
- October 3, 2011 – last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 to demonstrate meaningful use for the Medicare EHR incentive program.
- November 30, 2011 – last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for federal fiscal year 2011.
- December 31, 2011 – calendar 2011 payment year ends for eligible professionals.

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, Medicare and Medicaid incentive payments will be available to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) when they adopt certified EHR technology and successfully demonstrate “meaningful use” of the technology in ways that improve quality, safety, and effectiveness of patient-centered care.

Professionals who meet the eligibility requirements for both the Medicare and Medicaid EHR incentive programs must select which program they wish to participate in when they register. They cannot participate in both programs; however, after receiving payment, they may change their program selection once before 2015. Hospitals that are eligible for both programs can receive payments from both Medicare and Medicaid.

Some states will launch their Medicaid EHR incentive programs beginning Jan. 3, 2011, but most will launch their programs during the spring and summer. Eligible providers with questions about their state’s launch date should contact their state Medicaid agency. Eligible providers seeking to participate in the Medicaid programs must initiate registration at CMS’ registration site but must complete the process through an eligibility verification site maintained by their state Medicaid agency.

Under the EHR incentive programs, eligible professionals can receive as much as \$44,000 over a five-year period through Medicare. For Medicaid, eligible professionals can receive as much as \$63,750 over six years. Under both Medicare and Medicaid, eligible hospitals may receive millions of dollars for implementing and meaningfully using certified EHR technology.

“The benefits of EHRs are widely recognized, and support for the incentive programs is strong in the health care field and among policymakers,” Dr. Berwick said. “The changeover from paper to electronic records will be challenging for clinicians and hospitals, but CMS and ONC have taken steps to ease the transition. We’ve provided flexibility in meeting the meaningful use requirements, both agencies have conducted extensive outreach, and we have the resources in place to help providers acquire certified EHR technology and meet the programs’ requirements. Immediate registration is not required, but we encourage eligible providers to sign up as soon as they have certified EHR technology and are prepared to participate. We are ready to help.”

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Source: CMS PERL 201012-37

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Electronic health records incentive programs – information about provider registration

Registration opened on January 3, 2011 – are you ready? The new electronic health records (EHR) Web page may help. CMS is happy to announce an updated, reorganized, and more user-friendly website for the EHR incentive programs, still located at <http://www.CMS.gov/EHRIncentivePrograms>. Highlights of this update are described in this message.

You are encouraged to register for the Medicare and/or Medicaid EHR incentive programs as soon as possible. You can register before you have a certified EHR and should do so even if you do not have an enrollment record in PECOS.

- **Hospitals:** Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select “Both Medicare and Medicaid” during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select “Both Medicare and Medicaid” from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated, and this may cause significant delays in receiving a Medicare EHR incentive payment.
- **Eligible professionals:** Professionals eligible for both the Medicare and Medicaid EHR incentive programs must choose which incentive program they wish to participate in when they register. Until 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR incentive program.
- **Registration:** Learn how you can prepare at registration. This is also where you will find the link to register. Information on when registration will be available for Medicaid EHR incentive programs in specific states is posted at Medicaid state information.

Highlights of the Web update include:

- **Path to payment:** What steps must you take to receive an EHR incentive payment? Review this page to find out.
- **Meaningful use:** What is “meaningful use?” What are the criteria for meaningful use? How do I meet the meaningful use requirements? Learn answers to these questions and more. The EHR page now includes meaningful use objectives specification sheets for the Medicare and Medicaid EHR incentive programs. These bring together critical information on each objective to help eligible professionals and eligible hospitals/critical access hospitals understand what they need to do to demonstrate meaningful use successfully.
- **Educational materials:** Want to learn about eligibility, payment, and meaningful use? See these educational products to learn more.
- **Frequently asked questions:** Have questions? See these responses to frequently asked questions on topics including eligibility, program timeline, and meaningful use.

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

Source: CMS PERL 201012-43

2011 electronic prescribing incentive program update

Beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment to services covered under the Medicare Part B physician fee schedule. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx incentive program.

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

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

Note: Earning an eRx incentive for 2011 will not necessarily exempt an eligible professional or group practice from the payment adjustment in 2011.

How to avoid the 2012 eRx payment adjustment

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

2011 electronic prescribing incentive program update (continued)

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in NPPEs
- Does not have prescribing privileges. Note: He/she must report (G8644) at least one time on an eligible claim prior to June 30, 2011
- Does not have at least 100 cases containing an encounter code in the measure denominator
- Becomes a successful e-prescriber, and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.
- Group practices – for group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice must become a successful e-prescriber.
- Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the "Getting Started" Web page at <http://www.cms.gov/erx incentive> or download the *Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program* under *Educational Resources*.

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

Source: CMS PERL 201012-36

Medicare Contractor Satisfaction Survey

CMS launches the 2011 Medicare Contractor Provider Satisfaction Survey

It's that time again – time for you to let your voice be heard. The Centers for Medicare & Medicaid Services (CMS) has launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare for-service (FFS) providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions:

- Provider inquiries
- Provider outreach & education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers themselves may not be able to respond directly to the survey but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization that is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS.

If you are selected to participate, please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes. You may also respond by mail, fax, or telephone.

CMS is listening and wants to hear from you.

To learn more about the MCPSS, please visit the CMS website at <http://www.cms.gov/MCPSS>. If you have any questions or concerns, please call our toll-free MCPSS Provider Helpline number at 1-800-654-1431 or send an e-mail to MCPSS_survey@scimetrika.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 201101-08, 201012-18

General Information

2011 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing is available on the FCSO Medicare website at <http://medicare.fcso.com/MEDPARD/>.

Source: Pub 100-04, Transmittal 2070, CR 7157

CMS expands health care provider directory Launches first phase of physician compare website

More information for consumers including data about quality of care

The Centers for Medicare & Medicaid Services (CMS) enhanced the physician directory tool at www.medicare.gov December 30, 2010, with new information about physicians and other health care workers in their communities and the services those professionals provide.

The new feature, called physician compare, expands and updates CMS' health care provider directory, which has helped millions of beneficiaries find Medicare-participating doctors online for over a decade. The new tool expands the doctor-specific information into the suite of informational tools for Medicare beneficiaries and other consumers.

"The new Physician Compare tool begins to fill an important gap in our online tools by providing more information about physicians and other healthcare workers," said Donald Berwick, M.D., CMS administrator. "This helps to pave the way for consumers to have similar information about their physicians as they have for nursing homes, home health agencies and health and drug plans."

The new site, at www.medicare.gov/find-a-doctor, which was required by the Affordable Care Act of 2010, contains information about physicians enrolled in the Medicare program, which include doctors of medicine, osteopathy, optometry, podiatric medicine, and chiropractic. The site also contains information about other types of health professionals who routinely care for Medicare beneficiaries, including nurse practitioners, clinical psychologists, registered dietitians, physical therapists, physician assistants, and occupational therapists.

The physician compare website is designed to be consumer friendly and help all patients -- whether on Medicare or not -- locate health professionals in their communities. The information on the site includes contact and address information for offices, the professional's medical specialty, where the professional completed his or her degree as well as residency or other clinical training, whether the professional speaks a foreign language, and the professional's gender. The tool can also help Medicare beneficiaries identify which physicians participate in the Medicare program.

In addition to information about the physician's practice, physician compare also shows consumers whether the practice reported certain data to CMS through the physician quality reporting system, formerly known as the physician quality reporting initiative (PQRI). Currently, the PQRI reporting system is a voluntary reporting program that rewards physicians and other eligible health care professionals for reporting data on quality measures related

to services furnished to Medicare beneficiaries. These quality measures are based on the best available medical evidence and designed to help professionals improve care for patients. In 2009, over 200,000 professionals reported data to CMS through the physician quality reporting system.

Later in 2011, CMS plans a second phase of the website which will indicate whether professionals chose to participate in a voluntary effort with the Agency to encourage doctors to prescribe medicines electronically, rather than through traditional paper-based prescription methods.

In future years, the physician compare website will be expanded with information about the quality of care Medicare beneficiaries receive from physicians and the other health care professionals profiled on the site. The expansion will include information on quality of care and patient experience that can help consumers learn more about the care provided by Medicare-participating physicians. CMS is required by the Affordable Care Act to develop a plan to implement this expansion by 2013.

"Today's release of Physician Compare moves us closer towards CMS' goal to improve the quality of healthcare for people with Medicare in all the places where they receive care, including the doctor's office," said Berwick. "By using a considered, step-wise approach to spotlighting quality of care, we can create a tool that will help doctors and patients for decades to come."

CMS has been working closely with health care stakeholders as it develops its future plans for the physician compare website, and will continue to do so through public meetings and forums, as well as through the regular processes to update the physician fee schedule.

To learn more about the quality information CMS already collects through Medicare's physician quality reporting system, visit <http://www.cms.gov/pqri>. To visit the physician compare website, visit www.medicare.gov/find-a-doctor or click on the compare tab at www.healthcare.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 201101-06

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Expansion of the current scope of editing for ordering/referring providers

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: This article was revised on January 12, 2011, to clarify that the Centers for Medicare & Medicaid Services (CMS) has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Recent revisions to change request (CR) 6417 require MACs to delay rejecting claims until receiving further direction from CMS. Some language in this article was also revised to be more aligned with language in the CR. This information was previously published in the December 2010 *Medicare B Update!* pages 35-36.

Provider types affected

Physicians, nonphysician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare administrative contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421 at <http://www.cms.gov/MLN MattersArticles/downloads/MM6421.pdf>.)

Provider action needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and nonphysician practitioners who are eligible to order/refer such services. Physician and nonphysician practitioners who order or refer must be enrolled in the Medicare provider enrollment, chain and ownership system (PECOS) and must be of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and nonphysician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of medicine or osteopathy
- Dental medicine
- Dental surgery
- Podiatric medicine
- Optometry
- Chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner

- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker

Claims that are the result of an order or a referral must contain the national provider identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key points

- **During phase 1 (October 5, 2009- until further notice):** When a claim is received, the multi-carrier system (MCS) will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that the claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.
- **During phase 2 (start date to be announced):** If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.
- **In both phases,** Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:

Expansion of the current scope of editing for ordering/referring providers (continued)

- Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf> on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
- Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage.
- I don't have an enrollment record. What should I do? Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and nonphysician Practitioners" at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

Please note: The changes being implemented with CR 6417 do not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. Please refer to the *Background* section, above, for more details.

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R825OTN.pdf>.

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

MLN Matters® Number: MM6417 *Revised*

Related Change Request (CR) #: 6417

Related CR Release Date: December 16, 2010

Effective Dates: Phase 1: October 5, 2009,

Related CR Transmittal #: R825OTN

Implementation Dates: Phase 1: October 5, 2009, Phase 2: to be announced

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

No date set for expanded ordering/referring provider claim edits

Due to recent inquiries, the Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding expanded ordering/referring provider claim edits. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the provider enrollment, chain, and ownership system (PECOS). CMS will give providers ample notice before claim rejections begin. Recent revisions to change requests 6417 (<http://www.cms.gov/transmittals/downloads/R825OTN.pdf>) and 6421 (<http://www.cms.gov/transmittals/downloads/R823OTN.pdf>) require Medicare administrative contractors to delay rejecting claims until receiving further direction from CMS.

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

Source: CMS PERL 201101-23

Do not forward initiative reminder

As part of the Do Not Forward (DNF) Initiative, the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to use "return service requested" envelopes for all provider remittance advice mailings.

This requirement applies to the provider Medicare checks and remittance advices. When a provider check or remittance advice is returned to the contractor because of "return service requested," the following will occur:

- The contractor will flag the provider number as DNF.
- Provider enrollment will be notified of provider's new status.
- The contractor will stop sending paper checks and remittance advices to the provider.
- Electronic fund transfers will be stopped.

Only upon verification and update of all the provider's addresses will the flag be removed. Not only will the "pay to" address be verified, but also all "provider location" addresses will be verified. It is important that providers notify Medicare immediately of any change of address by completing and submitting the CMS-855I Medicare Enrollment Application for individual providers, and the CMS-855B Medicare Enrollment Application for groups and organizations.

Once the DNF flag has been removed, the contractor will:

- Pay any funds held due to DNF
- Reissue any remittance notices held due to DNF.

Source: Publication 100-04, Chapter 22, Section 50.1

Medical nutrition therapy manual correction

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians and other providers, including home health agencies (HHAs) who bill Medicare carriers, fiscal intermediaries (FI), Medicare administrative contractors (A/B MAC), or regional home health intermediaries (RHHI) for providing medical nutrition therapy (MNT) services to Medicare beneficiaries.

What you need to know

Change request (CR) 7262, from which this article is taken, corrects an error in the “*Medicare Claims Processing Manual*”, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS)), Section 300 (Medicare Nutrition Therapy (MNT) Services), which incorrectly defines renal disease.

Specifically, the manual currently defines renal disease as “chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months”. CR 7262 corrects this “6 month” language to read “36 months”. All other information relating to MNT remains the same.

Additional information

You may find more information about MNT by going to CR 7262, located at <http://www.cms.gov/Transmittals/downloads/R2127CP.pdf>. You will find the corrected “*Medicare Claims Processing Manual*”, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS)), Section 300 (Medicare Nutrition Therapy (MNT) Services) as an attachment to that CR.

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

MLN Matters® Number: MM7262

Related Change Request (CR) #: 7262

Related CR Release Date: December 29, 2010

Effective Date: January 1, 2002

Related CR Transmittal #: R2127CP

Implementation Date: March 29, 2011

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Notice of interest rate for Medicare overpayments and underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2011) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been **changed to 11.25 percent, January 24, 2011**. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
January 24, 2011 to present	11.25%
October 22, 2010 – January 23, 2011	10.75%
July 21, 2010 – October 21, 2010	11.00%
April 23, 2010 – July 20, 2010	10.875%
January 25, 2010 – April 22, 2010	11.25%
October 22, 2009 – January 24, 2010	10.875%
July 17, 2009 – October 21, 2009	11.25%

Source: CMS Pub. 100-06, Transmittal 182, CR 7154

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 your Medicare billing? Accessible through FCSO’s PDS portal at <https://medicare.fcsso.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 specified 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 bottom line.

Prompt payment interest rate revision

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

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

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

Interest is not paid on:

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

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

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

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DMEPOS competitive bidding updates

There are three updates that will be of interest to the provider community regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

Information mailed to referral agents

The DMEPOS competitive bidding program went into effect for nine product categories in nine competitive bidding areas (CBAs) on January 1, 2011. When the program became effective, beneficiaries with original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

The nine product categories are:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (group 2 only)
- Mail-order diabetic supplies
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories, and
- Support surfaces (group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach, FL only).

The nine competitive bidding areas are:

- Charlotte-Gastonia-Concord, NC-SC
- Cincinnati-Middletown, OH-KY-IN
- Cleveland-Elyria-Mentor, OH
- Dallas-Fort Worth-Arlington, TX
- Kansas City, MO-KS

- Miami-Fort Lauderdale-Pompano Beach, FL
- Orlando-Kissimmee, FL
- Pittsburgh, PA
- Riverside-San Bernardino-Ontario, CA

It is crucial that health care professionals who order items included in the program understand how this program affects their Medicare patients so that Medicare will continue to pay for covered services. Therefore, the Centers for Medicare & Medicaid Services (CMS) began mailing a letter to referral agents in CBAs to remind them that the program started January 1, 2011. For purposes of the Medicare DMEPOS competitive bidding program, “referral agent” includes such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists who refer beneficiaries for services in a CBA. A copy of the letter is now available on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp.

Supplier locator tool updated for DMEPOS competitive bidding

CMS has updated its online supplier locator tool with new features for the DMEPOS competitive bidding program. Here’s how to access a list of DMEPOS competitive bidding contract suppliers for a particular beneficiary’s competitive bidding area using the updated online supplier locator tool:

Visit <http://www.Medicare.gov/supplier>.

- Enter the Medicare beneficiary’s zip code and click “Submit.”
- A list of product categories will appear; those product categories with a star icon next to them are included in the competitive bidding program.
- After selecting a competitive bidding product category, click “View Results.”

DMEPOS competitive bidding updates (continued)

- A page will display stating you've selected a competitive bidding product category and briefly explain the program; click "Continue."
- A list of all Medicare contract supplier locations in the competitive bidding area will appear.

A list of the CMS-designated Medicare DMEPOS competitive bidding program contract suppliers for each CBA may also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp.

DMEPOS Competitive Bidding Program "Repairs and Replacements Fact Sheet"

The DMEPOS Competitive Bidding Program "Repairs and Replacements Fact Sheet" is now available to download, free of charge, from the *Medicare Learning Network*[®].

Effective January 1, 2011, beneficiaries with original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception

applies. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired.

This fact sheet contains helpful information on competitive bidding program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services noncontract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, Scroll down to "Downloads," and select "DMEPOS Competitive Bidding Fact Sheets."

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

Source: CMS PERL 201012-29

The Pre-Existing Condition Plan – a new health coverage option for the uninsured

Are you providing care to uninsured patients who have a pre-existing condition and can't find health coverage? If so, a new federal program – the Pre-Existing Condition Insurance Plan – can change or save the lives of your patients who've been locked out of the health coverage market because of a medical condition.

This program does not base eligibility on income and enrollees receive comprehensive health coverage at the same price that healthy people pay.

To qualify for the program, applicants must meet the following criteria:

- Be a citizen of the United States or residing here legally
- Have been uninsured for at least six months, and
- Have a pre-existing condition or have been denied coverage because of a medical condition.

The Pre-Existing Condition Insurance Plan covers physician and hospital services and prescription drugs. All insurance benefits are available to enrollees – even to treat a pre-existing condition. Premiums vary by state and annual out-of-pocket expenses for enrollees are capped.

Each state may use different methods to determine whether a person applying for the Pre-Existing Condition Insurance Plan has a pre-existing condition or whether he or she has been denied health coverage. As such, people need to check on how to establish eligibility in their state. For more information about the Pre-Existing Condition Insurance Plan and how to apply, visit www.PCIP.gov or, between the hours of 8:00 a.m. and 11:00 p.m. ET, call 866-717-5826 (TTY: 866-561-1604).

Share this important new health coverage option with your patients and colleagues.

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

Source: CMS PERL 201101-30

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April 2011 release of modified HCPCS code set

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

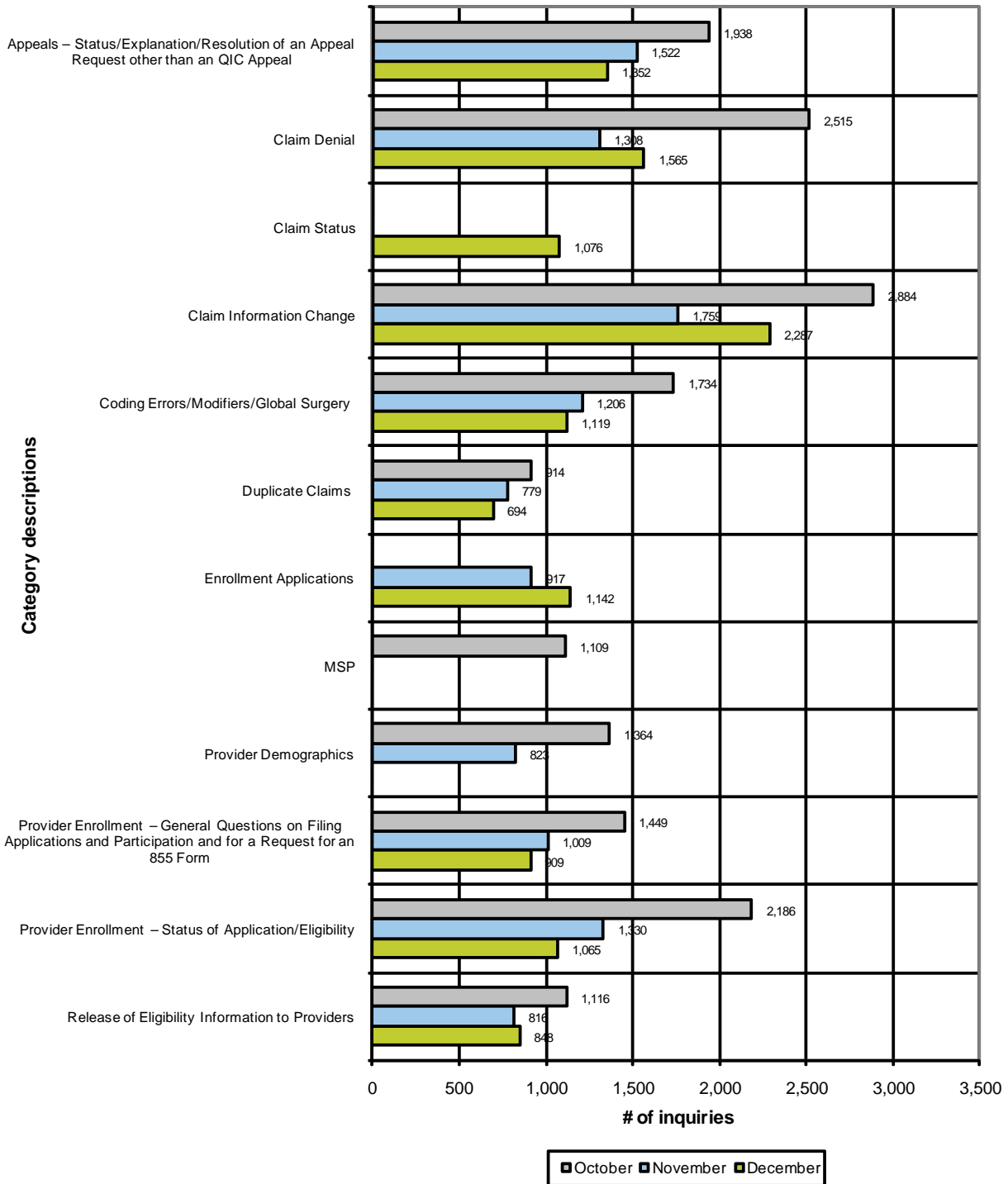
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201101-23

Top inquiries, denials, and return unprocessable claims for October-December

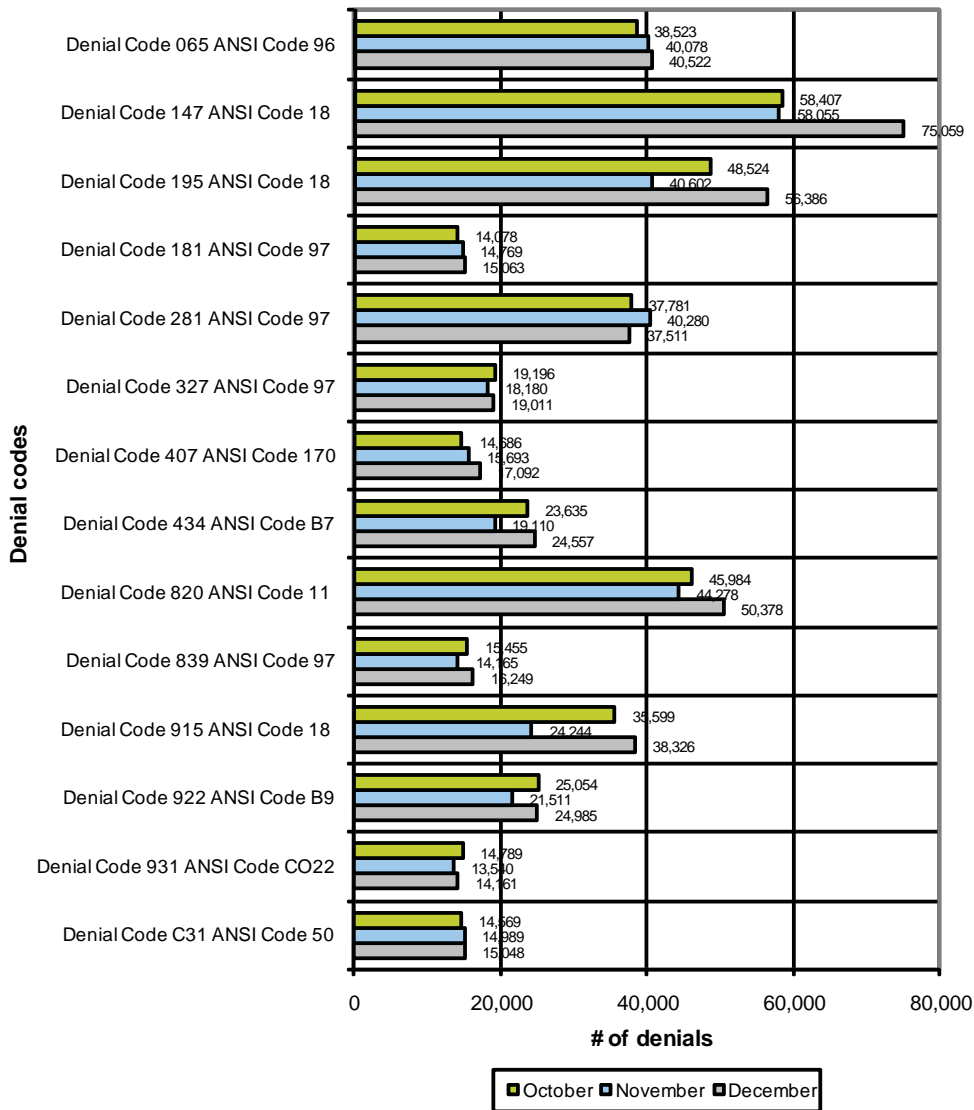
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during October-December 2010. For tips and resources to help you avoid or reduce the amount of time spent 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 October-December 2010



Top inquiries, denials, and return unprocessable claims for October-December 2010 (continued)

Florida Part B top denials for October-December 2010



Tips for avoiding duplicate denials

Before resubmitting a claim, check claims status through the Part B interactive voice response (IVR) system. Do not resubmit an entire claim when partial payment made; when appropriate, resubmit denied lines only. View frequently-asked questions (FAQs) regarding duplicate claims at <http://medicare.fcso.com/FAQs/138013.asp>.

Regarding evaluation and management (E/M) services, physicians in the same group practice of the same specialty must bill and be paid as though they were a single physician.

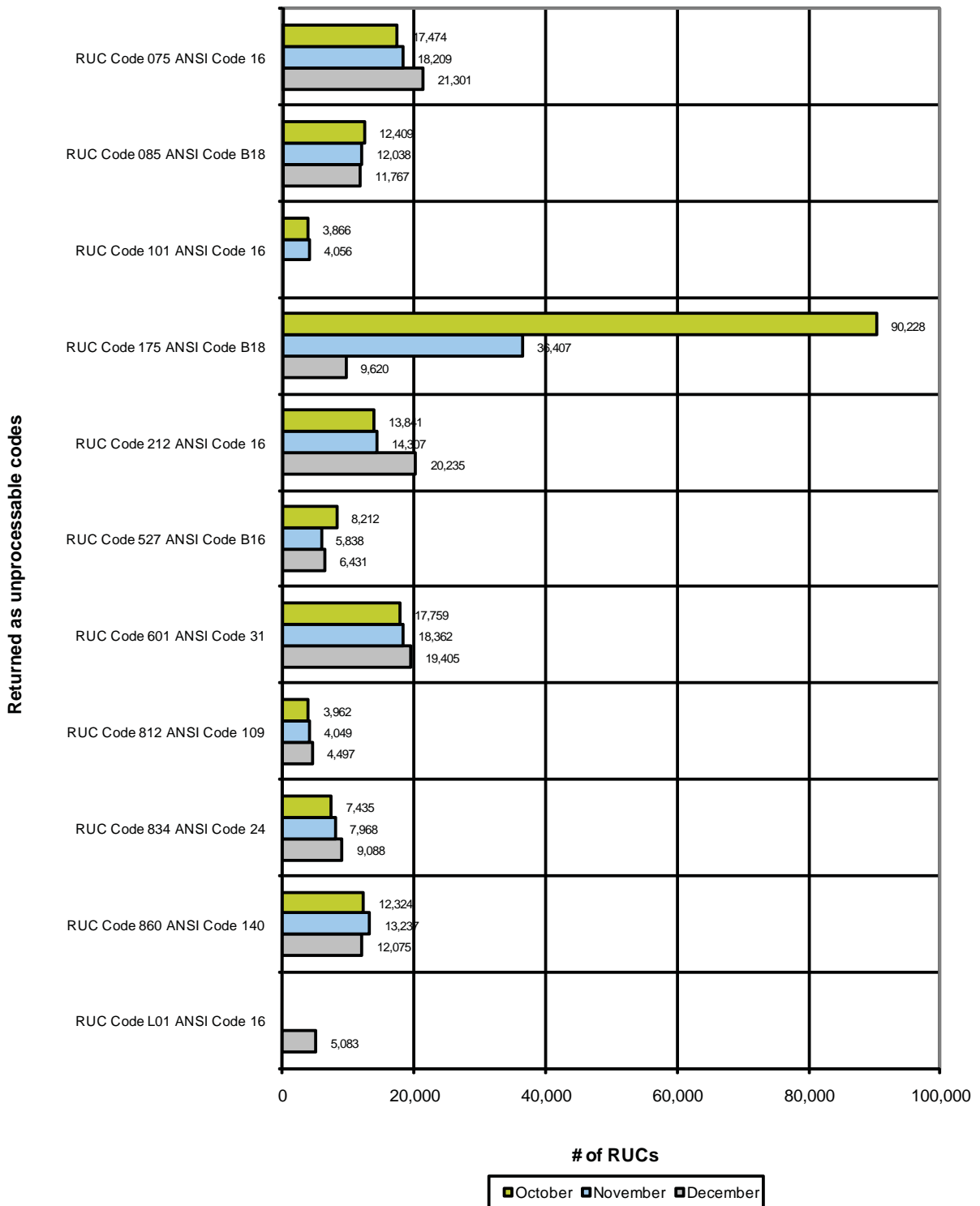
- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient by the same physician or by more than one physician of the same specialty in the same group, instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
- Physicians in the same group practice but who are in different specialties (e.g., a cardiologist and a general practice physician) may bill and be paid without regard to their membership in the same group.

FCSO also offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts or seminars on avoiding duplicate claims for Part B.

Visit the FCSO Events page at <http://medicare.fcso.com/Events/> to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

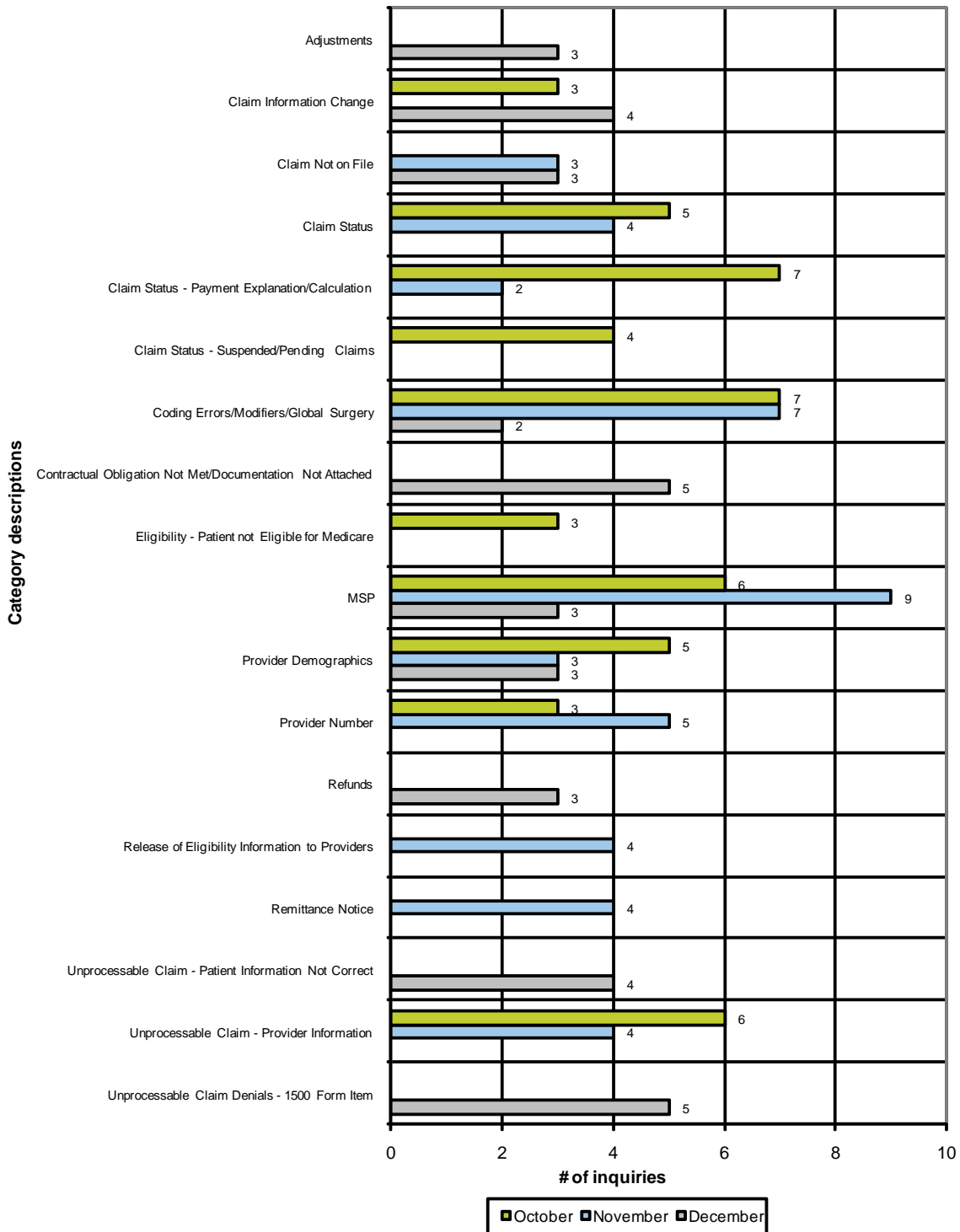
Top inquiries, denials, and return unprocessable claims for October-December 2010 (continued)

Florida Part B top return as unprocessable claims (RUC) for October-December 2010



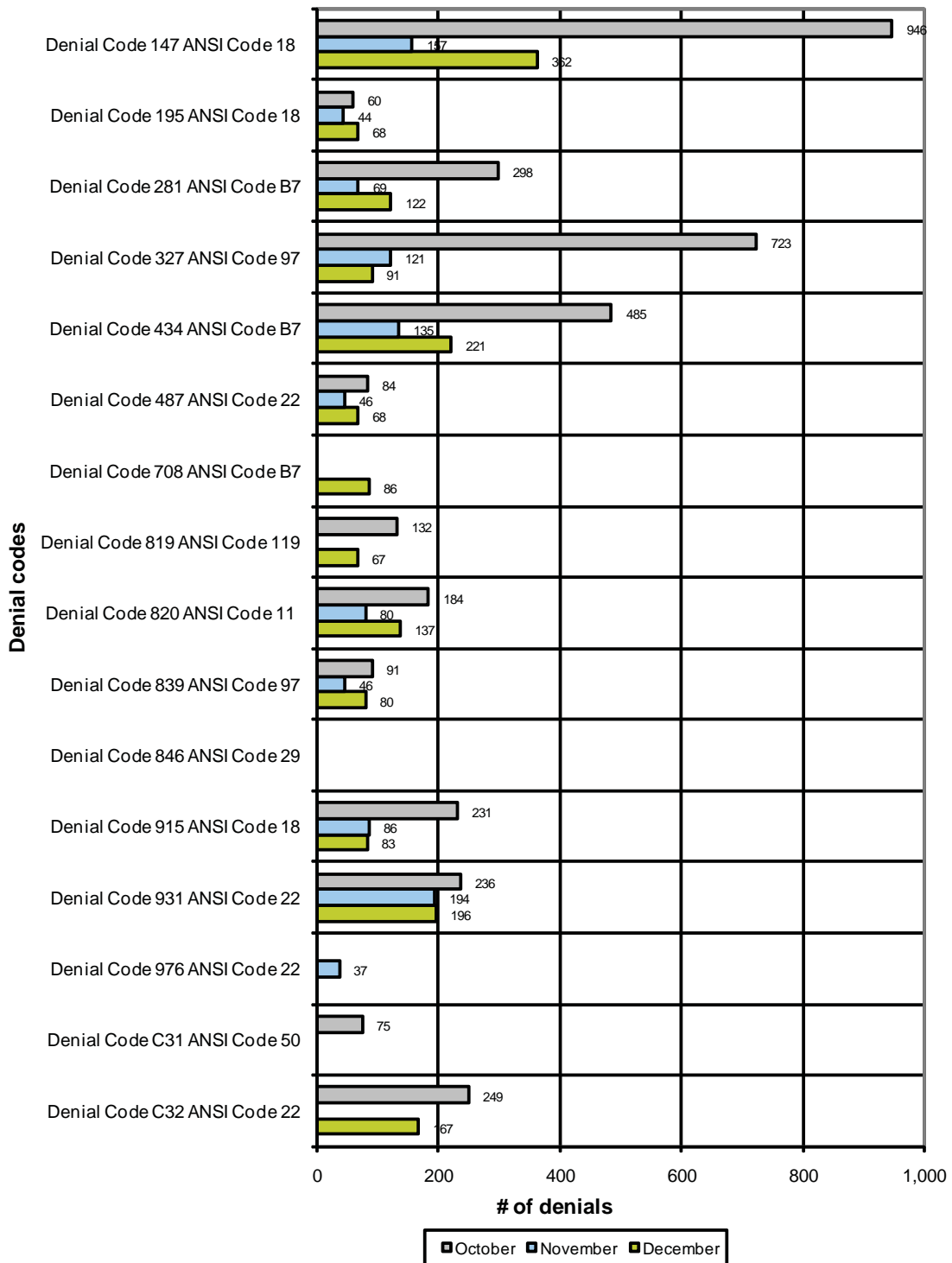
Top inquiries, denials, and return unprocessable claims for October-December (continued)

U.S. Virgin Islands Part B top inquiries for October-December 2010



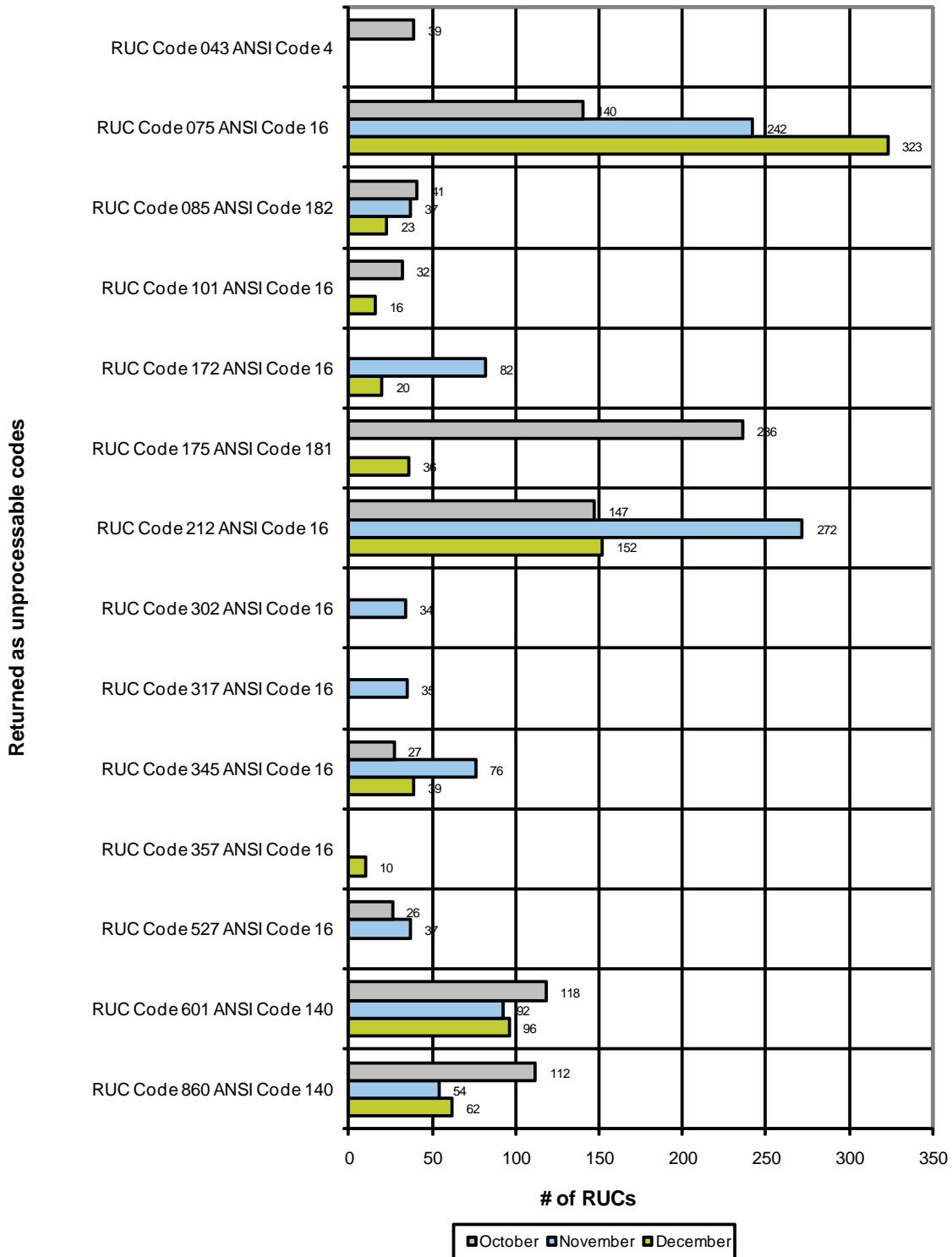
Top inquiries, denials, and return unprocessable claims for October-December 2010 (continued)

U.S. Virgin Islands Part B top denials for October-December 2010



Top inquiries, denials, and return unprocessable claims for October-December 2010 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for October-December 2010



Local Coverage Determinations

This section of the *Medicare B Update!* 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 that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (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 LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our website <http://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

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

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Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at http://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 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

J9010: Alemtuzumab (Campath®) – revision to the LCD

LCD ID number: L29055 (Florida)

LCD ID number: L29073 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for alemtuzumab (Campath®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, the approved Food and Drug Administration (FDA) indications were updated to read as follows:

Alemtuzumab (Campath®) is FDA approved as a single agent for the treatment of B-cell chronic lymphocytic leukemia (B-CLL).

In addition, the “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after January 11, 2011**, for services rendered **on or after September 19, 2007**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. 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.

J9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the LCD

LCD ID number: L29169 (Florida)

LCD ID number: L29423 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, the indication of neuroendocrine tumors (malignant poorly differentiated) was added under the off-labeled indications portion of the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. Also, under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM code 209.30 (Malignant poorly differentiated neuroendocrine carcinoma, any site) was added. In addition, the “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after January 21, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

Find fees faster: Try FCSO’s fee schedule lookup

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

Educational Events

Upcoming provider outreach and educational events February – March 2011

HIGLAS transition webcast

When: Wednesday, February 16
Time: 2:00 p.m.-3:00 p.m.

Virtual Medifest 2011

When: February 21-25
Time: 8:00 a.m.-5:00 p.m.

HIGLAS transition webcast

When: Tuesday, March 8
Time: 4:00-5:00 p.m.

Bimonthly Medicare Part B ACT: Medicare changes and hot issues

When: Wednesday, March 9
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.fcsomedicaretraining.com, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

The virtual event of the year

Now is the time to enter the virtual world of Medicare right from your office. Imagine a conference that has:

- No travel expenses
- Live, pre-recorded, and web-based training sessions right from your own computer
- Live question and answer sessions for selected sessions
- Total cost for YOU – free

So, get ready for one of the biggest events of 2011 as First Coast Service Options hosts the first Virtual Medifest conference **on February 21-25**. Registration has begun so be sure to navigate your way to FCSOMedicareTraining.com before sessions get full.

Preventive Services

Flu shot reminder

Flu season is here. While seasonal flu outbreaks may occur as early as October, they usually peak in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get your flu vaccine – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. 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, please visit

http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and <http://www.cms.gov/AdultImmunizations>.

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

Source: CMS PERL 201101-12

Other Educational Resources

2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the general equivalence mappings (GEMs), on the ICD-10 website at <http://www.cms.gov/ICD10>. See the links on this page for *2011 ICD-10-CM and GEMs* and *2011 ICD-10-PCS and GEMs*.

These updated files complete the requirements of Section 10109(c) of the Affordable Care Act of 2010. The Affordable Care Act required the Secretary of Health and Human Services to task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalks between ICD-9-CM and ICD-10 for the purpose of making appropriate revisions to said crosswalks. Section 10109(c) further requires that these revisions to the crosswalks be posted to the CMS website and treated as a code set for which the Secretary has adopted a standard.

In addition, CMS also has posted *ICD-10 GEMs 2011 Version Update, Update Summary*. This document describes the number of comments we received, the type of changes recommended, the types of changes made based on the comments, and the types of comments not accepted and reasons why some comments were not 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 201012-30

2011 Physician Quality Reporting System educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2011 Physician Quality Reporting System (PQRS) educational products on the PQRS Web page, which may be accessed at <http://www.cms.gov/PQRI>.

- *2011 Physician Quality Reporting System Measures List* – this document identifies and explains the measures used in physician quality reporting, including information on the reporting options/methods for each and if it is a patient-level measure. Measure developers and their contact information are also provided.
- *2011 Physician Quality Reporting System Quality-Data Code (QDC) Categories* – a table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual eligible professional as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require two or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the 2011 PQRS measure specifications) will result in invalid reporting.
- *2011 Physician Quality Reporting System Single Source Code Master* – this file includes a numerical listing of all codes included in 2011 physician quality reporting for incorporation into billing software.
- *2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes* – this zip file contains two documents which are the authoritative documents that describe 1) the 2011 measure specifications (including codes and reporting instructions) for the 194 individual physician quality reporting measures for claims or registry-based reporting and 2) changes from the 2010 program year measure specifications in the form of release notes delineated by measure number.
- *2010 Physician Quality Reporting System Implementation Guide* – provides guidance about how to implement 2011 physician quality reporting claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals.
- *2011 Physician Quality Reporting System Measures Groups Specifications Manual and Release Notes* – measures group specifications are different from those of the individual measures that form the group. The specifications and instructions for measures group reporting are, therefore, provided in a separate manual. This zip file contains two documents which are the authoritative documents that describe 1) the 2011 measures groups specifications (including codes and reporting instructions) for the 14 physician quality reporting measures groups for claims or registry-based reporting and 2) changes from the 2010 Measures Groups Specifications Manual in the form of release notes.
- *Getting Started with 2011 Physician Quality Reporting System of Measures Groups* – provides guidance on implementing the 2011 PQRS measures groups.
- *2011 Physician Quality Reporting System Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures* – provides guidance for those eligible professionals who satisfactorily submit quality-data codes for fewer than three physician quality reporting measures, and how the measure-applicability validation process will determine whether they should have submitted QDCs for additional measures.
- *2011 Physician Quality Reporting Measure-Applicability Validation Process Release Notes* – the release notes for the changes occurring for the 2011 physician quality reporting measure-applicability validation process (MAV).
- *2011 Physician Quality Reporting System Measure-Applicability Validation Process Flow* – a chart that depicts the MAV.
- *Group Practice Reporting Option I (GPRO I) Requirements for Submission of 2011 Physician Quality Reporting System Data* – provides guidance on how a large group practice of over 200 eligible professionals can self-nominate to participate in GPRO I for 2011 data submission.
- *2011 Physician Quality Reporting System Group Practice Reporting Option I (GPRO I) Measures List* – a document containing a list of the 2011 physician quality reporting GPRO I measures.
- *2011 Physician Quality Reporting GPRO I Narrative Measure Specifications and Release Notes* – this document contains descriptions of the 2011 physician quality reporting GPRO I measures and changes in the program since the 2010 reporting year.
- *Group Practice Reporting Option II (GPRO II) Requirements for Submission of 2011 Physician Quality Reporting System Data* – this document provides guidance on how a group practice ranging in size from 2-199 eligible professionals can self-nominate to participate in 2011 GPRO II for PQRS data submission.
- *Qualified EHR Vendors for the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Programs* – list of electronic health record (EHR) vendors and their programs that have become “qualified” to submit quality data to CMS by eligible professionals for 2011 PQRS reporting. Each of these EHR vendors has gone through a thorough vetting process for the product and version listed including checking their capability to provide the required PQRS data elements for the PQRS measures. Some EHRs are also capable of reporting the electronic prescribing measure. In addition to capturing the required data elements for the measure calculation, these “qualified” EHR products can also transmit the required information in the requested file format. While the listed EHR vendors and their EHR products

2010-2011 seasonal influenza resources for health care professionals (continued)

have successfully completed the vetting process, CMS cannot guarantee that any other product or version of software from the listed vendors will be compatible for EHR based submission for PQRS.

- **2011 EHR documents for eligible professionals** – this zipped file contains the following:
 - *2011 Physician Quality Reporting System EHR Measure Specifications* -- the detailed description of data element names and codes related to each of 20 2011 PQRS and eRx quality measures available for electronic submission.
 - *2011 Physician Quality Reporting System Physician Quality Reporting System EHR Measure Specifications – Release Notes* – the corresponding release notes for the 2011 EHR measure specifications.
 - 2011 EHR downloadable resource table
 - *2011 EHR Downloadable Resource Table – Release Notes*
- **2011 EHR documents for vendors** – this zipped file contains the following:
 - *Data Submission Specifications Utilizing HL7 QRDA Implementation Guide Based on HL7 CDA Release 2.0*
 - *Updated EHR Data Submission Specifications Utilizing QRDA – Release Notes* – release notes for data submission specifications utilizing HL7 quality reporting document architecture based on HL7 CDA release 2.0

- 2011 EHR downloadable resource table
- *2011 EHR Downloadable Resource Table – Release Notes*
- *Updated EHR Data Submission Specifications Utilizing QRDA Header Errors and Edits*
- *Updated EHR Data Submission Specifications Utilizing QRDA Body Errors and Edits*

To view the listing of educational products and their corresponding section pages, please visit the Spotlight section on the PQRS Web page at:

http://www.cms.gov/PQRI/02_Spotlight.asp.

Further information on the 2011 PQRS may be found in the 2011 Medicare physician fee schedule final rule with comment period (75 FR 73377 through 73621) that was published in the *Federal Register* on November 29, 2010. The final rule may be found on the CMS PQRS Web page at http://www.cms.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp. Click on the Statute/Regulations/Program Instructions section page on the left.

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

Source: CMS PERL 201101-17

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2011 electronic prescribing incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2011 electronic prescribing (eRx) incentive program educational products to the eRx Web page at <http://www.cms.gov/ERxIncentive>.

- *2011 eRx Measure Specifications and Release Notes* – provides guidance on the 2011 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the 2010 eRx measure specifications.
- *Claims-Based Reporting Principles for the 2011 eRx Incentive Program* – provides guidance on the principles for reporting the eRx measure on claims for the 2011 eRx incentive program.
- *2011 EHR Measure Specifications for eRx and Release Notes* – provides guidance on the 2011 electronic health record (EHR) measure specifications for eRx and release notes. In addition, the specifications contain a detailed description of data element names and codes.
- *2011 EHR Downloadable Resource Table and Release Notes* – an Excel spreadsheet and release notes listing 2011 EHR information.

- *2011 eRx Incentive Program GPRO I Measure Specifications and Release Notes* – provides guidance on the specifications for the eRx measure for use in 2011 eRx group practice reporting option (GPRO) I and release notes.

To view the listing of educational products and their corresponding section pages, please visit the Spotlight section on the eRx Web page at:

http://www.cms.gov/ERxIncentive/02_Spotlight.asp.

Further information on the 2011 eRx incentive program may be found in the 2011 Medicare physician fee schedule final rule with comment period (75 FR 73490 through 73610) that was published in the *Federal Register* on November 29, 2010. The final rule may be found on the Statute/Regulations/Program Instructions section page at http://www.cms.gov/ERxIncentive/04_Statute_Regulations.asp.

Reminder: Reporting for the 2011 eRx began January 1, 2011. There is no need to sign up or pre-register in order to participate.

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

Source: CMS PERL 201101-16

New fact sheets on DMEPOS competitive bidding

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Billing Procedures for Upgrades Fact Sheet* is now available to download, free of charge, from the *Medicare Learning Network*[®].

Beneficiaries with original Medicare who obtain competitively-bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This fact sheet contains helpful information on program rules that apply when a beneficiary wants to obtain an upgrade -- that is, an item or a component of an item that exceeds the beneficiary's medical need. It includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and advance beneficiary notice (ABN) requirements.

To view the fact sheet, please visit the "DMEPOS Competitive Bidding Educational Resources" page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Scroll to *Downloads* and select *DMEPOS Competitive Bidding Fact Sheets*.

Three new fact sheets on oxygen therapy supplies, positive airway pressure devices, and cardiac pacemakers

The *Medicare Learning Network*[®] has developed three new fact sheets to provide education on common comprehensive error rate testing (CERT) errors related to oxygen therapy supplies, positive airway pressure (PAP) devices, and cardiac pacemakers. These educational products are available in downloadable format at the URLs listed:

Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements – includes a checklist of the documentation needed to support claims submitted to Medicare for oxygen therapy supplies. For more details, visit http://www.cms.gov/MLNProducts/downloads/OxgnThrpy_DocCvg_FactSheet_ICN904883.pdf.

Cardiac Pacemakers – provides a list of common errors identified through the CERT review process and the covered indications for dual-chamber pacemakers. For more details, visit http://www.cms.gov/MLNProducts/downloads/CERT_Pmaker_FactSheet_ICN905144.pdf.

Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements – includes a checklist of the documentation needed to support claims submitted to Medicare for PAP devices. For more details, visit http://www.cms.gov/MLNProducts/downloads/PAP_DocCvg_FactSheet_ICN905064.pdf.

For additional resources that educate fee-for-service providers about common billing errors and other improper activities identified through CMS's claim review programs, including CERT, please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.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 201101-27

Fact sheet – DMEPOS Competitive Bidding Program Repairs and Replacements

The DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) Competitive Bidding Program is effective January 1, 2011. Beneficiaries with original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

The DMEPOS Competitive Bidding Program Repairs and Replacements fact sheet contains helpful information on the Competitive Bidding Program rules that apply when a DMEPOS item owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services noncontract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, scroll down to "Downloads," and select "DMEPOS Competitive Bidding Fact Sheets."

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

Source: CMS PERL 201012-44

New Web page for quality reporting for LTCHs, IRFs, and hospices

The Centers for Medicare & Medicaid Services (CMS) has created a Web page to support Section 3004 of the Affordable Care Act, Quality Reporting for Long Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs. This page has been created so the public can view information, and communications, related to Section 3004. This page is expected to expand as more information is provided. There is also provided a link for e-mailing comments, questions, or ideas to CMS pertaining to quality reporting and Section 3004.

The website link is: http://www.cms.gov/QualityInitiativesGenInfo/03_NewQualityReportingProgramsSection3004.asp
The e-mail address is (and can be found on the website): LTCH-IRF-Hospice-Quality-ReportingComments@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 201012-25

Glucose Testing Supplies: Complying with Documentation & Coverage Requirements fact sheet

The Medicare Learning Network® (MLN) would like to remind you that the *Glucose Testing Supplies: Complying with Documentation & Coverage Requirements* fact sheet has been developed to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to glucose testing supplies, which is currently one of the highest sources of CERT error rates. This fact sheet includes a checklist of the documentation needed to support claims submitted to Medicare for glucose testing supplies and is currently available in downloadable format at http://www.cms.gov/MLNProducts/downloads/GlucSup_DocCvge_FactSheet_ICN905104.pdf. Please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources that educate fee-for-service providers about common billing errors and other improper activities identified through the Centers for Medicare & Medicaid Services' claim review programs, including CERT.

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

Source: CMS PERL 201012-21

New Medicare Learning Network publications

The following publications are now available in print format from the Medicare Learning Network®. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

- *Hospice Payment System* (September 2010) – provides information about the coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees.
- *Comprehensive Outpatient Rehabilitation Facility* (July 2010) – provides information about basic, core and optional comprehensive outpatient rehabilitation facility (CORF) services, place of treatment requirements, rehabilitation plan of care requirements, and CORF payments.

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

Source: CMS PERL 201012-21

New tools to prevent and fight fraud

As part of the Obama Administration's ongoing efforts to prevent and fight fraud in our nation's health care system, U.S. Department of Health & Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder announced December 16 that the Centers for Medicare & Medicaid Services (CMS) would be acquiring new state-of-the-art fraud fighting analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid and the Children's Health Insurance Program.

Sebelius and Holder made the announcement at the University of Massachusetts, Boston at the fourth regional health care fraud prevention summit. The Attorney General and the HHS Secretary have crisscrossed the country this year bringing together a wide array of federal, state, and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud within the U.S. health care system.

As part of that summit, CMS will issue a solicitation for state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. These tools will integrate many of the Agency's pilot programs into the National Fraud Prevention Program and complement the work of the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT).

The recently-enacted Affordable Care Act provides additional tools and resources to fight fraud in the health care system by providing an additional \$350 million over the next ten years through the Health Care Fraud and Abuse Control Account. The Act toughens sentencing for criminal activity, enhances screenings and enrollment requirements, encourages increased sharing of data across government, expands overpayment recovery efforts, and provides greater oversight of private insurance abuses. For information on the 2009 Health Care Fraud and Abuse Control Program Report, please visit <http://www.justice.gov/dag/pubdoc/hcfareport2009.pdf>.

To read the entire HHS release issued on Thursday, December 16, 2010, please visit <http://www.hhs.gov/news/press/2010pres/12/20101216a.html>.

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

Source: CMS PERL 201012-28

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**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/prevaling charges or fee
schedule:**
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

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

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

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

**Phone numbers
Providers**

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

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

E-mail address: AskFloridaB@fcso.com
FAX: 1-904-361-0696

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

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

**Education event
registration (not toll-free):**
1-904-791-8103

**Electronic data
interchange (EDI)**
1-888-670-0940

- Option 1** -Transaction support
- Option 2** - PC-ACE support
- Option 4** - Enrollment support
- Option 5** - Electronic funds (check return assistance only)
- Option 6** - Automated response line

**DME, orthotic or prosthetic
claims**
Cigna Government Services
1-866-270-4909

Medicare Part A
Toll-Free:
1-866-270-4909

**Medicare websites
Provider**

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

**Centers for Medicare & Medicaid
Services**
www.cms.gov

**Beneficiaries
Centers for Medicare & Medicaid
Services**
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

Where to mail provider/supplier applications

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

Provider change of address

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

Educational purposes and review of customary/prevaling charges or fee schedule:

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address: AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services

1-866-270-4909

Medicare Part A

Toll-Free:

1-866-270-4909

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/ (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011.	40300260	Hardcopy \$33		
		CD-ROM \$55		
2011 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 11, 2011, are available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies or a CD-ROM are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy \$12		
		CD-ROM \$6		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

◆ ATTENTION BILLING MANAGER ◆