

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
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Medicare B Update!

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Publications staff

Terri Drury
 Cindi Fox
 Mark Willett
 Robert Petty

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.*

HIGLAS Transition

FCSO to transition to HIGLAS accounting system for Part B providers

On March 11, 2011, First Coast Service Options (FCSO) will be transitioning its Part B financial accounting system to the Healthcare Integrated General Ledger Accounting System (HIGLAS) for Florida, Puerto Rico, and U.S. Virgin Islands. HIGLAS is a CMS dual-entry accounting system that replaces only the current Medicare financial systems utilized by the Medicare administrative contractors.

Implementation of HIGLAS will enable the Centers for Medicare & Medicaid Services (CMS) to track Medicare payments and to accurately pay claims for over 40 million Medicare beneficiaries. HIGLAS will also provide CMS with enhanced oversight of contractors' accounting systems, as well as access to more accurate, timely, and consistent data for decision-making and for performance evaluations.

To ensure minimal disruption to you, please review this article with your appropriate staff to learn about the impacts and changes that this transition will have on your organization's Medicare payments. A detailed transition timeline is also provided.

Please note that this transition involves only FCSO's financial accounting system. This transition will not change the way you currently submit claims. FCSO and providers will continue to use the current claim processing system, multi-carrier system (MCS), for all claims processing activities.

Payment schedule interruption in March

To ensure a successful transition of the HIGLAS system, CMS has approved FCSO's waiver request to reduce the payment floor for both paper and electronic media claims (EMC). On **March 8-9**, the payment floor was reduced to zero for both EDI and paper claims. This means that during these two cycles, FCSO released payments for all claims already approved to pay.

This temporary payment floor reduction will result in two higher than normal payments, then lower payments over the next 10-14 days (March 14-25). This may give the appearance that your cash revenues have increased when in fact payments for some of your claims have been issued earlier than normal.

Providers are encouraged to monitor their payments and make adjustments as necessary to prevent cash flow problems during this time period.

Remittance advices impacts during transition

FCSO will not be issuing payments from **March 10-11**. Electronic remittance advices (ERAs) and paper RAs will not be available. FCSO will resume normal payment cycles and issuance of payments on **March 14** at which time providers will be able to retrieve their ERAs.

Claim processing impacts on federal holidays

Currently, FCSO's online claim processing system is available on federal holidays and FCSO processes claims on some federal holidays. With HIGLAS, FCSO's online system will continue to be available but claims will no longer be processed on federal holidays.

To review a list of federal holidays, visit medicare.fcso.com, select "Contacts" under "Popular Links," and click on 2011 holiday schedule link.

HIGLAS transition timeline

The HIGLAS transition will be completed and payment cycles will resume on Monday, March 14. For a summary of all key transition dates, please review the following timeline.

Date(s)	Activity
March 8-9	Released payments for all claims already approved to pay during these two payment cycles
March 9	Last MCS payment cycle (payment floor reduced to zero)
March 11	HIGLAS transition
March 10-11	No payments will be issued – ERAs and paper RAs are not produced
March 14	HIGLAS transition completed – payment floor reinstated, ERAs and RAs resume
March 14-25	Providers may experience significantly lower payments due to the early claim payments issued prior to transition.

Providers need to monitor and manage their cash flows during this time period.

FCSO to transition to HIGLAS accounting system for Part B providers (continued)

Additional changes with HIGLAS

Claim payments less than \$1.00

Current CMS instructions require carriers to hold claim payments of less than \$1.00 until another payment greater than \$1.00 is generated and then to combine the two payments. Payments less than \$1.00 will now be issued because HIGLAS functionality will not suppress these payments.

Claims and refund payments subject to a hold

Providers may be placed on a hold due to a forwarding address, bankruptcy, or payment suspension. Currently, the holds are applied to the net payment after any eligible overpayment receivables have been offset. In HIGLAS, the holds will be applied at the claim level. As a result, the held money will not be applied to eligible receivables until the hold has been released.

Claims and refund payments subject to third party payer (TPP) offset

A provider payment may be subject to offsetting to a TPP, such as the Internal Revenue Service. In the current environment, when a provider is subject to TPP, a provider check is pulled and the payment is remitted to the third party but no notification is provided on the RA. HIGLAS will communicate a TPP offset of a provider's payment on the provider's RA.

Stay informed

Providers can also stay informed on the latest HIGLAS news by subscribing to FCSO's Part B HIGLAS Transition eNews list. Select "Join eNews" from FCSO's provider education website.

Get motivated by Medicare ...

Find out about Provider Incentive Programs

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

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

CLAIMS

Changes to the time limits for filing Medicare fee-for-service claims

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

Provider types affected

This article is for all providers and suppliers submitting Part A and/or Part B claims to Medicare contractors (carriers, durable medical equipment 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 furnished to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7270, regarding changes to the time limits for filing Medicare fee-for-service (FFS) claims.

Caution – what you need to know

Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the *Medicare Claims Processing Manual* (Chapter 1) pertaining to the time limits for filing Medicare claims.

Go – what you need to do

CR 7270 also establishes exceptions, if certain conditions are met, to the time limit for filing Medicare claims. (See the *Background* and *Additional information* sections of this article, for further details regarding these changes.)

Background

The Social Security Act (Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B)) as well as the Medicare regulations at 42 CFR Section 424.44 (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr424.44.pdf), specify the time limits for filing Medicare FFS (Part A and Part B) claims.

Prior to the passage of the Affordable Care Act on March 23, 2010, a provider or supplier had from 15 to 27 months (depending on the date of service) to file a timely claim.

- For services furnished in the first nine months of a calendar year, claims had to be submitted to the appropriate Medicare contractor by December 31 of the following year.
- For services furnished in the last three months of a calendar year, claims had to be submitted to the appropriate Medicare contractor by December 31 of the second following year.

The Affordable Care Act (Section 6404) reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted

no later than December 31, 2010. The Affordable Care Act (Section 6404) also mandated that CMS may specify exceptions to the one calendar year time limit for filing Medicare claims.

CR 7270 instructs that claims for services furnished:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010.
- On or after January 1, 2010, the time limit for filing all Medicare FFS claims (Part A and Part B claims) is 12 months, or one calendar year from the date services were furnished.

Exceptions allowing extension of time limit

Medicare will allow for the following exceptions to the one calendar year time limit for filing FFS claims:

Administrative error: This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the department that was performing Medicare functions and acting within the scope of its authority. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.

Retroactive Medicare entitlement: This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.

Retroactive Medicare entitlement involving state

Medicaid agencies: This is where a state Medicaid agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The state Medicaid agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a state Medicaid agency recovered Medicaid payment from a provider or supplier.

Changes to the time limits for filing Medicare fee-for-service claims (continued)

Retroactive disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization: This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Additional information

The official instruction, CR 7270, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2140CP.pdf>. Attached to CR 7270 are the revised Manual instructions, which provide complete details on the timely filing requirements, including the exceptions process. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7270

Related Change Request (CR) #: 7270

Related CR Release Date: January 21, 2011

Effective Date: January 1, 2010

Related CR Transmittal #: R2140CP

Implementation Date: February 22, 2011

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Reminder – important information on the timely claims filing requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare fee-for-service physicians, providers, and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after January 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service – or Medicare will deny them.

In general, the start date for determining the one-year timely filing period is the date of service or “From” date on the claim. For institutional claims that include span dates of service (i.e., a “From” and “Through” date on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item “From” date is used for determining the date of service for claims filing timeliness.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the *MLN Matters* articles listed below related to this subject:

- MM6960 – “Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months” – <http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf>.
- MM7080 – “Timely Claims Filing: Additional Instructions” – <http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf>.
- MM7270 – “Changes to the Time Limits for Filing Medicare Fee-for-Service Claims” – <http://www.cms.gov/MLNMattersArticles/downloads/MM7270.pdf>.

You can also listen to a podcast on this subject by visiting http://www.cms.gov/CMSFeeds/02_listofpodcasts.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 201102-10, 201102-30

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 January 18, 2011. To reflect the revised change request (CR) 7064 that was issued on January 14, 2011. 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 January 2011 *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 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.

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

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.

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:

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

- 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 four 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 three 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 modifier AY 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*

Related Change Request (CR) #: 7064

Related CR Release Date: January 14, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2134CP

Implementation Date: January 3, 2011

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Drugs and Biologicals

April 2011 quarterly ASP update and revision to prior files

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

Provider types affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment 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) 7298 which instructs your Medicare contractors to download and implement the April 2011 average sales price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised January 2011, October 2010, July 2010, and April 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2011, with dates of service April 1, 2011, through June 30, 2011. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Section 1847A of The Medicare Modernization Act of 2003 (Section 303(c); see <http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf>) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis.

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

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

Additional information

The official instruction, CR 7298, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2135CP.pdf>. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7298

Related Change Request (CR) #: 7298

Related CR Release Date: January 21, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2135CP

Implementation Date: April 4, 2011

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April 2011 Quarterly HCPCS drug/biological code changes

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

What you need to know

Change request (CR) 7299 announces that effective for claims with dates of service on or after April 1, 2011, HCPCS code Q2040 (Injection, incobotulinumtoxin A, 1 unit) will be payable by Medicare. Specifically, your contractors will accept Q2040 as a valid HCPCS code for dates of service on or after April 1, 2011, using type of service (TOS) 1, 9, and Medicare physician fee schedule database (MPFSDB) status indicator "X" (Statutorily excluded from physician fee schedule). You should make sure that your billing staffs are aware of this HCPCS code change.

Additional information

You may find the official instruction, CR 7299, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2147CP.pdf>. If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7299

Related Change Request (CR) #: 7299

Related CR Release Date: February 4, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2147CP

Implementation Date: April 4, 2011

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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.

Note: This article was revised on January 25, 2011, to make the following changes: codes L3660, L3670, and L3675 were removed from the list of codes deleted from the HCPCS file; the purchase fee schedule calculation for complex rehabilitation power wheelchairs was added to the *Power-driven wheelchairs* section; and the language was clarified under the CY 2011 fee schedule update factor section. The transmittal number, CR date, and link for viewing the CR was also changed. This information was previously published in the January 2011 *Medicare B Update!* pages 13-16.

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 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 year (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. 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

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 DMEPOS fee schedule update (continued)

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				

HCPCS code updates

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

- A4566, A9273, and EO446 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
- L3672 and L3673

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

2011 DMEPOS fee schedule update (continued)

Factor	Category
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 change request 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 4-13. The purchase fee schedule amount for complex rehabilitation power wheelchairs is equal to the rental fee (for months 1-3) divided by 0.15. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248. This attachment identifies those codes where payment, when applicable, should be made at 15 percent of the purchase price for months 1-3 and 6 percent of the purchase price for months 4-13.

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 2-3 and 7.5 percent of the purchase price for rental months 4-13.

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.

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 percentage increase is 1.1 percent. Therefore, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent increase in the MFP, resulting in a net reduction of 0.1 percent for the MFP-adjusted update factor. In other words, the MFP-adjusted update factor of -0.1 percent is applied to the applicable CY 2010 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.

2011 DMEPOS fee schedule update (continued)

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 six months after the end of the 36th 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 was 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 durable medical equipment 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 that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary durable medical equipment 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.

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/R2142CP.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 *Revised*
 Related Change Request (CR) #:7248
 Related CR Release Date: January 24, 2011
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2142CP
 Implementation Date: January 3, 2011

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Additional HCPCS codes payable under the replacement part, accessories, and supplies pricing logic

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

Provider types affected

This article is for suppliers billing Medicare carriers and Medicare administrative contractors (A/B MACs) for certain durable medical equipment (DME) products provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7261 in order to provide three additional Healthcare Common Procedure Coding System (HCPCS) codes for replacement parts, accessories, and supplies for implanted prosthetic devices, which become effective January 1, 2011. These three HCPCS codes are separately billable to the A/B MACs and carriers under the guidelines established by CR 5917 and CR 6573.

The *Key points of CR 7261* section of this article lists the three additional HCPCS codes. Make certain billing staffs are aware of this change.

Key points of CR 7261

Beginning January 1, 2011, suppliers that are enrolled with the national supplier clearinghouse (NSC) as a DMEPOS supplier may bill Medicare carriers or A/B MACs for:

- HCPCS codes L8693 (Auditory Osseointegrated Device Abutment, Any Length, Replacement Only)
- Q0478 (Power Adapter 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).

Medicare contractors will process claims containing such codes, according to the instructions in CR 5917 and CR 6573.

These Medicare contractors will reprocess any claims containing the three HCPCS codes listed directly above submitted by DMEPOS suppliers with dates of service on or after January 1, 2011, through the implementation date of this CR, according to the guidelines established in CR 5917 and CR 6573.

When claims containing these codes are submitted to the DME MACs, they will be denied.

Additional information

The official instruction, CR 7261, issued to your Medicare A/B MAC and carrier regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R846OTN.pdf>. CMS published *MLN Matters*® article MM6573, related to CR 6573, which may be reviewed at <http://www.cms.gov/mlnmattersarticles/downloads/MM6573.pdf>. CMS published *MLN Matters*® article MM5917, related to CR 5917, which may be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM5917.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: MM7261

Related Change Request (CR) #:7261

Related CR Release Date: January 28, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R846OTN

Implementation Date: July 5, 2011

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

Laboratory/Pathology

Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests

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

Provider types affected

Clinical laboratories, hospitals and physicians submitting claims for certain complex diagnostic tests provided to Medicare beneficiaries to fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MACs] may be affected by this article.

Provider action needed

Stop – impact to you

Section 3113 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning July 1, 2011, or until the one hundred million dollar (\$100,000,000) payment ceiling established for the demonstration has been reached.

Caution – what you need to know

The demonstration will establish a separate payment method for the demonstration tests with a date of service (DOS) that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay. Under the demonstration, independent and hospital-based laboratories may bill separately for demonstration tests that are ordered within a 14 day period after a hospital discharge.

Note: Outpatient prospective payment system (OPPS) services, provided as part of an outpatient encounter, are currently separately payable and are, therefore, excluded from this demonstration.

Go – what you need to do

Change request (CR) 7278, on which this article is based, explains how to bill for the demonstration tests. Please read the *Background* section below for billing information for these claims. Be sure your staff is aware of these changes.

Background

The Affordable Care Act requires CMS to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years, beginning July 1, 2011, or until the one hundred million dollar (\$100,000,000) payment ceiling has been reached. The demonstration will establish a separate payment method for these tests with a DOS that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay.

Complex diagnostic laboratory test defined

Under this demonstration, the term “complex diagnostic laboratory” means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay
- Determined by the Secretary of Health & Human Services to be a laboratory test for which there is not

an alternative test having equivalent performance characteristics

- Billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under the coding system
- Approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act, and
- Described in Section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). This section of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm.

DOS rule

The DOS rule determines whether or not the laboratory service, under standard Medicare rules, is bundled into the diagnosis-related group (DRG) payment made to the hospital. In general, the DOS must be the date the specimen was collected.

- The test/service is bundled into the DRG if: 1) the test/service is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital; 2) the specimen was collected while the patient was undergoing a hospital surgical procedure; 3) it would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted; 4) the results of the test/service do not guide treatment provided during the hospital stay; and 5) the test/service was reasonable and medically necessary for treatment of an illness.
- The test/service is not bundled into the DRG if the test/service is ordered by the patient’s physician greater than 14 days following the date of the patient’s discharge from the hospital, allowing laboratories to directly bill Medicare Part B for the service.

Under the demonstration, CMS will allow independent and hospital-based laboratories to bill separately for certain complex diagnostic laboratory services that are ordered within a 14-day period after a hospital discharge. The DOS of the clinical diagnostic laboratory service must also be within the demonstration period, which runs from July 1, 2011, through June 30, 2013, inclusive, unless the dollar threshold is reached prior to June 30, 2013. Claims may be rejected if the DOS is greater than 14 days following the date of the patient’s discharge from a covered hospital stay.

Section 3113 Demonstration Fee Schedule

All HCPCS codes included in this demonstration will be identified on a “Section 3113 Demonstration Fee Schedule”. This fee schedule will be used to pay for HCPCS codes included in the demonstration and billed, using the demonstration project identifier 56, which needs to be entered:

Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests (continued)

- In item 19 on the CMS-1500 form
- In locator 63 on the UB04 form
- On the electronic claim in X12 837 Professional Claim (HIPAA version) in Loop 2300, REF02, REF01+P4, and
- On the X12 837 Institutional claim (HIPAA version) in Loop 2300, REF02, G1 in REF01 DE 128.

Claims submitted with the 56 project identifier without a HCPCS code involved in the demonstration will be rejected with a reason code 96 (Non-covered charge(s)) and a remark code of M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a demonstration project. For more information regarding these projects, contact your local contractor.) Claims submitted with the project identifier 56 with a DOS outside the date range of the demonstration or after the \$100,000,000 limit is reached will be rejected with these same codes.

Payment under the demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule.

HCPCS codes included in the demonstration project will be posted at

<http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240611&intNumPerPage=10>.

By submitting a claim with the Section 3113 Demonstration Project Identifier 56, the laboratory agrees to cooperate with the independent evaluation and the implementation contractors selected by CMS for purposes of this demonstration project. This may include providing data needed to assess the impact of the demonstration and participating in surveys and/or site visits as requested by these contractors.

Announcements and updates

Announcements and updates about this demonstration will be made via the project listserv available at:

https://list.nih.gov/cgi-bin/wa.exe?SUBED1=MEDICARE_LAB_DEMO&A=1.

Note: Claims with the demonstration project identifier 56 may be rejected after the one hundred million dollar (\$100,000,000) payment ceiling has been met.

Additional information

The official instruction, CR 7278, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. One transmittal revised the *Medicare Claims Processing Manual* and it may be viewed at

<http://www.cms.gov/Transmittals/downloads/R2144CP.pdf>. The other transmittal revised the *Demonstrations Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R67DEMO.pdf>.

MLN Matters® Number: MM7278

Related Change Request (CR) #: 7278

Related CR Release Date: January 28, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R2144CP & R67DEMO

Implementation Date: July 5, 2011

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Medicare Physician Fee Schedule Database

April update to the 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, nonphysician practitioners, and providers submitting claims to Medicare contractors (fiscal intermediaries, carriers or Part A/B Medicare administrative contractors, and regional home health intermediaries) for services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

What you need to know

Payment files were issued to contractors based upon the CY 2011 Medicare physician fee schedule (MPFS) final rule, released on November 2, 2010, and published in the *Federal Register* on November 29, 2010. As previously described in change request (CR) 7300, these payment files were modified in accordance with the MPFS final rule correction notice released on December 30, 2010, and published in the *Federal Register* on January 11, 2011, and by relevant statutory changes applicable January 1, 2011, including the Physician Payment and Therapy Relief Act of 2010, and the Medicare and Medicaid Extenders Act of 2010.

This article is based on CR 7319, which details changes included in the April quarterly update to those payment files. Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7319. However, contractors will adjust claims brought to their attention. Please be sure to inform your staff of these changes.

Background

Medicare physician fee schedule database (MPFSDB) payment file revisions

In order to reflect appropriate payment policy in line with the CY 2011 MPFS final rule, some payment indicators and practice expense (PE) relative-value units (RVUs) have been revised. New MPFS payment files have been created that include these changes.

MPFSDB indicator changes

The following HCPCS codes have MPFSDB indicator changes:

HCPCS code	Short descriptor	Indicator
31579	Diagnostic laryngoscopy	Global surgery: 000
57155	Insert uteri tandems/ ovoids	Co-surgeons: 2
64613	Destroy nerve neck muscle	Bilateral surgery: 2
64614	Destroy nerve extrem musc	Bilateral surgery: 2
77071	X-ray stress view	Bilateral surgery: 2

HCPCS code	Short descriptor	Indicator
92511	Nasopharyngoscopy	Global surgery: 000
93464 26	Exercise w/ hemodynamic meas	Multiple surgery: 0

Practice expense RVU changes

The following HCPCS codes have practice expense RVU changes. A detailed description of these changes may be found in CR 7319.

HCPCS code	Short descriptor
93503	Insert/place heart catheter
93224	Ecg monit/reprt up to 48 hrs
93225	Ecg monit/reprt up to 48 hrs
93226	Ecg monit/reprt up to 48 hrs

Added HCPCS code

The following HCPCS code has been added, effective April 1, 2011. More information on this addition may be found in CRs 7319 and 7299.

HCPCS code	Short descriptor
Q2040	Incobotulinumtoxin A

Discontinued HCPCS codes

The following HCPCS codes are discontinued for **dates of service on or after January 1, 2011**, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
90470	Immune admin H1N1 im/nasal
90663	Flu vacc pandemic H1N1

The following HCPCS codes are discontinued for **dates of service on or after April 1, 2011**, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
Q1003	Ntiol category 3
S2270	Insertion vaginal cylinder
S2344	Endosc balloon sinuplasty
S3905	Auto handheld diag nerv test

Correction to payment file OPPS cap “Imaging Payment Amount” field for CPT Code 92227

CPT code 92227 (Remote Dx retinal imaging), is subject to the OPPS payment cap determination and has an imaging cap indicator of 1. The CY 2011 MPFS relative value file correctly lists OPPS payment amounts (PE=0.53 and MP =0.02) for this code; however, these values were not carried over to the Imaging Payment Amount field in the Medicare contractor payment files, which listed the values as 0.00 for all carriers. This will be corrected in the MPFS payment files released for the April quarterly update, effective January 1, 2011.

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

Additional information

The official instruction, CR 7319, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2167CP.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: MM7319
 Related Change Request (CR) #: 7319
 Related CR Release Date: February 25 2011
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2167CP
 Implementation Date: April 4, 2011

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Fee changes resulting from the April update to the 2011 Medicare physician fee schedule

The purpose of this article is to provide notification of fee changes resulting from the April update to the 2011 Medicare physician fee schedule (MPFS). The following fee changes to the Medicare physician fee schedule (MPFS) are effective for services rendered on or after January 1, 2011, processed on or after April 4, 2011.

Florida

Code/Mod	Locality 01/02			Locality 03			Locality 04		
	Par	Nonpar	LChg	Par	Nonpar	LChg	Par	Nonpar	LChg
93224	\$103.23	\$98.07	\$112.78	\$109.31	\$103.31	\$119.42	\$112.86	\$107.22	\$123.30
93225	\$30.73	\$29.19	\$33.57	\$32.90	\$31.26	\$35.95	\$34.16	\$32.45	\$37.32
93226	\$45.32	\$43.05	\$49.51	\$48.47	\$46.05	\$52.96	\$50.18	\$47.67	\$54.82
93503	\$138.08	\$131.18	\$150.86	\$144.07	\$136.87	\$157.40	\$152.83	\$145.19	\$166.97

U.S. Virgin Islands

Code/Mod	Par	Nonpar	LChg
93224	\$104.14	\$98.93	\$113.77
93225	\$31.08	\$29.53	\$33.96
93226	\$45.94	\$43.64	\$50.19
93503	\$132.76	\$126.12	\$145.04

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Source: Pub 100-04, Transmittal 2150, Change request 7319

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Reprocessing claims affected by the Affordable Care Act and 2010 Medicare physician fee schedule changes

This message is for physicians, other practitioners, ambulance suppliers, inpatient/outpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and any other provider type affected by the post-effective date implementation of select provisions of the Affordable Care Act and the 2010 Medicare physician fee schedule (MPFS).

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

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims will be reprocessed. Given this large workload, the Centers for Medicare & Medicaid Services (CMS) is taking steps to ensure that new claims coming into the Medicare program are processed timely and accurately, even as the retroactive adjustments are being made. CMS will begin to reprocess these claims over the next several weeks. CMS expects this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your affected claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, CMS believes these circumstances fall under the “good cause” criteria described in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 34, Section 10.11 (<http://www.cms.gov/manuals/downloads/clm104c34.pdf>). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contractors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in the next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a \$25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than \$10, your contractor will not request repayment until the total amount owed accrues to at least \$10. See the *Financial Management Manual*, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (<http://www.cms.gov/manuals/downloads/fin106c04.pdf>) for more information.

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

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

Source: CMS PERL 201102-18

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Website survey

We would like to hear your comments and suggestions on the website through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

Radiology

Accreditation for supplying the technical component of advanced diagnostic imaging services

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 nonphysician practitioners who bill Medicare administrative contractors (MACs), and/or carriers for the technical component (TC) of advanced diagnostic imaging (ADI) services for Medicare beneficiaries. (Railroad Retirement Board is exempt from these requirements).

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7176 to alert providers, submitting claims for the TC of ADI, that they must be accredited by January 1, 2012, by one of the three organizations listed below in order to be reimbursed for services performed on or after that date. This requirement affects claims with a date of service on or after January 1, 2012.

Background

CMS approved three national accreditation organizations (AOs) to provide accreditation services for suppliers of the TC of ADI procedures. The accreditation will apply only to the suppliers of the images themselves, and not to the physician's interpretation of the image, and only to those who are paid under the physician fee schedule. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. This CR 7176 will set the systems parameters for this accreditation requirement.

Each of these designated AOs submits monthly reports to CMS that list the suppliers who have been or are accredited, as well as the beginning and end date of the accreditation and the respective modalities for which they receive accreditation. The designated AOs are:

1. The American College of Radiology
2. The Intersocietal Accreditation Commission
3. The Joint Commission

ADI submitted claims will only be paid if the code is listed on the provider's/supplier's eligibility file in the claims system.

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended Section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, nonphysician

practitioners and independent diagnostic testing facilities, that furnish the TC of advanced diagnostic imaging services.

MIPPA specifically defines ADI procedures as including diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine imaging such as positron emission tomography. The law also authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

Key points of CR 7176

- In order to furnish the TC of ADI services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.
- Provider's claims for the TC for ADI services will be denied:
 - If the provider is not enrolled or accredited by a designated CMS accreditation organization (Denial code N290: "Missing/incomplete/invalid rendering provider primary identifier."); or
 - If the code submitted is not listed on the provider's eligibility file (claim adjustment reason code 185: "The rendering provider is not eligible to perform the service billed.").

Additional information

The official instruction, CR 7176 issued to your carrier, A/B MAC, and carrier regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R858OTN.pdf>.

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

MLN Matters® Number: MM7176

Related Change Request (CR) #: 7176

Related CR Release Date: February 4, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R858OTN

Implementation Date: July 5, 2011

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General Coverage

Auto denial of claims submitted with a modifier GZ

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

Provider types affected

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

What you need to know

The Health and Human Services Office of General Counsel (OGC) has provided guidance that Medicare contractors that process both institutional and professional claims have discretion to automatically deny claims billed with the modifier GZ. The modifier GZ indicates that an advance beneficiary notice (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Medicare contractors will automatically deny claim line(s) items submitted with a modifier GZ, effective for dates of service on or after July 1, 2011. Further, your Medicare contractor will not perform complex medical review on any claim line item(s) submitted with the modifier GZ. In addition, line items denied due to the presence of the modifier GZ will reflect a claim adjustment reason code of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.) and a group code of CO (contractual obligation) to show provider/supplier liability.

Additional information

The official instruction, change request (CR) 7228, was issued to your carrier, FI, A/B MAC, and DME/MAC via two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R2148CP.pdf>. The second transmittal modifies the *Medicare Program Integrity Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R366PI.pdf>.

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

MLN Matters® Number: MM7228

Related Change Request (CR) #: 7228

Related CR Release Date: February 4, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R366PI and R2148CP

Implementation Date: July 5, 2011

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Sign up for our eNews electronic mailing list

Join our eNews mailing list and receive urgent and other critical information issued by First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education website. It's very easy to do. Simply go to our website <http://medicare.fcsocom>, click on the “Join eNews” link located at the top of the page and follow the instructions.

Electronic Data Interchange

Modifications to the implementation of the paperwork (PWK) segment for X12N version 5010

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

What you need to know

This article is based on change request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 under CR 7041. An article related to CR 7041 is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7041.pdf>. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any protected health information (PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.
- Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.
- Contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

Be sure your staffs are informed of this change.

Additional information

The official instruction, CR 7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R849OTN.pdf>.

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

MLN Matters® Number: MM7306

Related Change Request (CR) #: 7306

Related CR Release Date: January 28, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R849OTN

Implementation Date: July 5, 2011

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Get motivated by Medicare ...

Find out about Provider Incentive Programs

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

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

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.? at

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 contactor (MAC)? at

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

Reminder: 5010/D.0. errata requirements and testing schedule at

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

Reminder: Contact your MAC for their testing schedule at

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

Implementation calendar

Upcoming items

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?

May 2011

May 2-5: 20th Annual WEDI National Conference* at

<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* at

<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 at <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 at <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 at <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) at

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10>

February 2011

HIPAA 5010 & D.0 – implementation calendar and important reminders (continued)**October 2010**

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

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

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

http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf

November 8: WEDI 2010 fall conference* at

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C>

November 17: 5010 national call – coordination of benefits (COB) at

<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 at

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10>

January 2011

January 1: Beginning of transition year

January 11: HIMSS 5010 industry readiness update* <http://www.himss.org/asp/UnknownContent.asp?type=evt>

January 19: 5010 national call – errata/companion guides at <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* at

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029>

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

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

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

Source: CMS PERL 201102-15

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Try our E/M interactive worksheet

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

Have you started external testing of version 5010?

All Health Insurance Portability and Accountability Act (HIPAA) covered entities that submit transactions electronically are required to upgrade from version 4010A1 to version 5010 transaction standards by January 1, 2012.

Testing should be conducted both internally and with external business partners in preparation for the January 1, 2012, compliance deadline. Internal testing of version 5010 should have been completed by December 31, 2010. Now is the time to begin external testing.

Testing transactions using version 5010 standards will assure that you are able to send and receive compliant transactions effectively. And testing early will allow you to identify any potential issues, and address them in advance.

Stay ahead of the version 5010 and ICD-10 transitions! Know the deadlines and mark your calendars:

- **January 1, 2011** – begin external testing of version 5010 for electronic claims
 - Centers for Medicare & Medicaid Services (CMS) begins accepting version 5010 claims
 - Version 4010 claims continue to be accepted
- **December 31, 2011** – external testing of version 5010 for electronic claims must be complete to achieve Level II version 5010 compliance
- **January 1, 2012** – all electronic claims must use version 5010; version 4010A1 claims are no longer accepted
- **October 1, 2013** – claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures; CPT codes will continue to be used for outpatient services

CMS has resources that can help you with the version 5010 and ICD-10 transitions at www.cms.gov/icd10

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

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

Source: CMS PERL 201102-06

Medicare Remit Easy Print version 2.8 update

Version 2.8 of the Medicare Remit Easy Print (MREP) software is available for download at http://www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp. There are two new Medicare secondary payer (MSP)/non-MSP claims reports. The MSP claims report identifies the X12 835V4010A1 and v5010 claims within a remittance that were processed by Medicare as secondary. The non-MSP claims report identifies the X12 835V4010A1 and V5010 claims within a remittance that were processed by Medicare as primary.

Since changes are being made to the MREP software, the updated “Claim Adjustment Reason Codes/Remittance Advice Remark Codes” file is included with version 2.8 of the MREP software. However, the separate “Codes.ini” file is provided when version 2.8 of the MREP software is distributed.

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

Source: CMS PERL 201102-02

The countdown has begun ...

Are you ready for January 1?

Schedule your HIPAA-5010 testing today!

Call 888-670-0940, Option 1

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

General Information

Uninsured Americans with pre-existing conditions continue to gain coverage through Affordable Care Act

New resources available to increase awareness of new program for the uninsured

The U.S. Department of Health and Human Services (HHS) today made new resources available to the media, consumer groups, states, health care providers, and others to increase awareness of the Pre-existing Condition Insurance Plan (PCIP), a health plan for uninsured Americans with pre-existing conditions created by the Affordable Care Act.

Americans continue to enroll in the plan, which was created in 2010, to provide comprehensive health coverage – at the same price that otherwise healthy people pay – for uninsured Americans living with such conditions as cancer, diabetes, or heart disease, who have been unable to obtain affordable health insurance coverage.

This temporary program covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. In 2014, all Americans – regardless of their health status – will have access to affordable coverage either through their employer or through a new competitive marketplace, and insurers will be prohibited from denying coverage to anyone based on their health status.

The Department is actively working with states, consumer groups, chronic disease organizations, health care providers, social workers, other federal agencies, and the insurance industry to promote the plan, including holding meetings with state officials, consumer groups, and others. New resources that are available to communities to help inform eligible Americans of the plan include a new web badge that links to <https://www.pcip.gov/>, as well as a new newsletter and website drop-in language that partners can use in their outreach efforts.

HHS' Center for Consumer Information and Insurance Oversight is also working with the U.S. Social Security Administration (SSA) on a comprehensive outreach campaign, putting information about the plan in the approximately 3.2 million social security disability insurance application receipts distributed each year. SSA is also promoting the Pre-existing Condition Insurance Plan in its advocate newsletter, its website, and on TVs in the waiting rooms of SSA's more than 600 field offices.

Resources available to consumer groups, media, states and others include:

- **PCIP.gov** (<https://www.pcip.gov/>) – this website offers information about eligibility, benefits and more. Consumers can find online and print applications for the plan in their state. Frequently asked questions are also available to help both organizations and consumers better understand the program.
- **Web badge** – a new website button was released today that groups can post on their website to link to <https://www.pcip.gov/>. To add the button to your website, visit www.HealthCare.gov/stay_connected.html and embed the code listed.
- **Newsletter and website drop-in language** – also released today, this language is ready for consumer groups, state or local governments or other organizations to simply drop into their newsletters or post on their websites to help educate consumers about their health insurance options. To find this language, visit www.HealthCare.gov/center/brochures.
- **Posters and brochures** – organizations can download or print English and Spanish language brochures and posters about PCIP to share with consumers. Find the brochures and posters here, www.HealthCare.gov/center/brochures.

The entire press release may be found (February 10) at <http://www.hhs.gov/news/press/2011pres/02/20110210a.html>.

Visit <https://www.pcip.gov/> for more information on how the plan works in each state, including eligibility and how to apply. To find recent enrollment numbers, visit <http://www.healthcare.gov/news/factsheets/pcip02102011a.html>.

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Source: CMS PERL 201102-23

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ICD-9 and ICD-10 announcements

The agendas for the ICD-9-CM Coordination and Maintenance Committee meeting on March 9-10, 2011, are now available.

Procedures topics, March 9, 2011

The agenda is posted in the “Downloads” section at http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. Handouts will be available on this website a few days before the meeting.

Diagnosis topics, March 10, 2011

The link to the agenda is under “Upcoming Meeting, March 9-10, 2011” at http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm. Handouts will be available at this website a few days before the meeting.

This will be the last meeting to address ICD-9-CM and ICD-10 code updates before the partial code freeze is implemented.

The ICD-10 MS-DRGs v28 Definitions Manual is now available from CMS

The ICD-10 MS-DRGs v28 Definitions Manual (based on FY2011 MS-DRGs) is now posted on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp in the “Related Links Inside CMS” section. This update is part of the ICD-10 MS-DRG conversion project. In the conversion project, CMS is using the general equivalence mappings (GEMs) to convert CMS payment systems. CMS is sharing information learned from this project with other organizations facing similar conversion projects. Please note that the ICD-10 MS-DRGs will be subject to formal rulemaking. CMS also plans to post the ICD-10 FY 2011 Medicare code editor when it is completed in March 2011.

The ICD-10 abbreviated titles for both ICD-10-CM and ICD-10-PCS have been posted on the CMS website at http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp and http://www.cms.gov/ICD10/11b_2011_ICD10PCS.asp.

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Source: CMS PERL 201102-20

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‘Preparing for ICD-10 Implementation in 2011’ transcript and recording now available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider teleconference on “Preparing for ICD-10 Implementation in 2011” on January 12, 2011. The written transcript and audio recording are now available at <http://www.cms.gov/ICD10/Tel10/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1242831&intNumPerPage=10>. To access the file, scroll down the Web page to the *Downloads* section and select the appropriate file.

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

Source: CMS PERL 201101-47

2011 electronic prescribing (eRx) incentive program reminder – avoiding the adjustment

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

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

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

2011 electronic prescribing (eRx) incentive program reminder – avoiding the adjustment (continued)

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

How to avoid the 2012 eRx payment adjustment

- Eligible professionals – an eligible professional can avoid the 2012 eRx payment if he/she:
- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in National Plan & Provider Enumeration System (NPPES);
- Does not have prescribing privileges. **Note:** He/she must report (G8644) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; 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" page at <http://www.cms.gov/erx incentive> on the CMS website for more information; or download the Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program under Educational Resources.

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

Source: CMS PERL 201102-09

Revised brochure on the Medicare appeals process

The revised brochure titled *The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers* (revised January 2011) is now available in downloadable format from the *Medicare Learning Network*[®] at <http://www.CMS.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>. This brochure is designed to provide an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.

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

Source: CMS PERL 201102-43

Reminder for centralized billing for flu and pneumococcal vaccination claims

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact the Centers for Medicare & Medicaid Services central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Centers for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-10-07
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for centralized billing

- To qualify for centralized billing, an individual or entity providing mass immunization services for influenza virus and pneumococcal vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.

Reminder for centralized billing for flu and pneumococcal vaccination claims (continued)

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary \$10 for an influenza virus vaccination and give the beneficiary a coupon for \$10 to be used in the drugstore.

Note: The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per Section 1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is TrailBlazer Health Enterprises, LLC.
- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an approved electronic media claims standard format. Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises, LLC must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare health insurance claim number) as the contractor will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare summary notice (MSN) can be sent to the beneficiary by the contractor. Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare contractor. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises, LLC can provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises, LLC. This may be done by completing the CMS-855 (provider enrollment application), which may be obtained from TrailBlazer Health Enterprises, LLC.
- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.
- Each year the centralized biller must contact TrailBlazer Health Enterprises, LLC to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations
2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations
3. The approximate dates for when the vaccinations will be given
4. A list of the states in which influenza virus and pneumococcal clinics will be held
5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse)
6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations
7. Names and addresses of all entities operating under the corporation's application
8. Contact information for designated contact person for centralized billing program

Source: CMS Publication 100-04, Chapter 18, Section 10.3.1.1

Medicare and Medicaid Research Review call for papers (ongoing submissions accepted)

The Medicare & Medicaid Research Review (MMRR) is soliciting studies, policy analyses, and program evaluations that use rigorous, scientific research methods. It is interested in papers addressing changes in coverage, quality, access, the organization and delivery of health services, payment for health services, and innovative methods. (Do not presume from the title that the scope is narrowly defined to include only research directly involving the Medicare, Medicaid, or the Children's Health Insurance Programs. It is not; though manuscripts should have results or conclusions that pertain at least indirectly to these programs.)

Illustrative examples of topics include, but are not limited to:

- Development, use, and effects of quality-based and bundled-service payment models
- Impact of changes in cost sharing and coverage on care utilization patterns and outcomes
- Impact of Medicaid eligibility changes on the organization and delivery of care
- Descriptive analyses of longitudinal utilization and cost patterns among Medicare, Medicaid, and CHIP beneficiaries
- Impact of changes within the private health care system on Medicare, Medicaid, and CHIP, and
- Analyses of the types of health research questions amenable to quick study and implementation, and those questions that are not.

Submitted manuscripts must report the results of original scholarship. Manuscripts that are primarily editorial or opinion-based will not be considered. Manuscripts with results that directly support actionable recommendations will receive priority for publication. All manuscripts must be submitted by e-mail to MMRR-Editors@cms.hhs.gov following the guidelines available at http://www.CMS.gov/MMRR/Downloads/MMRR_Info_for_Authors_20101214.pdf.

Criteria for selection of manuscripts include:

1. Quality, rigor, and originality
2. Significance and usefulness for informing the future of Medicare, Medicaid, and CHIP, and
3. Clarity of writing and presentation.

Peer reviewer guidelines are also available at <http://www.CMS.gov/MMRR/downloads/MMRRPeerRevGuidelines.pdf>.

Questions can be directed to David Bott, PhD, Editor-in-Chief, at MMRR-Editors@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 201102-24

Be proactive: Use the PDS report

- Identify negative billing patterns
- Benefit from peer comparisons
- Prevent recurring billing issues
- Improve your bottom line

Accessible through FCSO's PDS portal at <http://medicare.fcsso.com/reporting/index.asp>

New DMEPOS medical equipment program offers value for Medicare beneficiaries

DMEPOS competitive bidding program focuses on providing access to high-quality products and services for people with Medicare

The Centers for Medicare & Medicaid Services (CMS) launched the first phase of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program on Saturday, January 1, 2011, in nine different areas of the country.

Through supplier competition, the program set new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs, and mail order diabetic supplies. CMS estimates that Medicare and beneficiaries will pay 32 percent less on average for these equipment and supplies. In most cases, Medicare beneficiaries who obtain these items in the nine competitive bidding areas will need to get them from the Medicare suppliers that were awarded contracts in order to have the items covered under Medicare. More than four million Medicare beneficiaries living in the nine competitive bidding areas can save money through this new program, while continuing to have access to quality medical equipment from accredited suppliers they can trust.

CMS is pleased to report that implementation of the program is going very smoothly. CMS continues to deploy a wide array of resources across all of the competitive bidding areas to address any concerns that may arise, including local State Health Insurance and Assistance Program (SHIP) offices, specially-trained customer service representatives at 1-800-MEDICARE, and caseworkers in Medicare's regional offices who all stand ready to assist beneficiaries who may have questions about the program. In addition, there is a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents, and suppliers to use for reporting concerns about a contract supplier or other competitive bidding implementation issues. This process is designed to ensure that all complaints are correctly routed, investigated, resolved, tracked, and reported.

To read the entire CMS press release issued on this topic on Wednesday, February, 16, 2011, visit http://www.CMS.gov/apps/media/press_releases.asp. Read more about how the Affordable Care Act improves Medicare at <http://www.Healthcare.gov/law/provisions/rebate/index.html>. And for additional information about the Medicare DMEPOS Competitive Bidding Program, please visit <http://www.CMS.gov/DMEPOSCompetitiveBid>.

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

Source: CMS PERL 201102-36

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CMS conducting follow-up calls for CERT program

The Centers for Medicare & Medicaid Services (CMS) will be conducting follow-up calls to providers for the comprehensive error rate testing (CERT) program. You or your staff may be contacted to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although you may have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation may change your claim's status from "improper payment" to "proper payment." This will allow CMS to calculate a more accurate Medicare fee-for-service error rate, while also reducing the amount of improper payments.

Source: CMS PERL 201102-39

The countdown has begun ...

Are you ready for January 1?

Schedule your HIPAA-5010 testing today!

Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at <http://medicare.fcsso.com/HIPAA/>

Fraud and Abuse

Health care fraud prevention and enforcement efforts recover record \$4 billion

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Associate Attorney General Thomas J. Perrelli announced a new report showing that the government's health care fraud prevention and enforcement efforts recovered more than \$4 billion in taxpayer dollars in Fiscal Year (FY) 2010. This is the highest annual amount ever recovered from people who attempted to defraud seniors and taxpayers. In addition, HHS announced new rules authorized by the Affordable Care Act that will help the department work proactively to prevent and fight fraud, waste and abuse in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

These findings, released Monday, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice (DOJ) and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent waste, fraud and abuse in the Medicare and Medicaid programs and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act, including the new rules announced Monday.

"President Obama has made it very clear that fraud and abuse of taxpayers' dollars are unacceptable. And for too long, our fraud prevention efforts have focused on chasing after taxpayer dollars after they have already been paid out," said Sebelius. "Thanks to the President's leadership and the new tools provided by the Affordable Care Act, we can focus on stopping fraud before it happens."

"Our aggressive pursuit of health care fraud has resulted in the largest recovery of taxpayer dollars in the history of the Justice Department," said Perrelli. "These actions are in large part because of the great work being led by the Health Care Fraud Prevention and Enforcement Action Team. Through this initiative, we are working in partnership with government, law enforcement and industry leaders, and the public to protect taxpayer dollars, control health care costs, and ensure the strength and integrity of our most essential health care programs."

Health care fraud and abuse control program report

More than \$4 billion stolen from federal health care programs was recovered and returned to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. This is an unprecedented achievement for the Health Care Fraud and Abuse Control Program (HCFAC), a joint effort of the two departments to coordinate federal, state, and local law enforcement activities to fight health care fraud and abuse.

The Affordable Care Act provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional \$350 million for HCFAC activities. The Administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

HHS and DOJ have enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams since 2009. HHS and DOJ hosted a series of regional fraud prevention summits around the country, and sent letters to state attorneys general urging them to work with HHS and Federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud. During FY 2010, HEAT and the Medicare Fraud Strike Force expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud.

In FY 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Strike Force enforcement accomplishments in all seven cities during FY 2010 include:

- 140 indictments involving charges filed against 284 defendants who collectively billed the Medicare program more than \$590 million;
- 217 guilty pleas negotiated and 19 jury trials litigated, winning guilty verdicts against 23 defendants; and
- Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration.

Including Strike Force matters, federal prosecutors opened 1,116 criminal health care fraud investigations as of the end of FY 2010, and filed criminal charges in 488 cases involving 931 defendants. A total of 726 defendants were convicted for health care fraud-related crimes during the year.

In addition to these criminal enforcement successes, 2010 was a record year for recoveries obtained in civil health care matters brought under the False Claims Act – more than \$2.5 billion, which is the largest in the history of the Department of Justice.

The HCFAC annual report may be found at <http://oig.hhs.gov/publications/hcfac.asp>. For more information on the joint DOJ-HHS Strike Force activities, visit: <http://www.StopMedicareFraud.gov/>.

*Health care fraud prevention and enforcement efforts recover record \$4 billion (continued)***New Affordable Care Act rules to fight health care fraud**

On Monday, January 24, HHS also announced new rules authorized by the Affordable Care Act which will help stop health care fraud. The provisions of the Affordable Care Act implemented through this final rule include new provider screening and enforcement measures to help keep bad actors out of Medicare, Medicaid, and CHIP. The final rule also contains important authority to suspend payments when a credible allegation of fraud is being investigated.

“Thanks to the new law, CMS now has additional resources to help detect fraud and stop criminals from getting into the system in the first place,” CMS Administrator Donald Berwick, M.D. said. “The Affordable Care Act’s new authorities allow us to develop sophisticated, new systems of monitoring and oversight to not only help us crack down on fraudulent activity scamming these programs, but also help us to prevent the loss of taxpayer dollars across the board for millions of American health care consumers.”

Specifically, the final rule:

- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud, for example durable medical equipment suppliers, will be subject to a more thorough screening process.
- Requires new enrollment process for Medicaid and CHIP providers. Under the Affordable Care Act, states will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding government. Providers that have been kicked out of Medicare or another state’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.

- Temporarily stops enrollment of new providers and suppliers. Medicare and state agencies will be on the lookout for trends that may indicate health care fraud – including using advanced predictive modeling software, such as that used to detect credit card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporarily stops payments to providers and suppliers in cases of suspected fraud. Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

The full text of the press release issued on January 24 is available at

<http://www.HHS.gov/news/press/2011pres/01/20110124a.html>.

A copy of the regulation went on display Monday, January 24, 2011, at the *Federal Register* and may be downloaded from the following link:

www.ofr.gov/inspection.aspx. Several days after the regulation is published, the preceding link will be deactivated and the published version of the regulation will be available on the National Archives website at www.archives.gov/federal-register/news.html. CMS will continue to take public comments on limited areas of this final rule for 60 days.

More information may be found at www.HealthCare.gov, a Web portal made available by the U.S. Department of Health and Human Services. A fact sheet on the new rules is available at www.HealthCare.gov/news/factsheets.

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Source: CMS PERL 201101-49, PERL 201101-46

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Additional information on HIPAA-5010 at <http://medicare.fcsso.com/HIPAA/>

Electronic Health Records

New Listserv for the Medicare and Medicaid electronic health record incentive

The Centers for Medicare & Medicaid Services (CMS) has a new Listserv about the Medicare and Medicaid electronic health record (EHR) incentive programs. The Listserv will provide timely, authoritative information about the programs, including registration and attestation updates, and details about the payment process.

By subscribing to the Listserv, CMS will keep you informed of upcoming deadlines and give you answers to the questions and concerns that have been gathered from eligible professionals and hospitals in the field. New updates will be emailed through the Listserv to keep you informed of any developments, and subscribers will be notified of any new frequently asked questions that are published on the CMS EHR incentive programs' website. These e-mail messages are another CMS resource, in addition to those listed below, that will help you navigate the EHR incentive programs.

CMS encourages you to let others know about the CMS EHR Listserv, and to share its messages. Go to http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp to join the Listserv and learn more.

The CMS EHR incentive programs website features the following resources:

- Path to payment (https://www.cms.gov/EHRIncentivePrograms/10_PathtoPayment.asp) – learn the necessary steps to receiving payments for the meaningful use of electronic health records.
- Registration guides https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp) – review a user guide of how to register and watch a video webinar that will help you navigate the registration website.
- Meaningful use (https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp) – read more about the details of meaningful use, including clinical quality measures, and how to meet the requirements.
- Calendar of important dates (http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp) – read more about key milestone dates for the EHR incentive program.

Want more information about the EHR incentive programs?

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

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

Source: CMS PERL 201102-22

Stay informed about the EHR incentive programs

Have you registered for the Centers for Medicare & Medicaid Services (CMS) electronic health record (EHR) incentive programs yet? Registration for the Medicare and Medicaid EHR incentive programs has already begun, and providers and hospitals began receiving their Medicaid EHR incentive payments in January. The University of Kentucky Healthcare, the University of Kentucky's teaching hospital, and Central Baptist Hospital became the first hospitals to receive payments, and physicians at the Gastorf Family Clinic in Durant, OK, became the first eligible professionals to collect their initial Medicaid EHR incentive program payments.

Not sure if you are eligible to participate in the EHR incentive programs? Need help with registration? The Medicare and Medicaid EHR incentive programs Web page features several resources to assist you, including:

- **The eligibility widget** – in order to register, you must first find out if you qualify as an eligible professional or eligible hospital. The eligibility widget will walk you step-by-step through the eligibility requirements, letting you know if you qualify for the Medicare or Medicaid EHR incentive programs. You can find this resource on the CMS website at http://www.CMS.gov/EHRIncentivePrograms/15_Eligibility.asp.
- **Information about registration** – to help you prepare, a list of all the information you will need during your registration process is provided for both eligible professionals and eligible hospitals. You can find this resource on the CMS website at http://www.CMS.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#BOOKMARK2
- **The eligible professional registration webinar** – are you ready to register? Check out the registration webinar for eligible professionals, which provides video guidance to help you through the registration process. View at <http://www.YouTube.com/user/CMSHHSgov#p/u/0/sKngNjd8Iuc>.
- **Hospital tip sheets** – located on the EHR incentive programs Web page are helpful tip sheets providing information on payment and eligibility guidelines for Medicare, Medicaid, and critical access hospitals. You can find these resources at http://www.CMS.gov/EHRIncentivePrograms/55_EducationalMaterials.asp.
- **EHR Listserv** – CMS has created a new Listserv specifically about the EHR incentive programs. The listserv will provide timely, authoritative information about the programs, including registration and attestation updates and

Stay informed about the EHR incentive programs (continued)

details about the payment process. By subscribing to the Listserv, you'll be kept informed of upcoming deadlines and answers to the questions and concerns that we have gathered from eligible professionals and hospitals in the field. New updates will be emailed through the listserv to keep you informed of any developments, and subscribers will be notified of any new frequently asked questions (FAQs) published on the CMS EHR incentive programs' Web page. Sign up at and learn more http://www.CMS.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp.

Learn more about the EHR incentive programs and keep up to date at <http://www.CMS.gov/EHRIncentivePrograms>.

EHR incentive programs: Not sure where to start?

Everyone's talking about the Medicare and Medicare EHR incentive programs. Not sure what it's all about? CMS has developed the following tip sheets to get you started. You can view them electronically or order free printed copies.

Payment and eligibility for professionals

- Eligibility flow chart (http://www.cms.gov/EHRIncentivePrograms/downloads/eligibility_flow_chart.pdf)
- Medicare tip sheet for eligible professionals (http://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf)
- Medicaid tip sheet for eligible professionals (http://www.cms.gov/MLNProducts/downloads/EHRIP_Eligible_Professionals_Tip_Sheet.pdf)
- Medicare EHR Incentive Program, Physician Quality Reporting System, and e-Prescribing Comparison (<http://www.cms.gov/MLNProducts/downloads/EHRIncentivePayments-ICN903691.pdf>)

Payment and eligibility for hospitals

- Tip sheet for Medicare hospitals (http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf)
- Tip sheet for critical access hospitals (http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf)
- Tip sheet for Medicaid hospitals (http://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf)
- For more information and the latest news and updates on the EHR incentive programs, visit <http://www.CMS.gov/EHRIncentivePrograms>.

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Source: CMS PERL 201102-40

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Information for eligible professionals about registration for the electronic health record incentive programs

Designation of a third-party to register – at this time, there is no method available for a third-party to register multiple eligible professionals (EPs) for the Medicare and Medicaid electronic health record (EHR) incentive programs. Beginning in May, the Centers for Medicare & Medicaid Services (CMS) plans to implement functionality that will allow an EP to designate a third-party to register and attest on his or her behalf. CMS will release detailed information about that process when it is available.

Please be aware that currently EPs are not permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third-parties can place your information at risk. Until CMS implements new functionality in May, each EP should register himself or herself separately for the Medicare and Medicaid EHR incentive programs.

Registration for the Medicaid program – eligible professionals must select between the Medicare and Medicaid EHR incentive programs. If you register for the Medicaid EHR incentive program, when you select “Medicaid” on the registration screen, you will be asked to select a state from the drop-down menu. Only states with launched programs (i.e., states that are prepared to confirm your eligibility and make payments) are listed in that drop-down menu. Each month, CMS will add new states as they launch programs. If you have questions about when your state will launch, visit the Medicaid State Information Web page at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp. You may also contact your state Medicaid agency for more information about the program; visit State EHR Incentive Program Launch Dates and HIT websites at <http://www.cms.gov/apps/files/medicaid-HIT-sites/> for the Medicaid EHR incentive program links for each state Medicaid agency.

For more information about the Medicare & Medicaid EHR incentive programs and to register, visit <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 201102-17

New tools to help register for the electronic health record incentive

New tools for providers include:

- **Interactive eligibility tool for eligible professionals:** Are you eligible to participate in the Medicare or Medicaid EHR incentive programs? Use the tool found at the bottom of the Eligibility page on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp.
- **Registration webinar for eligible professionals:** How do I register? CMS created a video containing step-by-step instructions to help ensure the registration process is a success. Watch the video found on the Registration and Attestation page of the CMS website at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
- **Medicaid state launch dates and websites:** When will your state offer an EHR incentive program? Information on when registration will be available for Medicaid EHR incentive programs in specific states is posted on the Medicaid State Information page of the CMS website at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp. Click on the map for information about your state: State EHR Incentive Program Launch Times and HIT Websites at <http://www.cms.gov/apps/files/medicaid-HIT-sites/>.
- **Medscape participant self-assessment, Medicare and Medicaid EHR incentives:** What do you know and do you know enough? Earn continuing medical education credit while you learn. Take the Medscape EHR self-assessment at <http://www.cms.gov/EHRIncentivePrograms/>. Participation may require the user to log in to Medscape; however registration is free and does not require any commitment.

For more information about the EHR incentive programs and to register at 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 201101-41

Get motivated by Medicare ...

Find out about Provider Incentive Programs

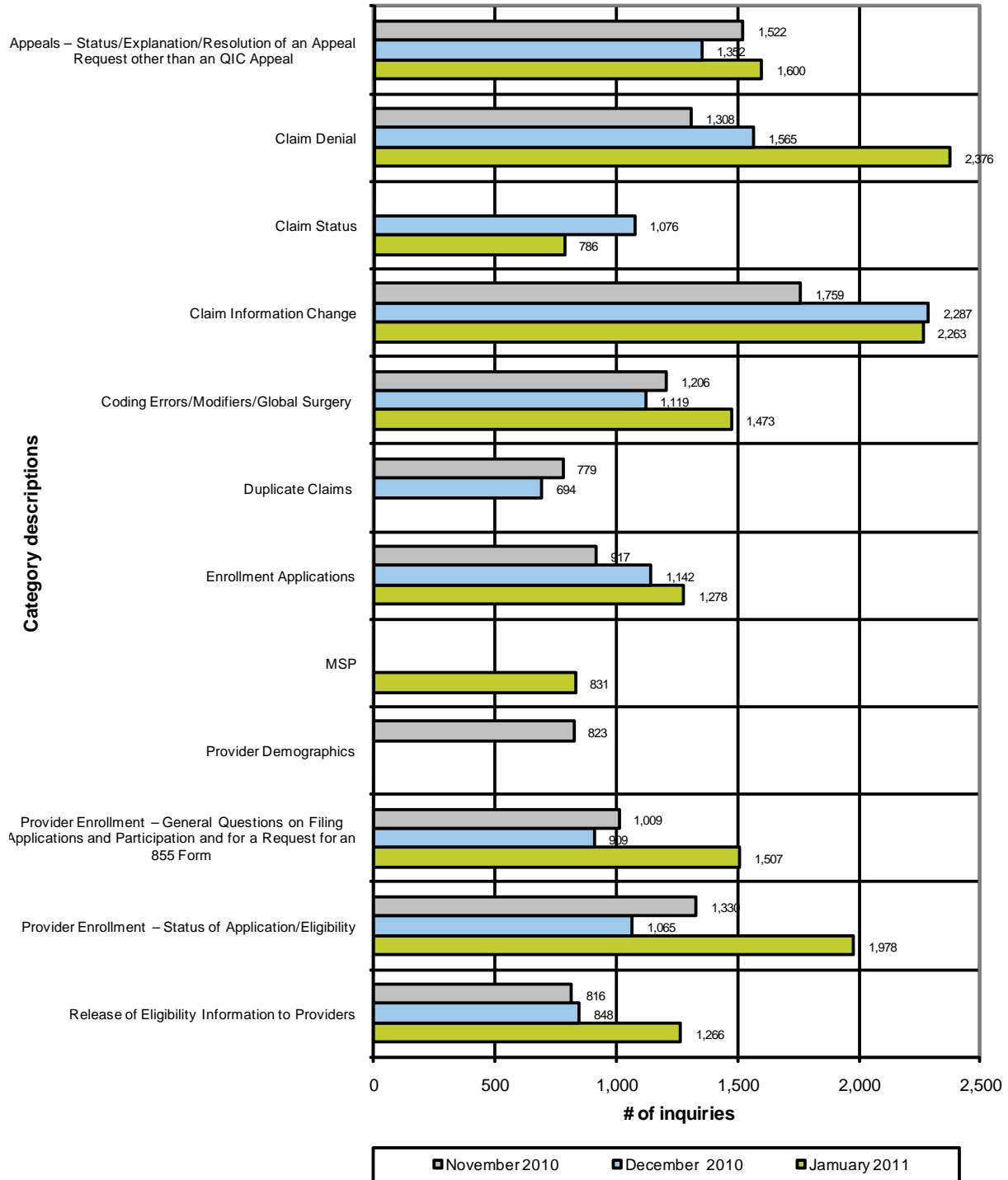
- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

Available at <http://medicare.fcsso.com/Landing/191460.asp>

Top inquiries, denials, and return unprocessable claims for November 2010-January 2011

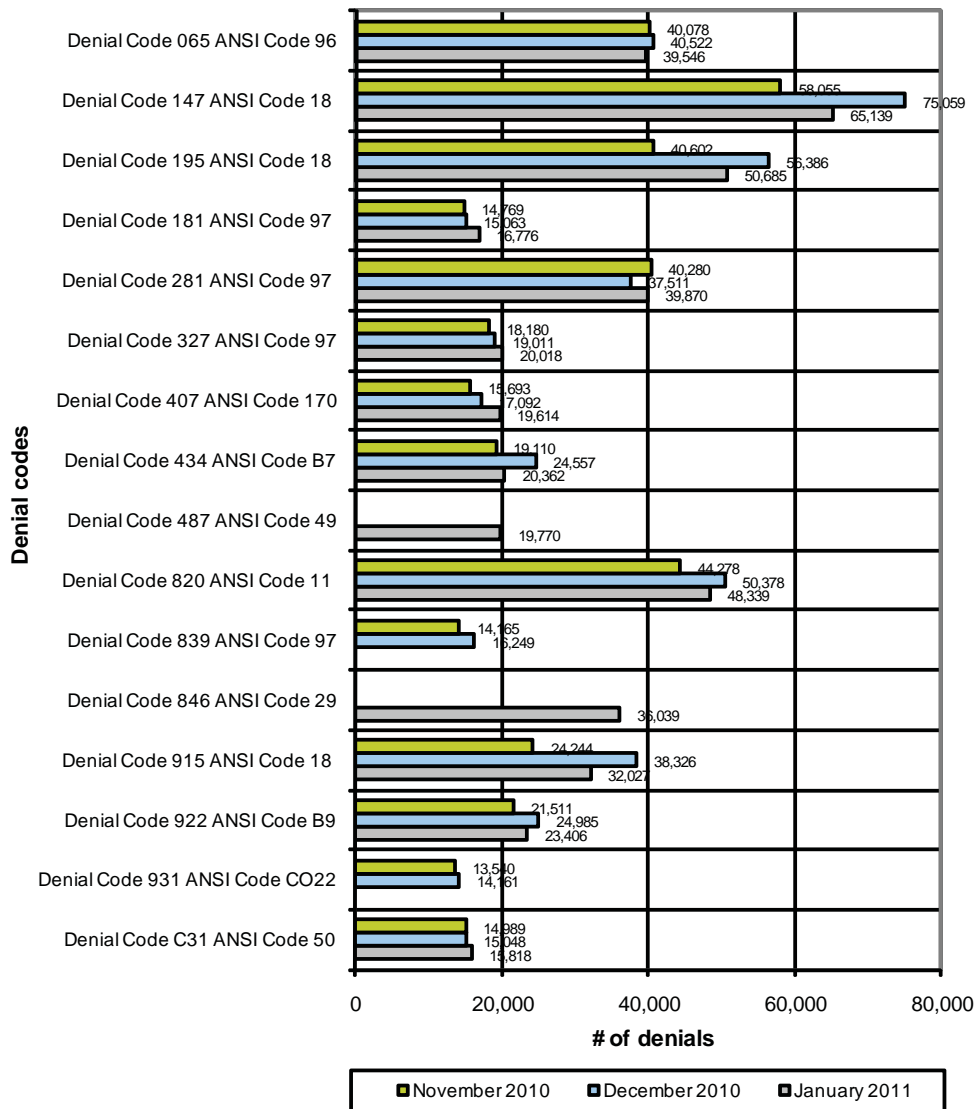
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during November 2010-January 2011. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Florida Part B top inquiries for November 2010-January 2011



Top inquiries, denials, and return unprocessable claims for November 2010-January 2011 (continued)

Florida Part B top denials for November 2010-January 2011



Steps to reduce the number of claim submission errors

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

Did you review your batch detail control listing?

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

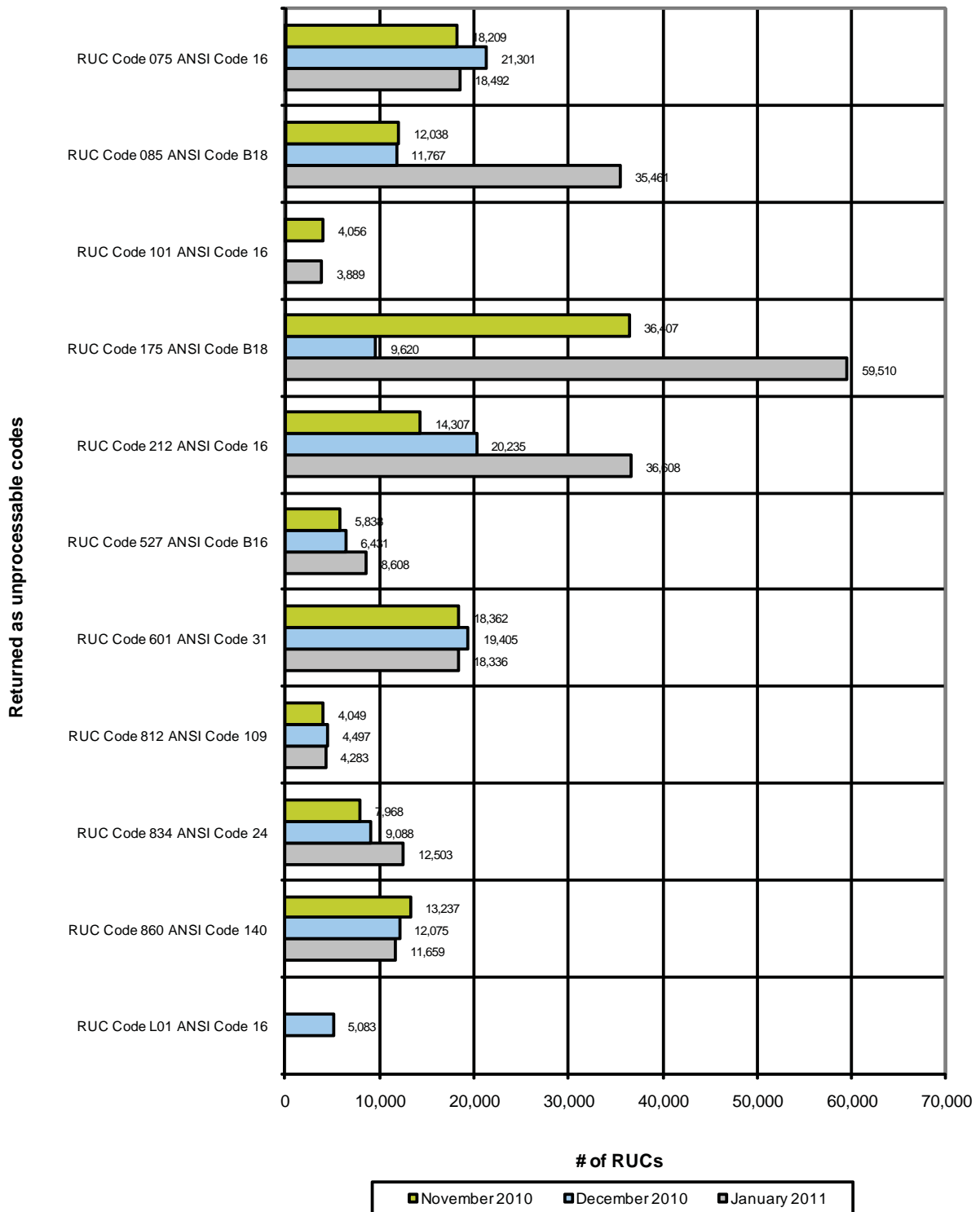
Did you know you can now create an account and receive your personalized Provider Data Summary report?

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

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

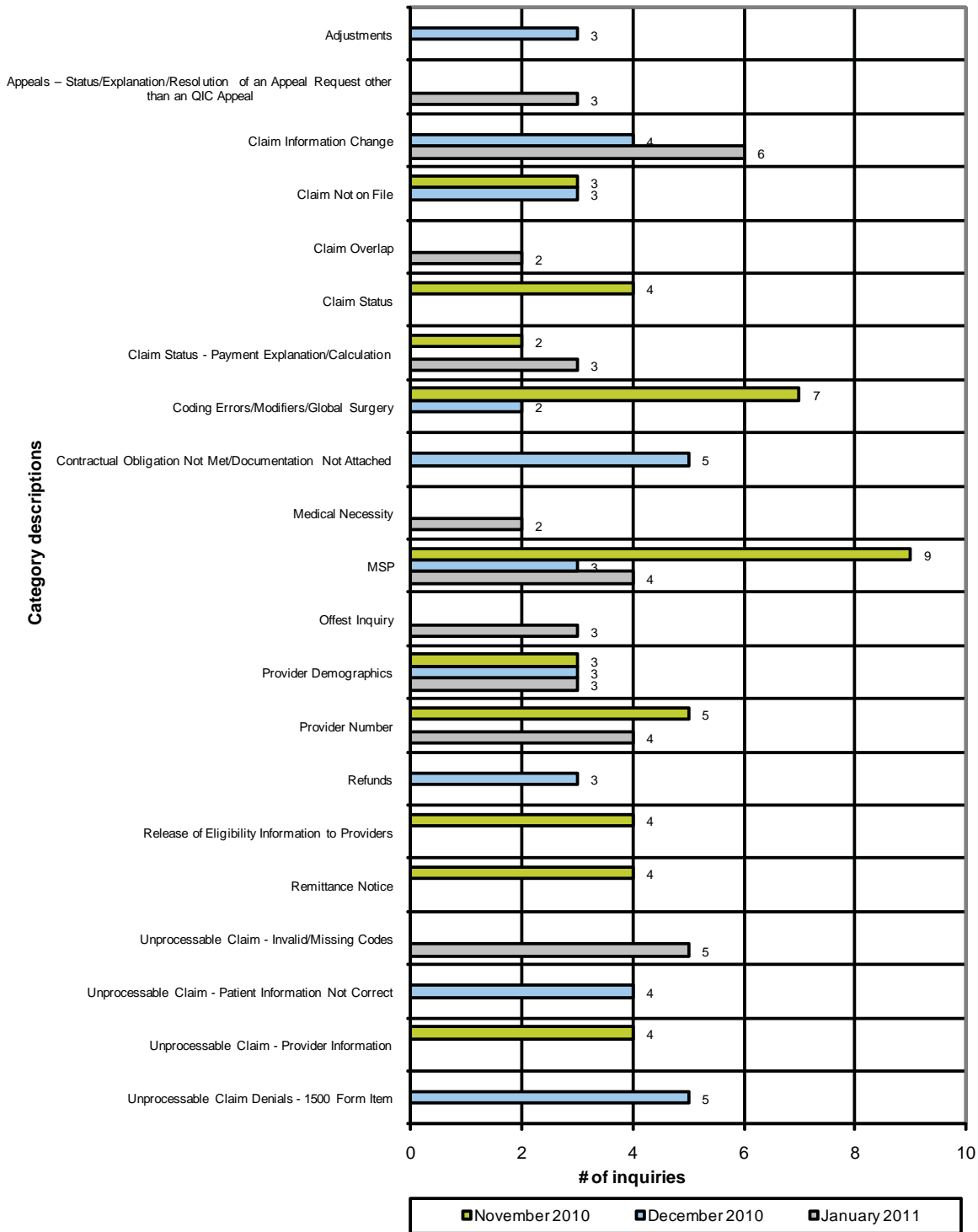
Top inquiries, denials, and return unprocessable claims for November 2010-January 2011 (continued)

Florida Part B top return as unprocessable claims (RUC) for November 2010-January 2011



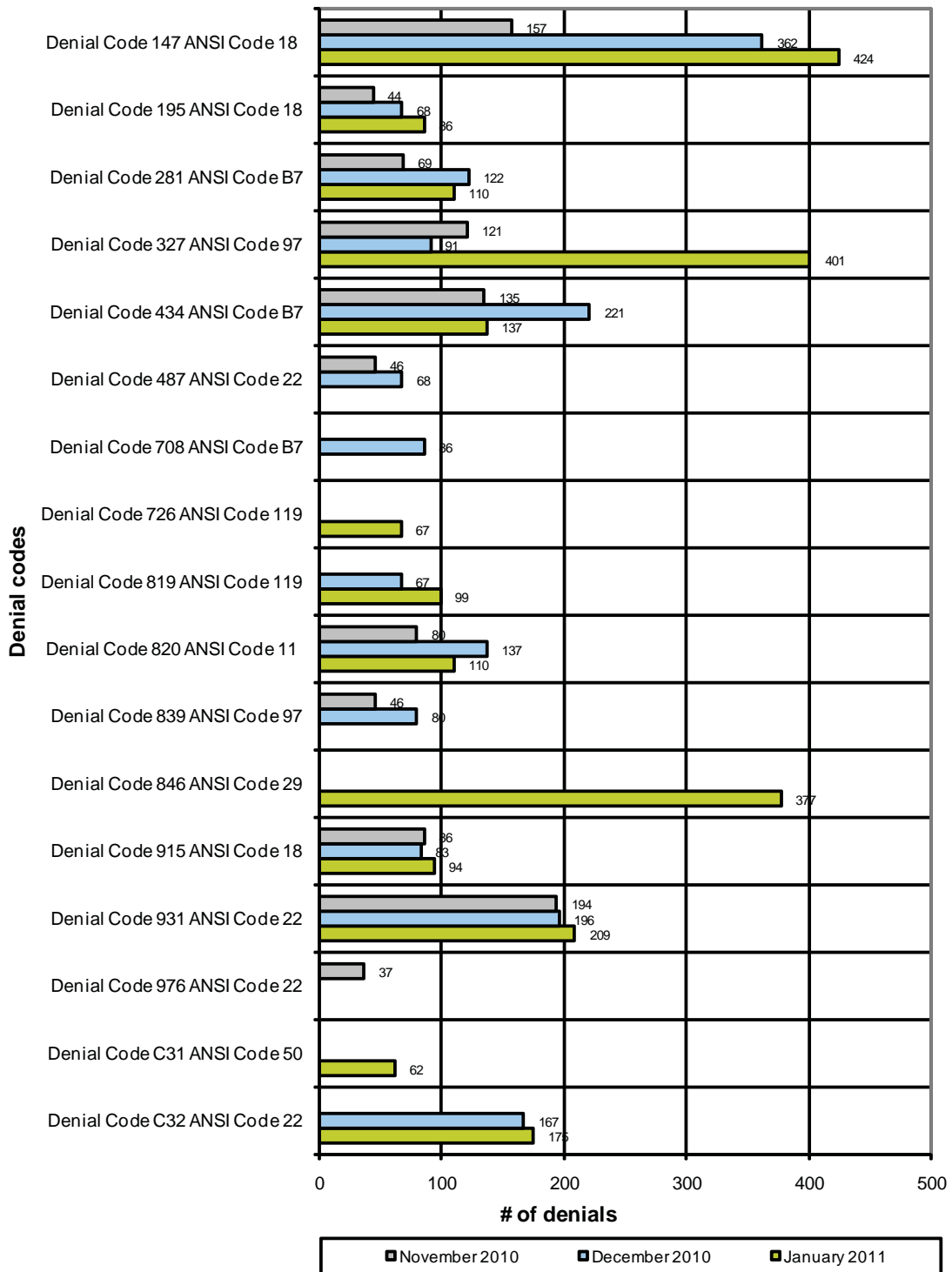
Top inquiries, denials, and return unprocessable claims for November 2010-January 2011 (continued)

U.S. Virgin Islands Part B top inquiries for November 2010-January 2011



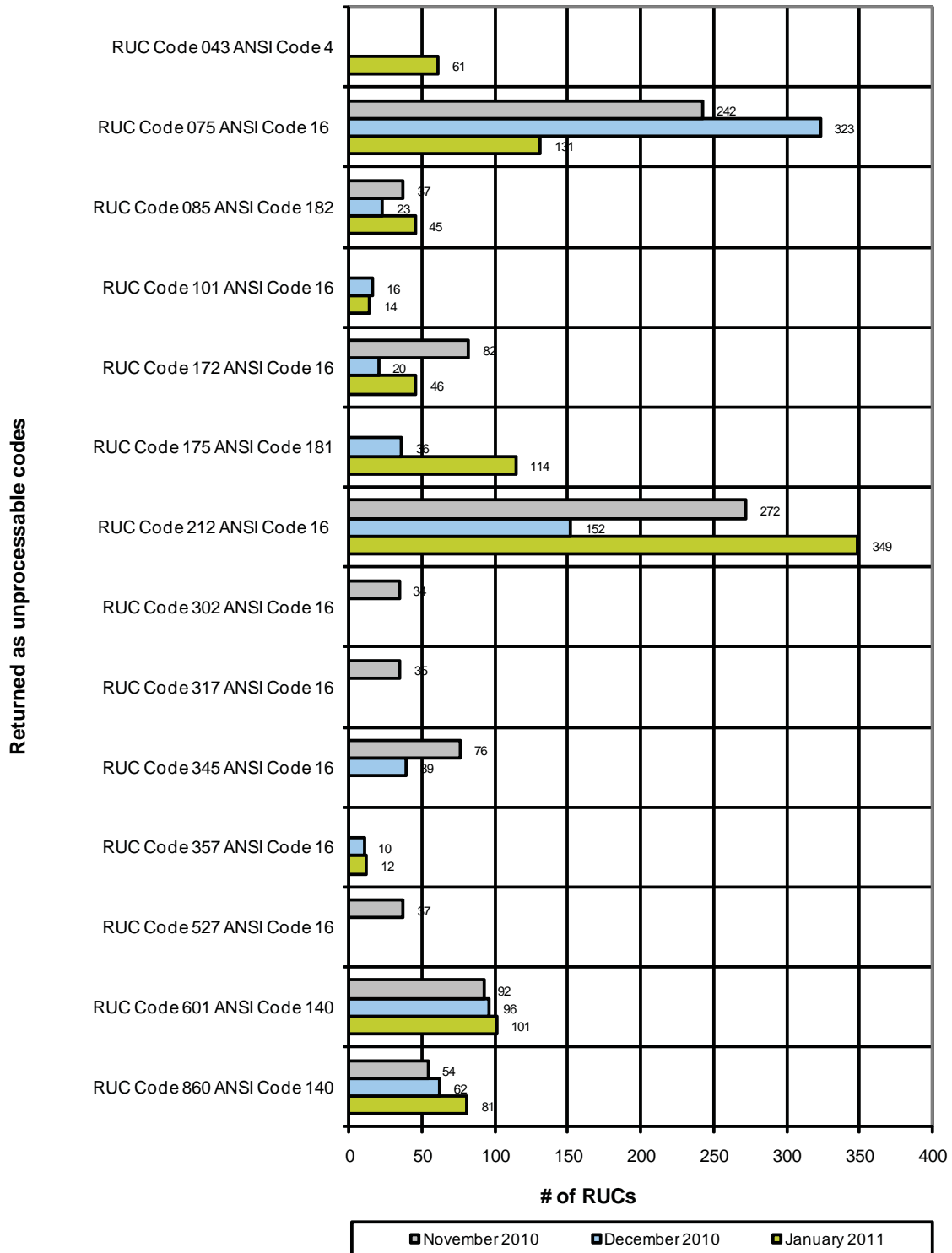
Top inquiries, denials, and return unprocessable claims for November 2010-January 2011 (continued)

U.S. Virgin Islands Part B top denials for November 2010-January 2011



Top inquiries, denials, and return unprocessable claims for November 2010-January 2011 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for November 2010-January 2011



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.fcsso.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

Local Coverage Determinations – Table of Contents

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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.fcsso.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

J9055: Cetuximab (Erbitux®) – revision to the LCD

LCD ID number: L29097 (Florida)

LCD ID number: L29112 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbitux®) was most recently revised on July 22, 2009. Since that time, based on consideration of current literature for “off label use” of Erbitux® for the first -line treatment of advanced non-small cell lung cancer (NSCLC) in combination with cisplatin and vinorelbine chemotherapy drugs the ‘Indications and limitations of Coverage and/or Medical Necessity’ section of the LCD was updated. Also, diagnosis code range 162.0-162.9 was added under the “ICD-9 Codes that Support Medical Necessity” section of the LCD. In addition the “Sources of Information and Basis for Decision” section of the LCD was updated to add additional references considered for this revision.

Effective date

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

J9395: Fulvestrant (Faslodex®) – revision to the LCD

LCD ID number: L29178 (Florida)

LCD ID number: L29430 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for fulvestrant (Faslodex®) 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 recommended dosing schedule language was revised under the “Utilization Guidelines” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after January 25, 2011**, for services rendered **on or after September 9, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

Get motivated by Medicare ...

Find out about Provider Incentive Programs

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

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

Additional Information

G0431: Qualitative Drug Screening – notification of correction LCD ID number: L30574 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for qualitative drug screening was most recently revised on February 13, 2011. When the LCD was updated on the Centers for Medicare & Medicaid Services (CMS) website for this revision, the descriptor for HCPCS code G0431 was incorrect. The descriptor incorrectly reflects “Drug screen single class, high complexity test, (e.g. immunoassay, enzyme assay), each specimen.” The correct descriptor for HCPCS code G0431, based on the 2011 HCPCS Level II book (effective January 1, 2011), is “Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter.” In addition to the descriptor change for HCPCS code G0431, CPT code 80100 and HCPCS code G0430 (which was replaced by HCPCS code G0434 “Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter”) were deleted.

The database will be updated to correct HCPCS code G0431 in the LCD in April 2011. In the meantime, the code descriptor in the 2011 HCPCS Level II book should be utilized for HCPCS code G0431.

A note with a comment will be added to the LCD to clarify the correct descriptor for HCPCS code G0431 in the interim.

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

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2010 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

J3490/C9272: Prolia™ (denosumab)

Prolia™ (denosumab) is a RANK ligand (RANKL) inhibitor indicated for treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy. Prolia™ was approved by the Food and Drug Administration (FDA) on June 1, 2010. Patients must be instructed to take calcium 1000 mg, daily and at least 400 IU of vitamin D daily due to hypocalcemia being a contraindication. Prolia™ is administered 60 mg every six months subcutaneous in the upper arm, upper thigh or abdomen and should be administered by a healthcare professional.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis and FDA guidance for use as well as the administration.

J3490/C9272: Xgeva™ (denosumab)

Xgeva™ (denosumab) is a RANK ligand (RANKL) inhibitor indicated for prevention of skeletal-related events in patients with bone metastases from solid tumors. Xgeva™ is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. Xgeva™ was approved by Food and Drug Administration (FDA) on November 18, 2010. Patients must be instructed to take 1000 mg. of calcium daily and at least 400 IU of vitamin D daily due to hypocalcemia being a contraindication. Xgeva™ is administered 120 mg every four weeks subcutaneous in the upper arm, upper thigh, or abdomen and should be administered by a health care professional.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis and FDA guidance for use as well as the administration.

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 March – May 2011

Bimonthly Medicare Part B ACT: Medicare data and CMS initiatives

When: Wednesday, March 16

Time: 2:00-3:30 p.m.

Bimonthly Medicare Part B ACT: Medicare changes and hot issues - not yet open for registration

When: Wednesday, May 11

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.

Preventive Services

January is National Glaucoma Awareness Month

The month of January has been designated as National Glaucoma Awareness Month. As we approach the end of this month, you are asked to please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of glaucoma and the glaucoma screening service covered by Medicare. Glaucoma is the second most common cause of blindness in the U.S. and affects nearly four million Americans, half of whom do not even know that they have this disease. Through early detection and treatment, blindness can be prevented.

What can you do?

As a health care professional who provides care to seniors, as well as Medicare patients, you can help protect the vision of your patients who may be at high-risk for glaucoma. Please educate them about their risk factors and remind them of the importance of getting an annual glaucoma screening exam covered by Medicare.

Medicare coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older
- A Medicare-covered glaucoma screening includes:
 - A dilated eye examination with an intraocular pressure (IOP) measurement
 - A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

Additional information

- **Glaucoma Screening Brochure** – this *Medicare Learning Network*[®] (MLN) brochure provides Medicare fee-for-service providers with an overview of the Medicare-covered glaucoma screening service. <http://www.cms.gov/MLNProducts/downloads/glaucoma.pdf>
- **Glaucoma Screening Web Page** – this CMS Web page provides an overview of the glaucoma screening service covered by Medicare as well as information on educational resources for health care providers. http://www.cms.gov/GlaucomaScreening/01_Overview.asp
- **The MLN Preventive Services Educational Products Web Page** – this Web page provides a list of MLN educational products related to Medicare-covered preventive services. These resources are specifically for Medicare fee-for-service providers and their staff. http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

For more information about National Glaucoma Awareness Month, please visit <http://preventblindness.org/news/observe.html>. Thank you for joining CMS in promoting increased awareness of glaucoma and the glaucoma screening benefit covered by Medicare.

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

Source: CMS PERL 201101-42

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

‘Quick Reference Information: Medicare Immunization Billing’ chart now in print

The “Quick Reference Information: Medicare Immunization Billing” chart, which provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for influenza vaccine, pneumococcal vaccine, and Hepatitis V Virus (HBV) vaccine and their administration, is now available to order in hardcopy, free of charge, from the *Medicare Learning Network*[®]. To order your copy, visit the Preventive Services Educational products page at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201102-13

Flu shot reminder

It's not too late to give and get the flu vaccine. Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) recommends that patients, health care workers, and caregivers be vaccinated against the seasonal flu. 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 the following CMS websites:

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 201102-01

February is American heart month

Heart disease is the leading cause of death for both men and women in the United States. Approximately every 25 seconds, an American will have a coronary event, yet many cases of heart disease can be prevented. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of cardiovascular screening blood tests for eligible Medicare beneficiaries. These tests can help determine a beneficiary's cholesterol and other blood-lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this coverage, which can determine whether beneficiaries may be at risk for cardiovascular disease.

Medicare coverage – the following cardiovascular screening blood tests are covered by Medicare for eligible beneficiaries for the early detection of cardiovascular disease:

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

These blood tests are covered once every five years for people with Medicare who have no apparent signs or symptoms of cardiovascular disease; the tests must be ordered by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) treating the beneficiary.

What can you do? – CMS needs your help to ensure that all eligible people with Medicare take advantage of the cardiovascular screening blood tests that can help identify beneficiaries who may be at risk for cardiovascular disease.

More information – for more information about Medicare coverage of cardiovascular screening blood tests, please refer to the following resources:

- *Expanded Benefits* brochure – this Medicare Learning Network® (MLN) brochure provides Medicare fee-for-service providers with an overview of the Medicare-covered cardiovascular screening blood tests, as well

as the “Welcome to Medicare” visit and the ultrasound screening for abdominal aortic aneurysms. Read at http://www.CMS.gov/MLNProducts/downloads/expanded_benefits.pdf.

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services including the cardiovascular screening blood tests. Read at http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- Cardiovascular Disease Screening page – this CMS page provides an overview of the cardiovascular screening blood tests covered by Medicare as well as information on educational resources for health care providers. Visit <http://www.CMS.gov/CardiovasDiseaseScreening>.
- The MLN Preventive Services Educational Products page – this page provides a list of MLN educational products related to Medicare-covered preventive services. These resources are specifically for Medicare fee-for-service providers and their staff. Visit at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp.

Additionally, visit the Centers for Disease Control and Prevention's American Heart Month website at http://www.CDC.gov/heartdisease/american_heart_month.htm

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

Source: CMS PERL 201102-12

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Other Educational Resources

Updates from the Medicare Learning Network

The following new and revised resources are available from the *Medicare Learning Network*® (MLN).

Publications For Your Medicare Beneficiaries fact sheet

The *Medicare Learning Network*® (MLN) has released a new product titled “*Publications For Your Medicare Beneficiaries*.” This fact sheet lists a variety of beneficiary-related publications available to assist providers in responding to patients’ questions related to Medicare, all of which can be printed and provided to patients. This product is available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/BenePubFS-ICN905183.pdf> and is suggested for all providers.

Guidelines for Teaching Physicians, Interns, and Residents fact sheet revised

The “*Guidelines for Teaching Physicians, Interns, and Residents*” (revised December 2010) is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>. This fact sheet provides information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines.

HIPAA EDI Standards Web-based training revised

The MLN is now offering the revised *HIPAA EDI Standards* Web-based training (revised January 2011) for continuing education (CE) credit. The goal of this activity is to provide information to physicians, suppliers, and health care professionals regarding electronic billing and other health care electronic transactions such as the Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA), electronic transaction standards and code sets required by HIPAA, and an overview of the steps involved in the Medicare electronic data interchange process. To take this training, visit <http://www.CMS.gov/MLNProducts> and click on “Web-Based Training Modules” under “Related Links Inside CMS.”

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers publication revised

The publication titled *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers* (revised October 2010) is designed to educate institutional and professional providers who bill Medicare with general remittance advice (RA) information. It includes instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims and provides guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs), as well as information on balancing an RA. This publication may be downloaded from http://www.CMS.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.

Evaluation and Management Services Guide publication revised

The publication titled *Evaluation and Management Services Guide* (revised December 2010) is now available in downloadable format from the MLN at http://www.CMS.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations. The “1995 Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services” are included in this publication.

CMS Email Subscription Service publication available in print

The educational tool titled *CMS Email Subscription Service* (revised October 2010), which provides education on the various CMS fee-for-service (FFS) electronic mailing lists, is now available in print format from the MLN. To place your order, visit <http://www.CMS.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201102-28

‘Ambulatory Surgical Center Fee Schedule’ fact sheet now available

The revised publication titled “*Ambulatory Surgical Center Fee Schedule*” (January 2011) is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/AmbSurgCtrFeeptymftsh508-09.pdf>. This fact sheet is designed to provide education on the ambulatory surgical center (ASC) fee schedule and includes information about the definition of an ASC, ASC payment, and how payment rates are determined.

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

Source: CMS PERL 201101-50

EHR-related fact sheets now available in print

The following fact sheets related to electronic health records (EHR) are now available in print format from the *Medicare Learning Network*. To place an order, visit <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

- *EHR Incentive Program for Critical Access Hospitals* (ICN #904627)
- *EHR Incentive Program for Medicare Hospitals* (ICN #904626)
- *Medicare Electronic Health Record Incentive Program for Eligible Professionals* (ICN #903695)
- *Medicaid Electronic Health Record Incentive Payments For Eligible Professionals* (ICN #904763)
- *Medicaid Hospital Incentive Payments Calculations* (ICN #904764)
- *Medicare EHR Incentive Program, Physician Quality Reporting System, and e-Prescribing Comparison* (ICN #903691) – identifies opportunities for certain Medicare providers to receive incentive payments for participating in important Medicare initiatives.

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

Source: CMS PERL 201102-13

Revised – ‘The 2007 Physician Quality Reporting Initiative’ publication

A revised *Medicare Learning Network*® publication titled “The 2007 Physician Quality Reporting Initiative (PQRI)” (November 2010) is now available in downloadable format at

<http://www.CMS.gov/MLNProducts/downloads/PQRIbooklet012811-ICN905743.pdf>. This booklet is a compilation of the Centers for Medicare & Medicaid Services’ (CMS) various educational resources relevant to the 2007 Physician Quality Reporting Initiative.

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

Source: CMS PERL 201102-45

Be proactive: Use the PDS report

- Identify negative billing patterns
- Benefit from peer comparisons
- Prevent recurring billing issues
- Improve your bottom line

Accessible through FCSO’s PDS portal at <http://medicare.fcso.com/reporting/index.asp>

**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 ◆