

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/>.

Routing Suggestions:

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



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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.fcso.com>. 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 website(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Update!* in hardcopy is limited to providers who have billed at least one Part B claim to FCSO Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *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.*

Annual Medicare B Update! hardcopy registration form

To receive free editions of the Part B publication in hardcopy, , or e-mail format, you must complete this registration form. To receive a hardcopy or e-mail of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by May 31, 2011.** Providers currently receiving hardcopy publications must renew by using this form. Providers who do not renew by the May 31 deadline will no longer receive free hardcopy versions after the September 2011 issue. The publication cycle begins every year on October 1 and concludes September 30.

If you miss the registration deadline, you still have the ability to receive a hard copy through subscription. The annual cost for a hardcopy subscription is \$33. Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider website: http://medicare.fcso.com/Publications_B/index.asp.

Provider/facility name: _____

National provider identifier (NPI): _____

Address: _____

City, state, ZIP code: _____

Contact person/title: _____

Telephone number: _____ Fax number: _____ E-mail address: _____

Registration type: NEW RENEWAL

Language preference: English Español

Rationale for needing a hardcopy:

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Will you accept publications via e-mail? YES NO

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Note: Providers who qualify will receive one copy of each monthly publication.

Fax your completed form to:
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1-904-361-0723

Please share your questions and/or concerns regarding this initiative with us. _____

Additional questions or concerns may be submitted via the Medicare provider education website at <http://medicare.fcso.com/Feedback/index.asp>. You also may fax your questions or comments to 1-904-361-0723. **Our Provider contact center will not be able to respond to inquiries about this form.**

CLAIMS

The importance of correctly coding the place of service

Provider types affected

This article is for physicians and their billing agents who submit claims to Medicare carriers or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Incorrectly coding the place of service code on your claims could result in overpayments that will need to be recovered.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) reminds physicians and their billing agents of the importance of correctly coding the place of service and the need for appropriate controls to prevent billing Medicare with incorrect place of service codes.

Go – what you need to do

It is extremely important that you correctly code the place of service on Part B claims. Using non-facility place-of-service codes for services that are actually performed in hospital outpatient departments or ambulatory surgical centers (ASCs) often results in overpayments. You must insure you have adequate controls in your (or your billing agent's) billing routines to identify potential place-of-service coding errors.

Background

Medicare Part B payments for physician services

Medicare Part B pays for services that physicians provide to Medicare beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. These services may be provided in facility settings, such as hospital outpatient departments and freestanding ASCs, or in non-facility locations, such as physician offices, urgent care centers, and independent clinics.

Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance.

Medicare reimbursement for practice expense

Practice expense reflects the overhead costs involved in providing a service. To account for the increased practice expense that physicians generally incur by performing services in their offices and other non-facility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations rather than in a hospital outpatient department or an ASC. Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors.

The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the service when the service is performed in a facility setting.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare; other offices hire billing agents to submit their claims. Physicians are responsible for any Medicare claims submitted by billing agents.

Audit finding of the Office of the Inspector General

The Office of the Inspector General (OIG) conducted an audit to determine whether physicians correctly coded non-facility places of service on selected Part B claims submitted to and paid by Medicare contractors. That report, titled *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007*, is available to the public at <http://oig.hhs.gov/oas/reports/region1/10900503.asp>.

Basically, the OIG found that, in many instances, physicians are incorrectly coding the place-of-service code. Specifically, in a very large portion of the claims audited, physicians used non-facility place-of-service codes on their claims for services that were actually performed in hospital outpatient departments or ASCs. This led to overpayments by Medicare on these claims. Medicare does recover these overpayments so it is critical to code correctly and avoid overpayments.

Additional information

To find an overview of place of service coding as well as a list of the appropriate codes, visit <http://www.cms.gov/PlaceofServiceCodes/>. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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 Implementation Date: N/A

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April update of correct coding initiative edits

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7331, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2011.

Background

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

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

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

The latest package of CCI edits, version 17.1, is effective April 1, 2011, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

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

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. The official instruction (CR 7331) issued to your carrier or A/B MAC regarding this change is at <http://www.cms.gov/Transmittals/downloads/R2179CP.pdf>. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7331

Related Change Request (CR) #: 7331

Related CR Release Date: March 18, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2179CP

Implementation Date: April 4, 2011

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Take advantage of FCSO's exclusive PDS report

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

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 201103-38

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>

Ambulance

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

Note: This article was revised on February 23, 2011, to reflect the revised change request (CR) 7018 issued on February 21, 2011. In this article, the CR transmittal number, release date, effective date, implementation date, and the Web address for accessing CR 7018 were revised. All other information remains the same. This information was previously published in the January 2011 *Medicare B Update!* page 5.

Provider types affected

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

What you need to know

This article is based on CR 7018, which updates the *Medicare Claims Processing Manual* to note provisions extending several ambulance payment rate increases that were recently enacted by the Affordable Care Act of 2010. Specifically, the Affordable Care Act extends the increases of 3 percent for rural services and 2 percent for urban services through December 31, 2010. These increases had been initially required by the Medicare Modernization Act and were extended by the Medicare Improvements for Patients and Providers Act of 2008. CR 7018 also corrects the same manual's Chapter 15, Section 30.1.2 to specify that the correct field for reporting the ZIP code of the point-of-pickup of an ambulance trip on a CMS-1500 claim form is Item 23, instead of item 32 as previously mentioned in that manual section.

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

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

Additional information

The official instruction, CR 7018, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2162CP.pdf>. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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2011 ambulance inflation factor and productivity adjustment

Note: This article was revised on February 17, 2011, to include the last note in the *Background* section regarding important information for provider-based ambulance services that have not converted to the 5010 format. All other information remains the same. This information was previously published in the December 2011 *Medicare B Update!* pages 8-9.

Provider types affected

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

What you need to know

Change request (CR) 7065, from which this article is taken, provides a new procedure for reporting fractional mileage amounts on ambulance claims, effective for claims for dates of service on or after January 1, 2011. Prior to that date, mileage is reported by rounding the total mileage up to the nearest whole mile. Be sure billing personnel are aware of this change that requires ambulance providers and suppliers to report to the nearest tenth of a mile for total mileage of less than 100 miles on ambulance claims as of January 1, 2011.

continued on next page

2011 ambulance inflation factor and productivity adjustment (continued)**Background**

Currently, the *Medicare Claims Processing Manual*, Chapter 15, Sections 30.1.2 and 30.2.1 require that ambulance providers and suppliers submitting claims to Medicare contractors use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to these instructions from the Centers for Medicare & Medicaid Services (CMS), providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837 electronic claim. For ambulance suppliers submitting claims to the Medicare carriers or A/B MACs, the *Medicare Claims Processing Manual*, Chapter 26, Section 10.4 additionally states that at least one (1) unit must be billed in Item 24G on the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than one mile during a covered trip, the supplier would enter one unit on the claim form with the appropriate HCPCS code for mileage.

In the CY 2011 Medicare physician fee schedule (MPFS) final rule, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. The final rule requires that, effective January 1, 2011, all Medicare ambulance providers and suppliers bill mileage that is accurate to a tenth of a mile.

Note: Currently the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in effect prior to January 1, 2011, that is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate

place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

For trips totaling 100 miles and greater, suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

For mileage totaling less than one mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Note: The remittance advice for provider-based ambulance services will indicate whole units, rather than fractions, for providers that have not transitioned to the 5010 format. However, the payment reported on the remittance advice may be paid based off fractional mileages as reported on the institutional claim.

Additional information

The official instruction, CR 7065, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2103CP.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: MM7065 *Revised*
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Consolidated Billing

Corrections to skilled nursing facility consolidated billing codes

When change request 7159 (2011 Annual Update of Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update) was implemented in January 2011, a few codes were not included in the claim processing system edits. A correction to add the codes listed below to the claims processing system edits was implemented on Monday, March 14, 2011.

Providers who submitted claims for these services before Monday, March 14, 2011, may have had claims incorrectly denied. Providers who believe they received an incorrect denial should contact their Medicare carrier or Medicare administrative contractor (MAC) to have the claims reopened and reprocessed. Claims containing any of the codes below that were processed on or after Monday, March 14, 2011, will process correctly. Additional questions should be directed to your Medicare carrier or MAC.

The affected HCPCS codes are as follows: 76519, 76529, 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76800, 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828, 76830, 76831, 76856, 76857, 76870, 76872, 76873, and 76876.

Source: CMS PERL 201103-42

Diabetes Self-Management Training

DSMT services – clarification of national standards

For qualified RDs, RNs, or pharmacists

The Centers for Medicare & Medicaid Services (CMS) recently clarified payment policy regarding the quality standards applicable to diabetes self-management training (DSMT) providers. In particular, CMS instructed contractors about the differences between the quality standards for entities following the CMS quality standards and those following the National Standards for Diabetes Self-Management Training Program (national standards).

- CMS quality standards** – DSMT providers following CMS quality standards generally require a multidisciplinary team approach to the provision of DSMT services (although there is an exception to this requirement which permits a registered dietitian who is also a certified diabetes educator to individually furnish DSMT services in a rural area). In addition, CMS has noted that a dietitian may not be the sole provider of the DSMT service. CMS has instructed contractors that this exception and special note are applicable only to those entities following the CMS quality standards.
- National standards** – national standards no longer require a multidisciplinary team approach, although these quality standards note that DSMT services are most effective when delivered by multidisciplinary teams consisting of a registered dietitian (RD), registered nurse (RN), and pharmacist as the key primary instructors for diabetes educators assisting in the delivery of services. Current national standards require that at least one member of the team (or, if no team, the individual furnishing the training) must be an RD, an RN, or a pharmacist. The national standards continue to call for all of the instructor(s) on the diabetes team to be certified as diabetes educator(s) or have recent educational and experiential preparation in education and diabetes management. However, the review and approval of credentials of DSMT program instructors is solely the role of the accrediting organization (listed below).

Until the *Medicare Benefit Policy Manual* is revised, contractors have been instructed to recognize that DSMT services may be furnished by an individual RD, RN, or pharmacist when those services are billed by, or on behalf of, a DSMT entity accredited as meeting the National Standards by the American Diabetes Association, Indian Health Service, or the American Association of Diabetes Educators, which are all CMS-approved accrediting organizations that use the national standards for DSMT programs. This clarification does not affect who can qualify as “certified providers” to bill for DSMT services and, as such, payment for DSMT services may only be made to a physician, individual, or other provider that bills Medicare for other services for which direct Medicare payment may be made by CMS.

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Diabetes self-management training services – clarification of national standards (continued)

When following the National Standards, RDs may submit claims and be paid directly for DSMT services, as appropriate, because RDs are permitted to bill and receive payment for other Medicare services. However, since pharmacists and RNs cannot bill and receive payment directly from CMS for these types of services, the DSMT services they furnish to Medicare beneficiaries are billed by other certified providers, as appropriate, on their behalf.

Source: CMS PERL 201102-48

Drugs and Biologicals

Payment update and common working file editing for influenza virus vaccine and pneumococcal vaccine codes

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs) for Medicare beneficiaries receiving influenza vaccines or pneumococcal vaccines (PPV) are affected.

What you need to know

The influenza virus vaccine Healthcare Common Procedure Coding System (HCPCS) code 90662 (*Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*) and PPV HCPCS code 90670 (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*) are being added to existing edits to prevent payment duplication for claims processed on or after July 5, 2011. Make sure your coding and billing staff is aware of this change.

Background

In order to prevent duplicate payments for influenza virus vaccine and PPV claims by the same contractor, the Centers for Medicare & Medicaid Services (CMS) has implemented a number of edits that were effective for claims received on or after July 1, 2002.

Change request (CR) 7128 provides instructions for payment and common working file (CWF) edits to be updated to include influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 for claims processed on or after July 5, 2011.

Basis for influenza vaccine and PPV payments

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to hospitals (Types of bill (TOB) 12x and 13x), skilled nursing facilities (SNFs) (TOBs 22x and 23x), home health agencies (HHAs) (TOB 34x), hospital-based renal dialysis facilities (RDFs) (TOB 72x), and critical access hospitals (CAHs) (TOB 85x) is based on reasonable cost;

- The payment for influenza virus vaccine HCPCS code 90662 and PPV HCPCS code 90670 to Indian Health Service (IHS) hospitals (TOB 12x, 13x) and IHS CAHs (TOB 85x) is based on 95 percent of the average wholesale price (AWP); and
- The payment for influenza virus vaccine HCPCS code 90662 and PPV code 90670 to comprehensive outpatient rehabilitation facilities (TOB 75x) and independent renal dialysis facilities (RDF) (TOB 72x) is based on the lower of the actual charge or 95 percent of the AWP.

Contractors will not search their files to either retract payment for claims already paid or retroactively pay claims. However, they will adjust claims brought to their attention.

Additional information

The official instruction, CR 7128 issued to your carrier, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2154CP.pdf>. If you have any questions, please contact your carrier, FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7128
 Related Change Request (CR) #: 7128
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 Related CR Transmittal #: R2154CP
 Implementation Date: July 5, 2011

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Revised April 2011 average sales price files are now available

The Centers for Medicare & Medicaid Services (CMS) has posted revised average sales price (ASP) files for April 2011 and restated files for prior quarters. All are available for download at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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

Source: CMS PERL 201103-46

Evaluation and Management

Incentive payment program for primary care services

Note: This article was revised on March 11 to add a reference to MM7267, informing providers that the primary care incentive payment program (PCIP) is being amended. This article was also revised on February 28, 2011, to reflect a revised change request (CR) 7060, issued on February 25. A reference to MM7115 was also added in the *Additional information* section. The CR release date, transmittal number, and the Web address for accessing CR 7060 has been updated. All other information is the same. This information was previously published in the November 2010 *Medicare B Update!* pages 13-15.

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare carriers and Part A/B Medicare administrative contractors (A/B MAC) for primary care services provided to Medicare beneficiaries are affected.

What you need to know

This article, based on CR 7060, explains that Section 5501(a) of The Affordable Care Act provides for an incentive payment for primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner. The incentive payment will be paid on a monthly or quarterly basis in an amount equal to 10 percent of the payment amount for such services under Part B. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Section 5501(a) of The Affordable Care Act revises Section 1833 of The Social Security Act by adding new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Social Security Act states that, in the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, there also will be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

Specifically, the incentive payments will be made on a quarterly basis and will equal 10 percent of the amount paid for primary care services under the Medicare physician fee schedule for those services furnished during the bonus payment year. (For bonus payments to critical access hospitals paid under the optional method, see Chapter 4, Section 250.12 of the *Medicare Claims Processing Manual* at <http://www.cms.gov/manuals/downloads/clm104c04.pdf>.)

Note: The new health professional shortage area (HPSA) surgical incentive payment program (HSIP) and the new PCIP will be implemented in conjunction with one another for CY 2011. A separate article will be available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7063.pdf> upon release of CR 7063 CR for HSIP. The former "special HPSA remittance" will now be known as the "special incentive remittance." This change is necessary as the PCIP is open to all eligible primary care providers, regardless of the geographic location in which the primary care services are being furnished.

Primary care practitioner defined

Section 5501(a)(2)(A) of The Affordable Care Act defines a primary care practitioner as:

- A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, or
- A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the physician fee schedule (PFS) for the practitioner in a prior period as determined appropriate by the Secretary of Health and Human services.

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Incentive payment program for primary care services (continued)

Primary care services defined

Section 5501(a)(2)(B) of The Affordable Care Act defines primary care services as those services identified by the following *Current Procedure Terminology (CPT)* codes as of January 1, 2009, (and as subsequently modified by the Secretary of Health and Human Services, as applicable):

- 99201 through 99215 for new and established patient office or other outpatient evaluation and management (E/M) visits
- 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services, and
- 99341 through 99350 for new and established patient home E/M visits.

These codes are displayed in the following table. All of these codes remain active in calendar year (CY) 2011 and there are no other codes used to describe these services.

Primary care services eligible for primary care incentive payments in CY 2011

CPT codes	Description
99201	<i>Level 1 new patient office or other outpatient visit</i>
99202	<i>Level 2 new patient office or other outpatient visit</i>
99203	<i>Level 3 new patient office or other outpatient visit</i>
99204	<i>Level 4 new patient office or other outpatient visit</i>
99205	<i>Level 5 new patient office or other outpatient visit</i>
99211	<i>Level 1 established patient office or other outpatient visit</i>
99212	<i>Level 2 established patient office or other outpatient visit</i>
99213	<i>Level 3 established patient office or other outpatient visit</i>
99214	<i>Level 4 established patient office or other outpatient visit</i>
99215	<i>Level 5 established patient office or other outpatient visit</i>
99304	<i>Level 1 initial nursing facility care</i>
99305	<i>Level 2 initial nursing facility care</i>
99306	<i>Level 3 initial nursing facility care</i>
99307	<i>Level 1 subsequent nursing facility care</i>
99308	<i>Level 2 subsequent nursing facility care</i>
99309	<i>Level 3 subsequent nursing facility care</i>
99310	<i>Level 4 subsequent nursing facility care</i>
99315	<i>Nursing facility discharge day management; 30 minutes</i>
99316	<i>Nursing facility discharge day management; more than 30 minutes</i>
99318	<i>Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment</i>
99324	<i>Level 1 new patient domiciliary, rest home, or custodial care visit</i>
99325	<i>Level 2 new patient domiciliary, rest home, or custodial care visit</i>
99326	<i>Level 3 new patient domiciliary, rest home, or custodial care visit</i>
99327	<i>Level 4 new patient domiciliary, rest home, or custodial care visit</i>
99328	<i>Level 5 new patient domiciliary, rest home, or custodial care visit</i>
99334	<i>Level 1 established patient domiciliary, rest home, or custodial care visit</i>
99335	<i>Level 2 established patient domiciliary, rest home, or custodial care visit</i>
99336	<i>Level 3 established patient domiciliary, rest home, or custodial care visit</i>
99337	<i>Level 4 established patient domiciliary, rest home, or custodial care visit</i>
99339	<i>Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes</i>
99340	<i>Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more</i>
99341	<i>Level 1 new patient home visit</i>
99342	<i>Level 2 new patient home visit</i>

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Incentive payment program for primary care services (continued)

CPT codes	Description
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit
99350	Level 4 established patient home visit

Primary care incentive payment program (PCIP)

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of nonphysician practitioners, enrolled in Medicare with a primary care specialty designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the PFS for such practitioner during the time period that has been specified by the Secretary.

CMS will provide Medicare contractors with a list of the national provider identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments.

Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP. In order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific nonphysician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary care services that equals or exceeds the 60 percent threshold.

Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data two years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.

Coordination with other payments

Section 5501(a)(3) of The Affordable Care Act provides payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under Section 1833(m) of The Social Security Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

Additional information

If you have questions about this article, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction, CR 7060, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2161CP.pdf>. You should also review *MLN Matters*® article MM7115 at <http://www.cms.gov/MLNMattersArticles/downloads/MM7115.pdf> for additional information relative to this program.

MLN Matters® Number: MM7060 *Revised*

Related Change Request (CR) #: 7060

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Summary information regarding the Medicare Primary Care Incentive Payment Program

Provider types affected

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

What you need to know

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

Q1. How does Section 5501(a) of the Affordable Care Act change Medicare?

A1. Beginning with services rendered on or after January 1, 2011 and continuing through December 31, 2015, Section 5501(a) of the Affordable Care Act authorizes an incentive payment of 10 percent of Medicare's payments to be paid to qualifying primary care physicians and NPPs who furnish specified primary care services.

Q2. Which Medicare specialty designations may potentially qualify as primary care physicians or NPPs?

A2. A potentially qualified primary care physician or NPP, as defined in Section 1833 (x) of the Social Security Act, is a physician with a Medicare specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine or an NPP with a specialty designation of nurse practitioner (NP),

clinical nurse specialist (CNS), or physician assistant (PA).

Q3. How can I confirm my primary specialty designation in Medicare?

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

Q4. What are the additional qualifying criteria for the primary care incentive payment program?

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

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

Q5. What are the specific primary care services that are eligible for incentive payments?

A5. The specific services are defined by the following *Current Procedural Terminology (CPT)* codes:

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

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

Q6. What if I am a physician or NPP newly enrolled in Medicare and do not have claims data from two years prior to the PCIP payment year?

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

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Summary information regarding the Medicare Primary Care Incentive Payment Program (continued)

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

Q7. How can I verify my percentage of primary care services from the claims data year used for eligibility determination (for example, CY 2009 data for the CY 2011 PCIP payment year)?

A7. You may contact your Medicare claim processing contractor to confirm your percentage of primary care services for CY 2009.

Q8. Do I need to enroll in the PCIP program to participate?

A8. No, there is no enrollment process for participation in the PCIP. The NPIs of qualified primary care physicians and NPPs are identified by CMS based on an analysis of historical Medicare claims.

Q9. How can I confirm that I am eligible for the PCIP?

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

Q10. If I qualify for the PCIP payments in calendar year (CY) 2011, will I have to qualify again for the remaining PCIP payment years?

A10. Yes, each physician or NPP must re-qualify for each PCIP payment year. Eligibility for established physicians and NPPs is determined using claims data from the most recent full calendar year (CY) of data available. For example, CY 2011 PCIP payment year eligibility was determined based on PFS claims from CY 2009.

Q11. What if I have changed Medicare claims processing contractors in the past two years?

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

Q12. Whom may I contact if I have questions regarding my PCIP eligibility status?

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

Q13. Do I need to identify PCIP participation on submitted claims?

A13. No, services eligible for PCIP payment are identified based on the qualifying physician's or NPP's NPI on the claim and the CPT codes for eligible primary care services.

Q14. What if I am part of a physician group?

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

Q15. What if I am a qualifying physician or NPP who has reassigned my Medicare billing rights to a critical access hospital (CAH)?

A15. Primary care incentive payments will be made to CAHs of behalf of qualifying primary care physicians and NPPs.

The rendering physician or NPP is identified on the CAH claim by the NPI in the "other provider" field and the eligible primary care services are identified by the CPT codes.

Q16. How often will PCIP payments be made?

A16. Primary care incentive payments will be made quarterly.

Q17. Will this incentive payment be coordinated with other bonus payments?

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

Q18. Will I receive a written notice from Medicare if I become eligible for the PCIP payment in future payment years?

A18. No, each PCIP payment year Medicare will provide a national PCIP eligibility file for contractors to post to their websites. Physicians and NPPs will continue to confirm PCIP eligibility for each payment year via this data file.

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Summary information regarding the Medicare Primary Care Incentive Payment Program (continued)

Q19. Will I receive written notice from Medicare if I become ineligible for the PCIP payment in future PCIP payment years?

A19. No, if you become ineligible for future PCIP payment years, you will not be contacted by Medicare.

Q20. What if I have other questions regarding my PCIP eligibility status?

A20. Physicians and NPPs should contact their claims processing contractor with any questions regarding their eligibility for the PCIP.

Additional information

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

MLN Matters® article MM7267 (*Primary Care Incentive Payment Program (PCIP) Eligibility for New Providers Enrolled in Medicare*) explains that (effective July 1, 2011), the PCIP is amended to include the participation of certain newly enrolled Medicare primary care physicians and NPPs who do not have a

prior two year claims history with which to determine eligibility. <http://www.cms.gov/MLN MattersArticles/downloads/MM7267.pdf>.

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

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

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 Implementation Date: January 1, 2011

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Expansion of Medicare telehealth services for calendar year 2011

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

Note: This article was revised on March 1, 2011, to reflect a revised CR 7049 that was issued on February 28, 2011. The CR was revised to show that implementation will not occur until April 4, 2011, by fiscal intermediaries and A/B MACs that use the Fiscal Intermediary Shared System to process claims. Also, Medicare contractors will not reprocess claims that are processed prior to the implementation dates above. They will adjust such claims that you bring to their attention. The CR release date, transmittal numbers, and the Internet address for accessing the CR have been revised. All other information remains the same. This information was previously published in the December 2010 *Medicare B Update!* pages 17-19.

Provider types affected

This article is for physicians, nonphysician practitioners (NPPs), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7049 to alert providers that 14 Healthcare Common Procedure Coding System (HCPCS) codes were added to the list of Medicare telehealth services for:

- Individual and group kidney disease education (KDE) services
- Individual and group diabetes self-management training (DSMT) services
- Group medical nutrition therapy (MNT) services
- Group health and behavior assessment and intervention (HBAI) services, and
- Subsequent hospital care and nursing facility care services.

Make sure your billing staffs are aware of these changes.

Background

As noted in the 2011 “Medicare Physician Fee Schedule Final Rule” published on November 29, 2010, CMS is adding 14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital

continued on next page

Expansion of Medicare telehealth services for calendar year 2011 (continued)

care and nursing facility care services. Payment for these services will be made at the applicable physician fee schedule (PFS) payment amount for the service of the physician or practitioner. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* and those changes may be reviewed by consulting CR 7049 at <http://www.cms.gov/Transmittals/downloads/R2168CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R140BP.pdf>.

Key points of CR 7049

CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services:
 - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour)
 - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour)
- Individual and group DSMT services (with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):
 - HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes)
 - HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes)
- Group MNT and HBAI services, *Current Procedural Terminology (CPT)* codes:
 - 97804 (*Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*)
 - 96153 (*Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)*)
 - 96154 (*Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)*)
- Subsequent hospital care services, with the limitation of one telehealth visit every three days; *CPT* codes:
 - 99231 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit*)
 - 99232 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication*)
 - 99233 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit*)
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, *CPT* codes:
 - 99307 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit*)
 - 99308 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit*)

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Expansion of Medicare telehealth services for calendar year 2011 (continued)

- 99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit)
- 99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit)

Note: The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

- For dates of service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GQ or GT.
- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GQ or GT by critical access hospitals (CAHs) that have elected Method II on TOB 85x.

Additional information

Your Medicare contractor will not search their files to reprocess any impacted claims that were processed prior to the implementation dates above. However, they will adjust such claims that you bring to their attention.

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the "*Medicare Benefit Policy Manual*" and those changes may be reviewed by consulting CR 7049 at <http://www.cms.gov/Transmittals/downloads/R2168CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R140BP.pdf>.

MLN Matters® Number: MM7049 *Revised*

Related Change Request (CR) #: 7049

Related CR Release Date: February 28, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2168CP and R140BP

Implementation Date: January 3, 2011, (for those billing carriers or A/B MACs); April 4, 2011, (for those billing fiscal intermediaries or A/B MACs)

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Laboratory/Pathology

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for specimen collection services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7313 which revises the payment of travel allowances for specimen collection services when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis, using HCPCS code P9604 for calendar year (CY) 2011.

Caution – what you need to know

The per mile travel allowance (P9603) is \$0.96 per mile and the per flat-rate trip basis travel allowance (P9604) is \$9.60. Payment of the travel allowance is made only if a specimen collection fee is also payable. Your Medicare contractor has the option of establishing a higher per mile rate in excess of the minimum \$0.96 per mile if local conditions warrant it.

Go – what you need to do

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

Background

CR 7313 revises the CY 2011 payment of travel allowances when billed on a:

- Per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603, and
- Flat rate basis using HCPCS code P9604.

Note: Payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses.

Medicare contractors have the discretion to choose either the mileage basis or flat rate. In addition, your Medicare contractor can choose how to set each type of allowance. Also, many contractors established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip (for both Medicare and non-Medicare patients). This is done either:

- At the time the claim is submitted by the laboratory, or
- When the flat rate is set by the Medicare contractor.

Per mile travel allowance (P9603) – The per mile travel allowance is a minimum of \$0.96 per mile. This per mile travel allowance rate is:

- Used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and
- Prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile rate was computed using the federal mileage rate of \$0.51 per mile plus an additional \$0.45 per mile to cover the technician's time and travel costs for a total of \$0.96 per mile.

The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the clinical laboratory fee schedule, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (P9604) – The per flat-rate trip basis travel allowance is \$9.60.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

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Clinical laboratory fee schedule – Medicare travel allowance fees for collection of.... (continued)**Additional information**

The official instruction, CR 7313, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2153CP.pdf>.

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

MLN Matters® Number: MM7313
 Related Change Request (CR) #: CR 7313
 Related CR Release Date: February 11, 2011
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2153CP
 Implementation Date: March 14, 2011

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Clinical laboratory fee schedule – Medicare travel allowance (article rescinded)

This article has been rescinded and replaced by article MM7313, which is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7313.pdf>. This information was previously published in the December 2010 *Medicare B Update!* pages 22-23.

MLN Matters® Number: MM7239
 Related Change Request (CR) #:7239
 Related CR Release Date: December 3, 2010
 Effective Date: January 1, 2010
 Related CR Transmittal #: R2110CP
 Implementation Date: January 3, 2011

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Editing changes to certain pathology services and new messages

This article was rescinded on February 17, 2011, since related change request 7061 was rescinded. The CR will not be replaced at this time. This information was previously published in the December 2010 *Medicare B Update!* pages 21-22.

MLN Matters Number: MM7061 *Revised*
 Related Change Request (CR) #: 7061
 Related CR Release Date: October 29, 2010
 Effective Date: N/A
 Related CR Transmittal #: R795OTN
 Implementation Date: N/A

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Codes subject to and excluded from Clinical Laboratory Improvement Amendments edits

Provider types affected

Clinical laboratories and providers that submit claims to Medicare carriers or Medicare administrative contractors (MACs) for laboratory test services provided to Medicare beneficiaries may be affected by this issue.

What you need to know

This article is based on change request (CR) 7277, which informs your Medicare carriers and MACs about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2011 that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits and excluded from CLIA edits. Be sure that your staff is informed of these changes.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year. You need to know about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

Discontinued codes

The following HCPCS codes were discontinued on December 31, 2010:

HCPCS	Description
G0430	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
82926	<i>Gastric acid, free and total, each specimen</i>
82928	<i>Gastric acid, free or total, each specimen</i>
86903	<i>Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened</i>
89100	<i>Duodenal intubation and aspiration; single specimen (e.g., simple bile study or afferent loop culture) plus appropriate test procedure</i>
89105	<i>Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube</i>
89130	<i>Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology</i>
89132	<i>Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology; after stimulation</i>
89135	<i>Gastric intubation, aspiration, and fractional collections (e.g., gastric secretory study); one hour</i>
89136	<i>Gastric intubation, aspiration, and fractional collections (e.g., gastric secretory study); two hours</i>
89140	<i>Gastric intubation, aspiration, and fractional collections (e.g., gastric secretory study); two hours including gastric stimulation (e.g., histalog, pentagastrin)</i>
89141	<i>Gastric intubation, aspiration, and fractional collections (e.g., gastric secretory study); three hours, including gastric stimulation</i>
89225	<i>Starch granules, feces</i>
89235	<i>Water load test</i>

New codes

The following HCPCS codes are new for 2011, are excluded from CLIA edits, and do not require a facility to have any CLIA certificate:

HCPCS	Description
88177	<i>Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (list separately in addition to code for primary procedure)</i>
88749	<i>Unlisted in vivo (e.g., transcutaneous) laboratory service</i>

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Codes subject to and excluded from CLIA edits (continued)

For 2011, the HCPCS code 88172 (*Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site*) is not subject to CLIA edits and does not require a facility to have any CLIA certificate.

The HCPCS codes listed in the chart that follows are new for 2011 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2), or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) may not be paid for these tests.

HCPCS	Description
G0432	Infectious agent antibody detection by Enzyme Immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by Enzyme-Linked Immunosorbent Assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0434	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimens
82930	<i>Gastric acid analysis, includes pH if performed, each specimen</i>
83861	<i>Microfluidic analysis utilizing an integrated collection and analysis device; tear osmolarity</i>
84112	<i>Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative</i>
85598	<i>Phospholipid neutralization; hexagonal phospholipid</i>
86481	<i>Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon producing T-cells in cell suspension</i>
86902	<i>Blood typing; antigen testing of donor blood using reagent serum, each antigen test</i>
87501	<i>Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype</i>
87502	<i>Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, reverse transcription and amplified probe technique, first 2 types or sub-types</i>
87503	<i>Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, multiplex for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)</i>
87906	<i>Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (e.g., integrase, fusion)</i>
88120	<i>Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual</i>
88121	<i>Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology</i>
88363	<i>Examination and selection of retrieved archival (i.e., previously diagnosed) tissue(s) for molecular analysis (e.g., kras mutational analysis)</i>

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of these changes. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 7277, issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2156CP.pdf>.

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

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Codes subject to and excluded from CLIA edits (continued)

MLN Matters® Number: MM7277
 Related Change Request (CR) #: 7277
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 Related CR Transmittal #: R2156CP
 Implementation Date: April 4, 2011

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New waived tests**Provider types affected**

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

Provider action needed**Stop – impact to you**

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare Carrier or A/B MAC for a *Current Procedural Terminology (CPT)* code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

For dates of service on or after April 1, 2011, claims that use code G0431QW will be denied. Effective January 1, 2011, the code G0430 has been deleted and replaced with code G0434. Therefore, the code G0434QW replaces G0430QW in the list attached to CR 7266.

Go – what you need to do

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

Background

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT* codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and, therefore, requiring certification) change each year. CR 7266, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes that are subject to CLIA edits

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The *CPT* codes for the following new tests **MUST** have the modifier QW to be recognized as a waived test. Note, however, that the tests mentioned on the first page of the list attached to CR 7266 (i.e., *CPT* codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

CPT code	Effective date	Description
87880QW	October 4, 2010	BTNX, Inc. Strep A Rapid Test
86308QW	October 4, 2010	Consult Diagnostics Mononucleosis Cassette {Whole Blood}
82274QW G0328QW	October 4, 2010	BTNX Inc. Rapid Response Fecal Immunochemical Test (FIT)
82274QW G0328QW	October 4, 2010	American IVD Biotechnology Services Inc. FOB/CRC Advanced+
82274QW G0328QW	October 4, 2010	American IVD Biotechnology Services Inc. FOB/CRC Advanced+
G0434QW	April 1, 2011	Amedica Biotech AmediCheck Instant Test Cup
G0434QW	April 1, 2011	Confirm Biosciences Drugconfirm instant multi-drug test kit, Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	Insight Medical Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	Jant Pharmacal Corporation Accutest Drug Test Cup
G0434QW	April 1, 2011	Micro Distributing II, Ltd Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	Millenium Laboratories Multi-Drug of Abuse Urine Test

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

CPT code	Effective date	Description
G0434QW	April 1, 2011	NexScreen LLC, NexScreen Cup
G0434QW	April 1, 2011	On the Spot Drug Testing Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	Physicians' Test Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	Total Diagnostic Solutions Multi-Drug of Abuse Urine Test
G0434QW	April 1, 2011	UCP Biosciences, Inc. Drug Screening Test Cards
G0434QW	April 1, 2011	UCP Biosciences, Inc. Multiple Drug Screen Cups

In 2011, the code G0430 has been deleted and replaced by G0434. Also, in 2011, the description for code G0431 was changed from "Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class" to "Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter."

Therefore, the following CLIA waived complexity test systems mentioned in the attachment to CR 7266 had their code changed from G0431QW to G0434QW:

- Phamatech QuickScreen One Step Amphetamine Test
- Accu-Stat Drugs of Abuse Home Test for Marijuana (THC)
- ADC CLIA Waived Marijuana (THC) Test
- First Check Diagnostics LLC, First Check Home Drug Test Marijuana
- Phamatech QuickScreen One Step THC Screening Test
- Phamatech At Home Drug Test (Model 9078)
- Phamatech At Home Drug Test (Model 9078T)
- Worldwide Medical Corporation, First Check® Home Drug Test (THC)
- Phamatech At Home Drug Test (Model 9073)
- Phamatech At Home Drug Test (Model 9073T)
- Phamatech QuickScreen One Step Cocaine Screening Test
- Phamatech At Home Drug Test (Model 9068)
- Phamatech QuickScreen One Step Methamphetamine Test
- DyanGen NicCheck II Test Strips
- Mossman Associates, Inc. NicCheck I Test Strips
- Phamatech At Home Drug Test (Model 9083)
- Phamatech QuickScreen One Step Opiate Screening Test
- Phamatech At Home Drug Test (Model 9133)

Note that Medicare contractors will not search their files to either retract payment or retroactively pay claims. They will, however, adjust claims if they are brought to their attention.

Additional Information

The official instruction, CR 7266 issued to your carrier, A/B MAC, regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2187CP.pdf>. The list of tests granted waived status under CLIA is attached to the CR.

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

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 Related Change Request (CR) #:7266
 Related CR Release Date: March 28, 2011
 Effective Date: April 1, 2011
 Related CR Transmittal #: R2187CP
 Implementation Date: April 4, 2011

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Screening for the human immunodeficiency virus infection

Note: This article was revised on February 24, 2011, to reflect the revised CR 6786, which was issued on February 23, 2011. The change request (CR) (and this article) were revised to change the three human immunodeficiency virus (HIV) screening G code descriptors to align with the respective descriptors in the official code files. The CR transmittal numbers, release date, and the Web address for accessing the transmittals were also changed. All other information is the same. This information was previously published in the May 2010 *Medicare B Update!* pages 16-17.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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

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

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

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

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

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

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

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

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

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

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Screening for the human immunodeficiency virus infection (continued)

(Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

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

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver. Prior to inclusion of the new G Codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

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

claims that you bring to their attention.

Additional information

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

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

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

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

Note: This article was revised on March 29, 2011, to reflect a revised CR 7278, which was issued on March 10, 2011. In this article, the transmittal date, transmittal numbers, and the Web addresses for accessing the transmittals were revised. All other information is the same. This information was previously published in the February 2011 *Medicare B Update!* pages 19-20.

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 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

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

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 and 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 may 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:

- 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>.

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

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, and 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/R2173CP.pdf>. The other transmittal revised the *Demonstrations Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R70DEMO.pdf>.

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Related Change Request (CR) #: 7278

Related CR Release Date: March 10, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R2173CP & R70DEMO

Implementation Date: July 5, 2011

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Medicare drug screen testing

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the clinical laboratory fee schedule (CLFS). Specifically, the article addresses the billing of two CLFS Healthcare Common Procedure Coding System (HCPCS) test codes - G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) - beginning January 1, 2011. HCPCS code G0434 is new for calendar year (CY) 2011. Please be certain that your billing staffs are aware of these changes.

Background

Each year, the Centers for Medicare and Medicaid Services (CMS) hosts an annual public meeting to discuss test codes that have been established by the *Common Procedural Terminology (CPT)* committee, and may be covered by Medicare, and paid based on the CLFS in the upcoming calendar year.

During the 2009 Annual Public Meeting, CMS introduced two new CY 2010 HCPCS codes for reporting qualitative drug screen testing - G0430 (Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure), which was reported once per procedure and G0431, which is reported once per drug class. (Please note that G0430 was deleted beginning January 1, 2011). After the introduction of these codes, CMS determined that it needed to further refine these drug screen testing codes and revise the descriptors to avoid unnecessary or excessive utilization of code G0431 for relatively simple point-of-care tests that screen for multiple substances. During the 2010 Annual Public Meeting, CMS introduced code G0434 to report qualitative point-of-care drug screen testing and to limit billing for such testing to one time per patient encounter. CMS also revised the descriptor for code G0431 to emphasize that the code describes all screening for multiple drug classes per patient encounter.

CMS recognizes that there could be rare instances where a patient requires multiple, medically necessary screening tests for drugs of abuse to be performed in a single day. For instance, a patient seen in an outpatient pain clinic who requires a drug screening test as a part of his/her care is later admitted to an emergency department after an automobile accident and requires another medically necessary drug screening test. The use of "per patient encounter" will allow payment to be made for this rare circumstance.

Medicare drug screen testing (continued)

Effective January 1, 2011, CMS will utilize two test codes to report drug screen testing:

- G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity test(s), keeping the following points in mind:
 - G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc, that are not CLIA waived.
 - Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver shall bill using the modifier QW.
 - Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation do not append the modifier QW to claim lines.
 - Only one unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the modifier QW on claim lines.
- G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. Note that the descriptor has been revised for CY 2011. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:
 - G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).
 - CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.
 - CLIA moderate complexity tests should be reported under test code G0434 with one unit of service (UOS).
 - G0431 may only be reported once per patient encounter.
 - Laboratories billing G0431 must not append the modifier QW to claim lines.

CMS has also made changes to the following related tests:

- G0430 was deleted as of January 1, 2011.
- Code 80100 has not been priced under Medicare effective January 1, 2011.
- Code 80104 has not been priced under Medicare effective January 1, 2011.

Also, please remember that code 80101 has not been priced under Medicare since July 1, 2010.

Additional information

CMS publishes a list of test products with CLIA waived status each quarter. Providers may use this list to determine if a particular test product can be appropriately performed by a laboratory with a CLIA waiver and is eligible to be billed using the modifier QW. Concerning CLIA moderate or high complexity tests, providers should confirm a test's status with the test manufacturer.

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

Additional information concerning the CLFS may be found at <http://www.cms.hhs.gov/ClinicalLabFeeSched>.

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Medicare Physician Fee Schedule Database

April update to the calendar year 2011 Medicare physician fee schedule database

Note: This article was revised on March 20, 2011, to reflect the revised change request (CR) 7319 issued on March 18, 2011, to change the MPFS payment file names described in the Recurring Update Notification in the section titled: Revised MPFS payment file names. Also, the CR release date, transmittal number, and the Web address for accessing CR 7319 were changed. All other information remains the same. A previous update added the section with the heading of "Correction to Payment File OPFS Cap "Imaging Payment Amount" field for CPT code 92227." This information was previously published in the February 2011 *Medicare B Update!* pages 21-22.

Provider types affected

This article is for physicians, non-physician 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 calendar year (CY) 2011 MPFS final rule, released on November 2, 2010, and published in the *Federal Register* on November 29, 2010. As previously described in 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 *Current Procedural Terminology (CPT)* codes have MPFSDB indicator changes:

CPT	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
92511	Nasopharyngoscopy	Global surgery: 000
93464 26	Exercise w/ hemodynamic meas	Multiple surgery: 0

PE RVU changes

The following procedure codes have PE RVU changes. A detailed description of these changes can be found in CR 7319.

CPT	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 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	Short descriptor
Q2040	Incobotulinumtoxin A

Discontinued codes

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

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

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April update to the calendar year 2011 MPFSDB (continued)

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	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.

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/R2180CP.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>.

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Emergency update to the CY 2011 Medicare physician fee schedule database

Note: This article was revised on March 20, 2011, to reflect a new change request (CR). That CR corrected the implementation date. The transmittal number, release date and web address of the CR was also changed. All other information remains the same. This information was previously published in the January 2011 *Medicare B Update!* pages 36-39.

Provider types affected

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

Provider action needed

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

Background

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

Medicare physician fee schedule revisions and updates

Some physician work, practice expense (PE) and malpractice (MP) relative value units (RVUs) published in the CY 2011 MPFS final rule have been revised to align their values with the CY 2011 MPFS final rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and

continued on next page

Emergency update to the CY 2011 MPFSDB (continued)

procedure status indicator changes, in the CY 2011 MPFS final rule correction notice public use data files located at <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at <http://www.cms.gov/Transmittals/downloads/R8330TN.pdf>.

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

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

Physician Payment and Therapy Relief Act of 2010

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

Medicare and Medicaid Extenders Act (MMEA) of 2010

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

Physician payment update

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

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

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

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

Extension of Medicare physician work geographic adjustment floor

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

Extension of MPFS mental health add-on

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through

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Emergency update to the CY 2011 MPFSDB (continued)

December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy may also be found in the attachment to CR 7300.

Extension of exceptions process for Medicare therapy caps

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

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

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

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

Durable medical equipment, prosthetics, orthotics, and supplies updates

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

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

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

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

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Emergency update to the CY 2011 MPFSDB (continued)

	JURIS	CATG	L3660	L3670	L3675
MD	D	PO	\$85.06	\$112.42	\$141.00
ME	D	PO	\$113.42	\$93.60	\$141.00
MI	D	PO	\$85.06	\$93.60	\$144.48
MN	D	PO	\$85.06	\$93.60	\$144.48
MO	D	PO	\$106.53	\$124.79	\$143.74
MS	D	PO	\$85.06	\$118.57	\$145.25
MT	D	PO	\$111.02	\$93.60	\$146.04
NC	D	PO	\$85.06	\$118.57	\$145.25
ND	D	PO	\$111.02	\$93.60	\$146.04
NE	D	PO	\$106.53	\$124.79	\$143.74
NH	D	PO	\$113.42	\$93.60	\$141.00
NJ	D	PO	\$87.06	\$110.96	\$141.00
NM	D	PO	\$85.06	\$97.17	\$145.24
NV	D	PO	\$100.69	\$124.79	\$141.00
NY	D	PO	\$87.06	\$110.96	\$141.00
OH	D	PO	\$85.06	\$93.60	\$144.48
OK	D	PO	\$85.06	\$97.17	\$145.24
OR	D	PO	\$85.06	\$97.28	\$141.00
PA	D	PO	\$85.06	\$112.42	\$141.00
RI	D	PO	\$113.42	\$93.60	\$141.00
SC	D	PO	\$85.06	\$118.57	\$145.25
SD	D	PO	\$111.02	\$93.60	\$146.04
TN	D	PO	\$85.06	\$118.57	\$145.25
TX	D	PO	\$85.06	\$97.17	\$145.24
UT	D	PO	\$111.02	\$93.60	\$146.04
VA	D	PO	\$85.06	\$112.42	\$141.00
VT	D	PO	\$113.42	\$93.60	\$141.00
WA	D	PO	\$85.06	\$97.28	\$141.00
WI	D	PO	\$85.06	\$93.60	\$144.48
WV	D	PO	\$85.06	\$112.42	\$141.00
WY	D	PO	\$111.02	\$93.60	\$146.04
AK	D	PO	\$100.22	\$148.35	\$141.00
HI	D	PO	\$107.12	\$158.62	\$141.00
PR	D	PO	\$82.83	\$105.08	\$169.21
VI	D	PO	\$87.06	\$110.96	\$169.21

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

Additional information

The official instruction, CR 7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R833OTN.pdf>. If you have any questions, please contact your carrier, RHHI, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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 Related Change Request (CR) #:7300
 Related CR Release Date: January 7, 2010
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 Related CR Transmittal #: R833OTN
 Implementation Date: No later than January 14, 2011

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Mental Health Services

Clarification to outpatient mental health treatment limitation

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and Part A/B Medicare administrative contractors [MACs]) for Medicare beneficiaries receiving outpatient mental health services.

What you need to know

With CR 7307, the Centers for Medicare & Medicaid Services (CMS) is amending one sentence in Section 210.1 D of the Medicare Claims Processing Manual to clarify policy regarding application of the outpatient mental health treatment limitation to ICD-9 diagnosis codes for Alzheimer's related disorders. This sentence was changed inadvertently in a prior manual update.

The amended sentence shows that Alzheimer's related disorders are identified by Medicare contractors under ICD-9 codes that are within the 290-319 code range (290.XX or others as your Medicare contractor determines appropriate) or outside the 290-319 code range as determined appropriate by your contractor.

Background

Section 210 of the Manual was revised initially under CR 6686 (issued 10-3-09) to implement Section 102 of the Medicare Improvements and Patient Protection Act (MIPPA). The MIPPA legislation authorized a reduction in the coinsurance percentage that Medicare patients are required to pay for certain outpatient mental health treatment services. In addition to including the changed coinsurance percentages for 2010-2014, changes were made to clarify the diagnoses/services to which the limitation does and does not apply. For claims reported with a primary diagnosis of an Alzheimer's related disorder, Medicare contractors will look to the nature of the service rendered in determining whether it is subject to the limitation.

Additional information

The official instruction, CR 7307, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2166CP.pdf>.

You may want to review the *MLN Matters*[®] article related to CR 6686 (MM6686), which may be found at <https://www.cms.gov/MLNProducts/articles/downloads/MM6686.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: MM7307

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Implementation Date: March 25, 2011

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Preventive Services

Waiver of coinsurance and deductible for preventive services

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

Note: This article was revised on March 3, 2011, as a result of revisions to change request (CR) 7012 made on March 2, 2011. In the article, the CR release date, transmittal number, and the Internet address for accessing CR 7012 were revised. All other information remains the same. This information was previously published in the December 2010 *Medicare B Update!* pages 26-27.

Provider types affected

This article is for physicians, hospitals, and other providers who submit claims to Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC), for providing preventive services to Medicare beneficiaries.

What you need to know

CR 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and for those preventive services that: 1) are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) are appropriate for the individual.

Background

Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and coinsurance/copayment) for identified preventive services: In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration
- Screening mammography
- Screening PAP smear and screening pelvic examination
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training (DSMT)
- Bone mass measurement
- Screening for glaucoma
- Medical nutrition therapy (MNT) services
- Cardiovascular screening blood test
- Diabetes screening tests
- Ultrasound screening for abdominal aortic aneurysm (AAA), and
- Additional preventive services (identified

for coverage through the national coverage determination (NCD) process.

Currently, these are limited to human immunodeficiency virus (HIV) testing.

Preventive services that do not have a USPSTF grade A or B

The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B. These include digital rectal examinations provided as prostate screening tests, glaucoma screening, DSMT services, and barium enemas provided as colorectal cancer screening tests. In the case of a screening barium enema, the deductible is waived under another section of the statute. The deductible continues to apply to the other services and coinsurance/copayment also continue to apply to all of them. The table in CR 7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR 7012 is available at <http://www.cms.gov/Transmittals/downloads/R8640TN.pdf>.

Extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic or therapeutic

The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (*Current Procedural Terminology* [CPT] code range of 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier PT has been created effective January 1, 2011, and providers and practitioners should append the modifier PT to a least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario.

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Waiver of coinsurance and deductible for preventive services (continued)**Additional information**

You may find more information about the waiver of coinsurance and deductible for preventive services by going to CR 7012, located at <http://www.cms.gov/Transmittals/downloads/R864OTN.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: MM7012 *Revised*

Related Change Request (CR) #: 7012

Related CR Release Date: March 2, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R864OTN

Implementation Date: January 3, 2011

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Annual wellness visit including personalized prevention plan services

Note: This article was revised on February 17, 2011, to reflect changes made to change request (CR) 7079.

The changes made were the deletion of “voluntary advance care planning” as a specified element of the AWV, clarification that payment methodology for types of bill (TOB) 12x and 13x is based on the Medicare physician fee schedule, and that for TOBs 71x and 77x, the AWV does not qualify for separate payment with another encounter. The CR transmittal numbers, CR release date, and the Web addresses for accessing CR 7079 have also changed. All other information remains the same. This information was previously published in the December 2010 *Medicare B Update!* pages 24-26.

Provider types affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Medicare administrative contractors [MACs], and/or fiscal intermediaries [FIs] for services provided to Medicare beneficiaries.

Provider action needed

The Affordable Care Act provides for an annual wellness visit (AWV), including personalized prevention plan services (PPPS) for Medicare beneficiaries as of January 1, 2011. CR 7079 provides the requirements for the AWV, which are summarized in this article. Make sure billing staff are aware of these services and how to bill for them.

Background

Pursuant to section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended sections 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This amendment's expanded coverage is subject to certain eligibility and other limitations that allow payment for an AWV, including PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply to the AWV. The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

Who is eligible to provide the AWV with PPPS?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act))
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act), or
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in the first bullet point of this section.

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Annual wellness visit including personalized prevention plan services (continued)

What is included in an initial AWV with PPS?

The initial AWV providing PPS provides for the following services to an eligible beneficiary by a health professional:

- Establishment of an individual's medical/family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
- Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the national coverage determination (NCD) process.

What would be included in a subsequent AWV/PPS?

In subsequent AWVs, the following services would be provided to an eligible beneficiary by a health professional:

- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- An update to the written screening schedule for the individual, as that schedule is defined in this section, which was developed at the first AWV providing PPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Any other element(s) determined by the Secretary through the NCD process.

Billing requirements

Two new HCPCS codes, G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first) and G0439 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq) will be implemented January 1, 2011, through the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE).

Effective for services on or after January 1, 2011, Medicare contractors will pay claims containing these codes provided the requirements for coverage and eligibility are met. Institutional providers need to submit these claims via types of bill (TOB) 12x, 13x, 22x, 23x, 71x, 77x, or 85x. Institutional providers will be paid as follows:

- For services performed on a 12x TOB and 13x TOB, hospital inpatient Part B and hospital outpatient, payment shall be made based on the MPFS.

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Annual wellness visit including personalized prevention plan services (continued)

- For TOBs 22x and 23x, skilled nursing facilities will be paid based on the MPFS.
- Rural health clinics (TOB 71x) and federally qualified health centers (TOB 77x) will be paid based on the all-inclusive rate. However, for TOBs 71x and 77x, the AWV does not qualify for separate payment with another encounter.
- For services performed on an 85x TOB, critical access hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85x with revenue codes 096x, 097x, and 098x) will be paid based on MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

Other billing requirements

Remember that G0438 is for the first AWV only. Thus, submission of G0438 for a beneficiary for whom a claim with code G0438 has already been paid will result in a denial of the later G0438 with a claim adjustment reason code (CARC) of 149 (Lifetime benefit maximum has been reached for the service/benefit category.) and a remittance advice remarks code (RARC) of N117 (This service is paid only once in a patient's lifetime.).

Remember also that the G0438 or G0439 must not be billed within 12 months of a previous billing of a G0402 (IPPE), G0438, or G0439 for the same beneficiary. Such subsequent claims will be denied with a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) and a RARC of N130 (Consult plan benefit documents/guidelines for information about restrictions for this service).

If a claim for a G0438 or G0439 is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will also be denied as that beneficiary is eligible for the IPPE or "Welcome to Medicare" physical. Such claims with G0438 or G0439 will be denied with a CARC of 26 (Expenses incurred prior to coverage) and a RARC of N130.

Additional information

The official instruction, CR 7079, was issued to your carrier, FI, or A/B MAC via two transmittals. The first modified the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R2159CP.pdf>. The second transmittal updates the *Medicare Benefit Policy Manual*, which is at <http://www.cms.gov/Transmittals/downloads/R138BP.pdf>. See these two transmittals for more complete details regarding this benefit.

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

MLN Matters® Number: MM7079 *Revised*

Related Change Request (CR) #: 7079

Related CR Release Date: February 15, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R138BP and R2159CP

Implementation Date: April 4, 2011

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Correction to the preventive services table for CPT codes 90471 and 90472

Please note that a correction has been issued by the Centers for Medicare & Medicaid Services (CMS) to the preventive services table (via change request 7012), with specific regard to *Current Procedural Terminology* (CPT) codes 90471 and 90472. Beginning Friday, April 1, for services that were furnished on or after Saturday, January 1, 2011, when providers are furnishing hepatitis B vaccines in outpatient facility settings they must report HCPCS code G0010 (administration of hepatitis B vaccine) rather than CPT code 90471 or 90472. This is in order to ensure that cost-sharing waivers are correctly applied to vaccine administration. As of Friday, April 1, change request 7012 will no longer recognize CPT codes 90471 and 90472 for applying cost-sharing waivers on claims submitted for preventive services.

Source: CMS PERL 201103-18

Radiology

MRI with implanted permanent pacemakers or implantable cardioverter defibrillators

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, A/B Medicare administrative contractors [MACs] and durable medical equipment MACs or DME MACs) for magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

What you need to know

Effective for claims with dates of service on or after February 24, 2011, the Centers for Medicare & Medicaid Services (CMS) will allow for coverage of MRI for Medicare beneficiaries with implanted permanent pacemakers (PMs) or implantable cardioverter defibrillators (ICDs) when those beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence about the utility and safety of MRI exposure. Coverage under the coverage with evidence development (CED) paradigm is contingent on all the criteria at Section 220.2.C.1 of the *Medicare National Coverage Determinations (NCD) Manual*, being met. That section of the *NCD Manual* is attached to CR 7296, which is available at <http://www.cms.gov/Transmittals/downloads/R132NCD.pdf>.

CMS contractors will use existing clinical trial coding conventions to help identify on a claim that MRI for beneficiaries with implanted PMs or ICDs was provided pursuant to a Medicare-approved clinical study under CED. Currently, there is a clinical trial pending approval for this purpose. Subject to this one exception for beneficiaries in CMS-approved clinical studies with implanted PMs or ICDs, Medicare will continue to retain the current contraindications at 220.2.C.1 in the *NCD Manual*.

Background

CMS recently issued a 2010 NCD that merged the magnetic resonance angiography (MRA) NCD at Section 220.3 under the NCD for MRI at Section 220.2 in Chapter 1 of the *NCD Manual*. In addition, a 2009 NCD removed a contraindication from 220.2.C.2 of the *NCD Manual* concerning blood flow measurement. Currently, coverage is limited to MRI units that have received Food and Drug Administration (FDA) premarket approval, and such units must be operated within the parameters specified by the approval. Other uses of MRI for which CMS has not specifically indicated national coverage or national noncoverage are at the discretion of Medicare's local contractors.

As noted by the requester, payment for an MRI examination is not currently covered by Medicare if certain contraindications are present. These include cardiac PMs. In June 2010, CMS received an external request to remove the contraindications for MRI for patients with implanted permanent PMs, as well as to provide Medicare coverage for patients who undergo MRI with an ICD in a clinical trial setting.

As a result of the CMS review, CR 7296 allows for an exception in coverage for patients in clinical studies approved by CMS, but retains the contraindications in other circumstances.

Additional information

The official instruction, CR 7296 was issued to your FI, RHHI, A/B MAC, and/or DME/MAC via two transmittals. The first updates *NCD Manual*, and it is at <http://www.cms.gov/Transmittals/downloads/R132NCD.pdf>. The second transmittal updates *Medicare Claims Processing Manual*, and it is at <http://www.cms.gov/Transmittals/downloads/R2171CP.pdf>.

If you have any questions, please contact your 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: MM7296

Related Change Request (CR) #: 7296

Related CR Release Date: March 4, 2011

Effective Date: February 24, 2011

Related CR Transmittal #: R132NCD and R2171CP

Implementation Date: April 4, 2011

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Surgery

Inappropriate Medicare payments for transforaminal epidural injection services

Provider types affected

Physicians who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MAC]) for providing transforaminal epidural injection services to Medicare beneficiaries are affected.

What you need to know

This special edition article is based on the August 2010 Department of Health and Human Services Office of the Inspector General report entitled "Inappropriate Medicare Payments For Transforaminal Epidural Injection Services."

It summarizes the study's objectives which were:

1) To determine the extent to which Medicare Part B physician payments for transforaminal epidural injections met Medicare requirements, and 2) To determine the safeguards that existed to ensure Medicare Part B payments for transforaminal epidural injections met Medicare requirements. The report also describes the study's identified problems with transforaminal epidural injections; and its findings and recommendations. This article is intended to remind physicians of the importance of properly documenting the services for which they bill and to assure the documentation meets Medicare's requirements. In addition, the documentation must show such services meet Medicare's medical necessity requirements.

Background

Chronic pain affects many adults in the United States. One type of interventional pain management technique used to diagnose or treat pain is transforaminal epidural injection; in which the injection is given through a spinal column foramen (or foramina) enabling the physician to inject the medication as close to the source of pain as possible, reducing inflammation and relieving the patient's pain.

In order to determine the extent to which Medicare Part B payments for transforaminal epidural injections met Medicare requirements and to evaluate the safeguards that existed to ensure Medicare Part B payments for these injections met Medicare requirements, the Office of the Inspector General (OIG) performed a study focused on the procedure performed in 2007. The OIG did this by: 1) conducting a medical record review of a sample of Medicare claims from 2007; 2) reviewing CMS and Medicare contractor policies related to safeguarding transforaminal epidural injection services, and 3) conducting structured telephone interviews with Medicare contractor staff.

Study Methodology

For the medical record review component of the study, a random sample of 433 Medicare physician line item claims were selected from approximately 800,000 claims (amounting to \$141 million in allowed physicians payments) consisting of all 2007 allowed physician services for transforaminal epidural injection CPT codes 64479 (Injection; anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level), 64480, (Injection; anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level), 64483 (Injection; anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level), and 64484 (Injection; anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level) for services billed in offices, ambulatory surgical centers (ASCs), or hospital outpatient departments. The reviewers determined whether the service was adequately documented and medically necessary and whether the appropriate CPT code and modifier(s) were used.

Findings

The study found that in 2007:

1. Thirty-four percent of transforaminal epidural injection services that Medicare allowed did not meet Medicare requirements.
2. Nineteen percent of transforaminal epidural injection services had a documentation error with ten percent of transforaminal epidural injection services undocumented and nine percent were insufficiently documented.
3. Further, the study found that thirteen percent of injection services had a medical necessity error and eight percent had a coding error resulting in overpayments for services that were miscoded—primarily using add-on codes and bilateral modifiers improperly, and in some instances, actually performing less intensive procedures, but billing for transforaminal epidural injections.

Note: The documentation errors were found more often to occur in office settings (forty one percent of all errors occurring in physicians' offices, compared to twenty-eight percent occurring from care provided in facilities).

The Centers of Medicare & Medicaid Services concurred with all of the study's findings and reminds physicians to comply with Medicare's documentation requirements, as well as with all medical necessity requirements. Based on Chapter 3, Section 11 of the *Medicare Program Integrity Manual* for Medicare

continued on next page

Inappropriate Medicare payments for transforaminal epidural injection services (continued)

to consider coverage and payment for any item or service, the information submitted by the supplier or provider (e.g., claims) must be corroborated by the documentation in the patient's medical record that Medicare coverage criteria have been met. The patient's medical record includes: physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and/or test reports. This documentation must be maintained by the physician and/or provider and available to the contractor upon request.

This supporting information may be requested by CMS and its agents on a routine basis in instances where diagnoses on the claims do not clearly indicate medical necessity. The *Medicare Program Integrity Manual* is available at

<http://www.cms.gov/Manuals/IOM/list.asp>.

Section 1833(e) of the Social Security Act states that "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

Also, consider any local coverage determinations (LCDs) that may have been made by your Medicare contractor. These LCDs are documented in the CMS Medicare coverage database available at <http://www.cms.gov/mcd>. For example, LCD number L30481 requires, among other requirements, the following:

- Documentation in the medical record must contain the initial evaluation including history and physical examination, diagnosis, pain and disability of moderate to severe degree, site of injection with name and dosage of drug instilled, and the patient's response to the prior injections.
- Documentation of conservative therapies that were tried and failed except in acute situations such as acute disc herniation with disabling and debilitating pain, herpes zoster and post herpetic neuralgia, reflex sympathetic dystrophy, post operative and obstetric pain and intractable pain secondary to carcinoma.
- Pre and post procedure evaluation documenting patient's response to the injection, including pain level and ability to perform previously painful maneuvers must be included in the medical record.

LCD number L27512 requires the following specific documentation requirements for transforaminal epidural and paravertebral facet joint injections:

- The patient's medical record must indicate the medical necessity of services for each date of service billed and the frequency. This must include the patient's history (complete pain history and inclusion of failed conservative measures), physical examination and adequate follow-up

documentation specific to patient response to the nerve blocks.

- The pre-procedure evaluation leading to suspicion of the presence of the facet joint pathology must be explicitly documented in the patient's medical record along with the post procedure conclusions or the reasoning behind the need for a transforaminal epidural injection must be explicitly documented in the patient's medical record along with post procedure conclusions. All documentation must be available to Medicare upon request.
- The primary codes 64479, 64483, 64490 and 64493 are used for a single injection in the cervical/thoracic or lumbar/sacral areas of the spine, respectively. Each primary code has an associated add-on code, 64480, 64491, 64492 (cervical/thoracic) and 64484, 64494 and 64495 (lumbar/sacral) for use when injections are provided at multiple spinal levels. Unilateral injections are performed on one side of the joint level, while bilateral injections are performed on the right and left side of the joint level. The Centers for Medicare and Medicaid Services (CMS) requires physicians to indicate a bilateral injection by using billing modifier 50. Unilateral injections must be identified by an appropriate RT or LT.
- In addition, LCD number 27512 discusses the following general documentation requirements:
 - All documentation must be maintained in the patient's medical record and available to the contractor upon request.
 - Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
 - The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
 - The patient's record should document an appropriate history and physical examination by the anesthesiologist/anesthetist specifying the medical indications requiring his/her presence when applicable. The indications should be recorded by both the anesthesiologist/anesthetist and the provider performing the injection in their respective notes.

Additional information

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

You may find the entire OIG report on inappropriate *continued on next page*

Inappropriate Medicare payments for transforaminal epidural injection services (continued)

Medicare payments or transforaminal epidural injection services at <http://oig.hhs.gov/oei/reports/oei-05-09-00030.pdf>.

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 Related Change Request (CR) #: N/A
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 Implementation Date: N/A

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Therapy Services

2011 annual update to the therapy code list

Provider types affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for outpatient rehabilitation therapy services should take note of this article.

Provider action needed

This article is based on change request (CR) 7364, which updates the therapy code list for calendar year (CY) 2011 by adding *Current Procedural Terminology (CPT) code 95992 (Standard Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day)* to the “Sometimes Therapy” list.

Background

CR 7364 updates the therapy code list by adding one “sometimes therapy” code for CY 2011 shown in the table below.

Code	Descriptor
95992	<i>Standard Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day</i>

Additional information

You may also find more information about the therapy code lists at http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The official instruction, CR 7364, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2175CP.pdf>.

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

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 Related Change Request (CR) #: N/A
 Related CR Release Date: March 18, 2011
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2175CP
 Implementation Date: July 5, 2011

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General Coverage

Smoking- and tobacco-use cessation counseling

Note: This article was revised on February 24, 2011, to add a reference to MM5878 in the *Additional information* section. MM5878 announced replacement codes for the temporary G codes discussed in this article. All other information remains the same. This information was previously published in the Fourth Quarter 2005 *Medicare B Update!* pages 62-64.

Provider types affected

Physicians, other Medicare-recognized practitioners, and providers billing Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers for smoking and tobacco-use cessation counseling

Provider action needed

Stop – Impact to You

Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco-use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco-use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco-use as based on FDA- approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year; each attempt may include a maximum of four intermediate or intensive sessions. Maximum eight sessions in one year are covered.

Caution – What you need to know

CMS has established two new “G” codes for billing for the new levels of smoking and tobacco-use cessation counseling, effective for dates of service on or after March 22, 2005.

Note: For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco-use cessation counseling, use the unlisted code 99199. On and after July 5, 2005, when billing for this counseling, use the appropriate new “G” codes. Include one unit per session in the unit’s field of the claim.

Go – What you need to do

Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco-use cessation counseling services you provide on or after March 22, 2005.

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco-use cessation counseling, based on current public health service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco-use. Patients must be competent and alert at the time that services are provided.

What is covered

When certain coverage conditions, frequency and other limitations are met, smoking and tobacco cessation counseling is covered under Medicare Part B. Medicare Part B coverage includes two attempts each year. Each attempt may include a maximum of four intermediate or intensive sessions. A total of eight sessions are covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

Billing codes

The following two new Health Common Procedure Coding System (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

G0375 - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. **Short descriptor:** Smoke/Tobacco counseling 3-10.

G0376 - Smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. **Short descriptor:** Smoke/Tobacco counseling greater than 10.

Because these new “G” codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco-use cessation counseling.

Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

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Smoking- and tobacco-use cessation counseling (continued)

Note: Code 99199 is carrier priced. Also, providers whose claims are subject to payment under the outpatient prospective payment system (OPPS) should use the G codes instead of 99199. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as three minutes or less in duration) bundled into the normal evaluation and management (E/M) visit.

Smoking and tobacco-use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

Note: Providers are reminded that they should keep on file appropriate documentation in the patient’s medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco-use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E/M services on the same day as smoking cessation services are billed should use the appropriate HCPCS code in the 99201-99215 range and modifier 25 to show that the E/M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, meaning charges to the beneficiary may be no more than 115 percent of the allowed amount.

Smoking and tobacco-use cessation counseling services may be billed to FIs and RHHIs on types of bills (TOB) 12x, 13x, 14x, 22x, 23x, 34x, 71x, 73x, 74x, 75x, 83x, and 85x. On TOBs 71x and 73x (rural health clinics [RHCs] and federally qualified health centers [FQHCs]), FIs will pay for claims with revenue code 052x. For TOB 13x (Indian Health Service [IHS]), FIs shall accept revenue code 0510. CAH Method II providers should use the appropriate revenue code in the range of 096x through 098x when reporting smoking and tobacco-use cessation counseling services. For other TOBs, on claims received on or after July 5, 2005, FIs and RHHIs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/training).

Payment by FIs/RHHIs is as follows:

Type of facility	Method of payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/Tribally owned or operated hospitals and hospital based facilities	AIR
IHS/Tribally owned or operated non-hospital based facilities	Medicare physician fee schedule (MPFS)
IHS/Tribally owned or operated critical access hospitals (CAHs)	Facility specific visit rate
Hospitals subject to the OPPS	Ambulatory payment classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled nursing facilities (SNFs) <i>Note:</i> Included in Part A PPS for skilled patients.	MPFS
Comprehensive outpatient rehabilitation facilities (CORFs)	MPFS
Home health agencies (HHAs)	MPFS
CAHs	Method I: Technical services are paid at 101 percent of reasonable cost; Method II: Professional services are paid at 115 percent of the MPFS database
Maryland hospitals	Payment is based according to the Health services cost review commission (HSCRC). That is 94 percent of submitted charges subject to any unmet deductible, coinsurance, and noncovered charges policies.

Additional information

Note: When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, the services are considered “incident to” and do not constitute a billable visit. In addition, Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

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Smoking- and tobacco-use cessation counseling (continued)

For complete details, please see the official instructions issued to your carrier/FI/RHHI regarding this change, which may be found by going to <http://www.cms.gov/Transmittals/downloads/R562CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R36NCD.pdf>.

The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

You may want to review MM4104, which announced the implementation (effective April 1, 2006) of the capability for providers to access the common working file for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received. That article may be found at <http://www.cms.gov/MLNMattersArticles/downloads/MM4104.pdf>.

You may also want to review MM5878, which contains information on replacement codes for the temporary G codes discussed in this article. MM5878 is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM5878.pdf>.

If you have questions regarding this issue, contact your carrier/FI/RHHI on their toll-free number, which is available at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters Number: MM3834

Related Change Request (CR) #: 3834

Related CR Release Date: May 20, 2005

Effective Date: March 22, 2005

Related CR Transmittal #: 36 and 562

Implementation Date: July 5, 2005

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Electronic Data Interchange

Claim status category code and claim status code update

Provider types affected

All physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs), durable medical equipment MACs (DME MACs) and the DME Common Electronic Data Interchange (CEDI) contractor for Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7348, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 will be updated during the June 2011 meeting of the national Code Maintenance Committee. Code changes approved at that meeting will be posted at <http://www.wpc-edi.com/content/view/180/223/> on or about July 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 5, 2011.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction, CR 7348 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2177CP.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: MM7348

Related Change Request (CR) #: 7348

Related CR Release Date: March 18, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R2177CP

Implementation Date: July 5, 2011

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Important reminders about HIPAA 5010 & D.0 implementation

Provider types affected

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

Provider action needed

Stop – impact to you

The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that electronic data interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

Caution – what you need to know

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This special edition *MLN Matters*[®] article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 version 5010 and NCPDP version D.0 standards. Remember that the HIPAA standards, including the ASC X12 version 5010 and version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. A separate *MLN Matters*[®] articles will address the ICD-10 implementation.

Go – what you need to do

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

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

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

More information about Medicare's EDI requirements can be found in the *Medicare Claims Processing Manual*, Chapter 24 – “General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims,” at <http://www.cms.gov/manuals/downloads/clm104c24.pdf>. Electronic billing and EDI transaction information may be found at <http://www.cms.gov/ElectronicBillingEDITrans/>. This section contains information on:

- EDI transaction and corresponding paper claims requirements,
- Links to those chapters of the *Medicare Claims Processing Manual* that contain further information on these types of transactions,
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment,
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically, and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 version 4010/4010A1 for health care transactions, and the NCPDP version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current version 4010/4010A and NCPDP version 5.1 with version 5010 and version D.0, respectively. The final rule (CMS-0009-F) titled, “Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards,” may be found at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>.

Subsequently, CMS is performing activities to convert from processing the ASC X12 version 4010A1 to HIPAA ASC X12 version 5010, and the NCPDP version 5.1 to NCPDP version D.0.

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Important reminders about HIPAA 5010 & D.0 implementation (continued)

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I compliance means** “that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.”
- **Level II compliance means** “that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.”

The CMS Medicare fee-for-service (FFS) implementation schedule is:

- Level I April 1, 2010, through December 31, 2010
- Level II January 1, 2011, through December 31, 2011, and
- Fully compliant on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (version 4010/4010A1) with version 5010, and NCPDP EDI standards version 5.1 with version D.0. For more information see http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp. CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare FFS business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare FFS. Maintenance will be performed without notification, as needed to support Medicare FFS.

Readiness assessment 1: Have you done the following to be ready for 5010/D.0? Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing version 5010 and D.0 as early as possible in 2011.

Be prepared. To download readiness checklists and a resource card with helpful Web links go to

http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp.

Readiness assessment 2: What do you need to have in place to test with your MAC?

Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted), and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 national call presentation on Provider Outreach and Education – Transition Year Activities may be found at http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources may be found at <http://www.cms.gov/Versions5010andD0/>.
- Educational resources (i.e., *Medicare Learning Network*[®] (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) may be found at http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp.
- The dedicated HIPAA 5010/D.0 Project Web page, which includes technical documents and communications at national conferences, may be found at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp.

Errata requirements and testing schedule

HIPAA version 5010 has new errata, which may be found at http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf. According to the published regulation (*Federal Register*, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. Compliance

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Important reminders about HIPAA 5010 & D.0 implementation (continued)

with the errata must be achieved by the original regulation compliance date of January 1, 2012. Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 errata versions in April 2011. Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the “Downloads” section at <http://www.cms.gov/ElectronicBillingEDITrans/>.

CMS 5010 provider outreach and education materials CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- **Version 5010-** the new version of the X12 standards for HIPAA transactions
- **Version D.0** – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions
- **Version 3.0** – a new NCPDP standard for Medicaid pharmacy subrogation

The information posted at http://www.cms.gov/Versions5010andD0/01_overview.asp on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The “Overview” Web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- **Federal regulation and notices** http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp – contains general information related to federal regulations and notices and contains the following link to the final rule for X12 5010, D.0 and 3.0 document. <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>
- **CMS Communications** http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp – includes versions 5010 & D.0 implementation information and the following downloads:
 - **5010 Implementation Calendar** [PDF, 325KB]; see <http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf>.
 - **Readiness Assessment** – What do you need to have in place to test with your MAC? [PDF, 241KB]; see http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf.

- **Educational Resources** http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp – includes information designed to increase national awareness and assist in the implementation of versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:

- **Version 5010 Resource Card** [PDF, 243KB] http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf
- **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 fact sheet** [PDF, 1208KB] <http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf>
- **Checklist for Level I Testing Activities** [PDF, 324 KB] <http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf>
- **Provider Action Checklist for a Smooth Transition** [PDF, 333KB] <http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf>
- **Versions 5010 and D.0 MLN Matters® articles** [PDF, 31KB] http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf
- **5010 National Calls** <http://www.cms.gov/Versions5010andD0/V50/>

Throughout the implementation of version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 Web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional information

A special edition *MLN Matters®* article on the ICD-10 code set may be found at <http://www.cms.gov/MLN MattersArticles/downloads/SE0832.pdf>.

CMS is also using the open door forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the open door forums may be found at <http://www.cms.gov/OpenDoorForums/>. Information about listservs (e-mail updates) may be found at <http://www.cms.gov/AboutWebsite/EmailUpdates/>.

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Important reminders about HIPAA 5010 & D.0 implementation (continued)

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

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 Related Change Request (CR) #: N/A
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 Related CR Transmittal #: N/A
 Implementation Date: N/A

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

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

Important implementation reminders

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

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

Readiness assessment: Have you done the following to be ready for 5010/D.0.? Found out more 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)? Visit http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf

Readiness assessment: Do you know the implications of not being ready? Find out more at http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf

Implementation calendar**Current events****April 2011**

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

Upcoming events**May 2011**

May 2-5: 20th Annual WEDI National Conference* (<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1>)

May 25: 5010 national call – topic to be determined (TBD)

June 2011

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

July 2011

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

August 2011

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

October 2011

TBD: MAC hosted outreach and education session (last push for implementation)

October 24-27: WEDI 2011 fall conference * (<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11927000002B1>)

December 2011

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

Past events**June 2010**

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

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

July 2010

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

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

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

September 2010

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

October 2010

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

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

November 2010

November 4: Version 5010 resource card published (http://www.cms.gov/MLNProducts/downloads/5010EDL_RefCard_ICN904284.pdf)

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

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

December 2010

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

January 2011

January 1: Beginning of transition year

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

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

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

February 2011

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

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

March 2011

March 1: New readiness assessment – Do you know the implications of not being ready? Find out more at http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf

March 30: 5010 National Call – Provider Testing and Readiness (<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1244551&intNumPerPage=10>)

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 201103-15

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

Implementation of provider enrollment provisions in CMS-6028-FC

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

Caution – what you need to know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

Go – what you need to do

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.) Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Screening Processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited,

moderate, or high. The risk levels denote the level of the contractor’s screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the “high” category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.
- This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is \$505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;

Continued on next page

Implementation of provider enrollment provisions in CMS-6028-FC (continued)

- An application that was rejected prior to the Medicare Contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR § 424.570.

The provider or supplier must pay the application fee electronically through Pay.gov (<https://www.pay.gov/paygov/>), either via credit card, debit card, or check. CMS will send to the contractor on a regular basis a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via Pay.gov. However, providers and suppliers are strongly encouraged to submit with their application a copy of their Pay.gov receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request

As already stated, the application fee for CY 2011 is \$505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must

instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

- Considerable bad debt expenses,
- Significant amount of charity care/financial assistance furnished to patients,
- Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
- Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or
- Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request

Appeal of the denial of hardship exception decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual*, which is attached to CR 7350.

Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium,

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Implementation of provider enrollment provisions in CMS-6028-FC (continued)

even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.

- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within six

months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening. Additional Information The official instruction, CR 7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/transmittals/downloads/R371PI.pdf>. Attached to CR 7350, you will find the complete details, regarding this issue as defined in the PIM revisions. If you have any questions, please contact your FI, RHHI, carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7350
 Related Change Request (CR) #: 7350
 Related CR Release Date: March 23, 2011
 Effective Date: March 25, 2011
 Related CR Transmittal #: R371PI
 Implementation Date: March 25, 2011

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Implementation of provider screening and risk-based categories for provider/supplier enrollment

It is the continuing goal of the Centers for Medicare & Medicaid Services (CMS) to reduce fraud, waste, and abuse through all available avenues. The Affordable Care Act requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the level of risk posed to the Medicare system. With the enactment of the Affordable Care Act, CMS has the increased ability to focus its efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and that only legitimate claims are paid.

Effective Friday, March 25, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories – limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier and determine the degree of screening to be performed by the Medicare administrative contractor (MAC) processing the enrollment application. Providers/suppliers in the "limited" screening category will include:

- Physicians
- Non-physician practitioners other than physical therapists
- Medical groups or clinics
- Ambulatory surgical centers
- Competitive acquisition program / Part B vendors
- End-stage renal disease facilities
- Federally-qualified health centers
- Histocompatibility laboratories
- Hospitals (including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities)
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions

Continued on next page

Implementation of provider screening and risk-based categories for provider/supplier ... (continued)

- Rural health clinics
- Skilled nursing facilities

Providers in the “moderate” screening category will include:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities (IDTFs)
- Physical therapists enrolling as individuals or as group practices
- Portable X-ray suppliers (PXRS)
- Revalidating home health agencies (HHAs)
- Revalidating durable medical equipment, prosthetics, and orthotics (DMEPOS) suppliers

Providers in the “high” screening category will include:

- Newly-enrolling DMEPOS suppliers
- Newly-enrolling HHAs
- Providers and suppliers reassigned from the “limited” or “moderate” categories due to triggering events.

Triggering events include the following instances:

- Imposition of a payment suspension within the previous 10 years
- A provider or supplier has been terminated or is otherwise precluded from billing Medicaid
- Exclusion by the Office of the Inspector General (OIG)
- A provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location

- A provider or supplier has been excluded from any federal health care program
- A provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years or
- Instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the “limited” screening category will largely be the same as those currently in use; screening procedures for the “moderate” screening category will include all current screening measures, as well as a site visit; screening procedures for the “high” screening category will include all current screening measures, as well as a site visit and, at a future date a fingerprint-based criminal background check.

CMS will continuously evaluate whether we need to change the assignment of categories of providers and suppliers to the various risk categories. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the *Federal Register*. However, CMS will not publish a notice or a proposed rule in the *Federal Register* that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.

For more information, please refer to the regulation published to the *Federal Register* at <http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>. And for additional clarification, look out for an official *MLN Matters* article that will be released on the subject in the near future.

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

Source: CMS PERL 201103-09

No date set for expanded ordering/referring provider claim edit

There was an editorial oversight in the Office of Inspector General (OIG) Compendium of Unimplemented Recommendations (March 2011 Edition). The OIG report states that CMS will delay the implementation of Phase 2 of change request (CR) 6417 and CR 6421 until Tuesday, July 5, 2011. This is incorrect.

CMS has not yet determined when it will begin to apply the ordering/referring provider claim edit to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied. Recent revisions to CRs 6417 and 6421 require Medicare administrative contractors (MAC) to delay rejecting claims until receiving further direction from CMS.

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

Source: CMS PERL 201103-43

How institutional providers will pay the Medicare enrollment application fee beginning Friday, March 25

Section 6401(a) of the Affordable Care Act (ACA) requires the Secretary [of Health and Human Services] to impose a fee on each “institutional provider of medical or other items or services and suppliers.” The fee is to be used by the Secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes, including those under Section 1866(j) and Section 1128J of the Social Security Act. The application fee is \$505 for calendar year 2011; based upon provisions of the ACA this fee will vary from year-to-year based on adjustments made pursuant to the consumer price index – all urban consumers (CPI-U). The application fee is to be imposed on institutional providers that are newly-enrolling, re-enrolling/re-validating, or adding a new practice location, for applications received on and after Friday, March 25, 2011. The Centers for Medicare & Medicaid Services (CMS) has defined “institutional provider” to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and nonphysician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

Institutional providers applying to participate in the Medicare program must first submit a completed CMS-855 application. An enrollment application can be submitted in one of two ways:

1. Electronically, using Internet-based PECOS – once you have completed and submitted your enrollment application using Internet-based PECOS, you should then promptly pay the application fee through www.Pay.gov. Once you are on Pay.gov, type “CMS” in the search box under “Find Public Forms” and click the “GO” button. Click on the “CMS Medicare Application Fee” link. Complete the form and submit payment as directed. You will get a confirmation screen indicating that payment was successfully made. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the

Medicare contractor along with the certification statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid. The Medicare contractor will process the provider enrollment application in the order in which it was received. Normal processing timeframes apply to your provider enrollment application.

2. Complete the paper Medicare enrollment application (CMS-855) – once you have completed filling out the CMS-855 paper application, you should promptly pay the application fee through www.Pay.gov. Once you are on Pay.gov, type “CMS” in the search box under “Find Public Forms” and click the “GO” button. Click on the “CMS Medicare Application Fee” link. Complete the form and submit payment as directed. You will get a confirmation screen indicating your payment was successful. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the Medicare contractor along with the completed CMS-855 application. CMS also notifies the Medicare contractor that your application fee has been paid. The Medicare contractor will process your provider enrollment application in the order in which it was received. Normal processing timeframes apply to your provider enrollment application.

Pay.gov is operated by the U.S. Department of the Treasury and is a Web-based application that allows you to make online payments to government agencies by electronic check, credit card, or debit from your checking or savings account. Pay.gov accepts Visa, MasterCard, American Express, and Discover. Do not mail application fee payments. Pay.gov cannot accept payments by mail or phone. Please note that all fees must be paid via Pay.gov and that paper checks will not be accepted. Users need not worry about submitting the incorrect amount; CMS has pre-populated the field for the correct payment amount for the specific calendar year. Users may not make

Continued on next page

How institutional providers will pay the Medicare enrollment application fee ... (continued)

multiple payments in one transaction and must make separate payments for each application.

CMS has reviewed the security of Pay.gov and is confident in the measures used to protect its users. Pay.gov uses 128-bit SSL encryption to protect your transaction information while you're logged in to Pay.gov. In addition, any account numbers you set up in your profile are encrypted before being stored in our database. When you access your profile, any account numbers you have entered will be masked on-screen; each account number in your profile will be displayed as a group of asterisks followed by the last four digits of the account number.

Your Medicare application is processed by the Medicare contractor via the provider enrollment, chain, and ownership system (PECOS). The application fee, paid electronically by check, debit card, or credit card, is processed through Pay.gov. Therefore, if you have problems submitting your application fee, you should

use the Help Tools available on the Pay.gov site for questions specific to the payment processing. Other questions regarding payment policies and procedures may be sent to the Medicare provider and supplier enrollment e-mail account at Dpse_admin@cms.hhs.gov.

For more information, please refer to the regulation published to the *Federal Register* at <http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>. And for additional clarification, look out for an official *MLN Matters* article that will be released on the subject in the near future.

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

Source: CMS PERL 201103-48

Implementation of application fees for Medicare provider/supplier enrollment

Effective Friday, March 25, Medicare administrative contractors (MACs) will begin collecting application fees with certain provider/supplier enrollment applications (both paper and online applications) as described below. The application fee is currently \$505 for calendar year 2011; however, this fee will vary from year-to-year based on adjustments made pursuant to the consumer price index for urban areas (CPI-U).

Note that these application fees do not apply to physicians, non-physician practitioners, physician organizations, and nonphysician organizations. All institutional providers of medical or other items or services or suppliers must pay the application fee. ("Institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or the associated Internet-based PECOS enrollment applications.)

All application fees must be submitted via paper check, until the Centers for Medicare & Medicaid Services (CMS) specifies a mechanism for submitting electronic funds at a future date. Note also that MACs will accept hardship exception requests from institutional providers; however, determinations on whether to grant these requests will be made on a case-by-case basis. CMS and its contractors will not be able to process any applications without the proper application fee having been paid and credited to the United States Treasury or an approved hardship exception. If the fee is not submitted, the application will be rejected or billing privileges revoked (as applicable) unless a hardship exception request is subsequently granted. If CMS has denied a hardship exception request, then an institutional provider has 30 days to submit the application fee to the CMS contractor.

For more information, please refer to the regulation published to the *Federal Register* at <http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>. And for additional clarification, look out for an official *MLN Matters* article that will be released on the subject in the near future.

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

Source: CMS PERL 201103-08

Primary Care Incentive Payment Program eligibility for new providers

Provider types affected

Newly enrolled physicians and certain non-physician practitioners who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for providing primary care services to Medicare beneficiaries are affected by this change.

Provider action needed

Change request (CR) 7267, from which this article is taken, announces that (effective July 1, 2011) the Primary Care Incentive Payment Program (PCIP) is amended to include the participation of certain newly enrolled Medicare primary care physicians and non-physician practitioners who do not have a prior two-year claims history with which to determine eligibility. You should make sure that your billing staffs are aware of this change in PCIP eligibility.

Background

Section 5501(a) of the Affordable Care Act revised Section 1833 of the Social Security Act (the Act) by adding a new paragraph (x), entitled "Incentive Payments for Primary Care Services." This new paragraph 1833(x) states that primary care providers who provide primary care services (on or after January 1, 2011, and before January 1, 2016) will be paid, quarterly, an amount equal to 10 percent of the payment amount for such services paid under the physician fee schedule (PFS).

Eligibility of new providers for payment under PCIP

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, Medicare-enrolled primary care practitioners are eligible for a 10 percent PCIP payment for the primary care services they furnish if they:

- Have a primary specialty designation of 08 (family practice), 11 (internal medicine), 37 (pediatrics), 38 (geriatrics), 50 (nurse practitioner), 89 (certified clinical nurse specialist), or 97 (physician assistant)
- Provided the following eligible primary services:
 - Evaluation and management (E/M) codes 99201-99215 for new and established patient E/M office or outpatient visits;
 - E/M codes 99304-99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home or custodial care E/M services; and domiciliary, rest home or home care plan oversight services; or
 - E/M codes 99341-99350 for new and established patient home E/M visits; and
 - Provided PCIP eligible primary care services that account for at least 60 percent of the allowed charges under Part B (excluding hospital inpatient care and emergency

department visits) for such practitioners during the time period that has been specified by the Secretary.

Claims data used to determine eligibility

If you are newly enrolled in Medicare (with no claims data from two years prior to the PCIP payment year), your PCIP eligibility will be determined using the prior year's available claims data with no minimum time period in which you must have been enrolled in Medicare. For example, for CY 2011, if you were newly enrolled in Medicare in CY 2010, Medicare will use your available claims data from CY 2010 to determine PCIP eligibility. Therefore, as a newly enrolled eligible primary care practitioner, you would need to wait no more than one year following your enrollment and first billing in order for primary care services you furnish to be subject to the PCIP in the year following your initial enrollment.

Timing for PCIP payments

However due to the lag time required to process claims data, PCIP eligibility determinations for newly enrolled primary care practitioners will be delayed until after the end of the third quarter of the PCIP payment year. PCIP payments will ultimately be made for all primary care services the eligible practitioners furnished throughout the full PCIP payment year, but the timing of eligibility determination will result in a single cumulative PCIP payment for newly enrolled primary care practitioners based on eligible services rendered from January 1 through December 31 of the payment year that will be made following the fourth quarter of the incentive payment year.

Subsequent payments will be made quarterly based on each quarter's eligible claims as long as you remain eligible. You are not guaranteed eligibility for PCIP payment in subsequent years, as you will need to newly qualify for each PCIP payment year.

PCIP payment calculations for newly enrolled providers

By November 28 of the PCIP payment year, carriers and A/B MACs will post the "PCIP Payment for New Providers Enrolled in Medicare File" on their websites. The PCIP Payment is calculated as follows:

- For each qualifying NPI on the "PCIP Payment for New Providers Enrolled in Medicare File," contractors will accumulate the total paid amount (or review paid claims history) for codes *Current Procedural Terminology (CPT)* codes 99201-99215, and 99304-99350 for all four quarters of the payment year.
- For each payment, the contractors will calculate a payment equal to 10 percent of the amount paid for each of these codes.

Note: If a physician or group practice submits a claim for a primary care service, it must be reported under a practitioner with a qualifying NPI in order for the service to qualify for the incentive payment;

Primary Care Incentive Payment Program eligibility for new providers (continued)

Participation in the health professional shortage area (HPSA) and PCIP programs
Beginning in CY 2011, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment and the PCIP payment. The PCIP incentive payment is based on the amount paid, and not the Medicare approved amount. You will receive a special remittance form with the incentive payment so that you will be able identify which type of incentive payment (HPSA physician and/or PCIP) was paid for each program.

Additional information

For further details, please see the official instruction (CR 7267) issued to your Medicare contractor at <http://www.cms.gov/Transmittals/downloads/R2152CP.pdf>. You will find the revised *Medicare Claims Processing Manual*, Chapter 12 (Physicians/non-physician Practitioners), Sections 230 (Primary Care Incentive Payment Program (PCIP)), 230.1 (Definition of Primary Care Practitioners and Primary Care Services), 230.2 (Coordination with Other Payments), and 230.3 (Claims Processing and Payment) as an attachment. Please refer to the *Medicare Claims Processing*

Manual, Chapter 12 (Physicians/non-physician Practitioners), Section 90.4.4 (Payment) for details about HPSA physician bonus program and a PCIP incentive payment under this new PCIP program. If you have questions, please contact your Medicare carrier, FI, Part A/B Medicare administrative contractors (A/B MAC), durable medical equipment regional carrier (DMERC), DME/MAC, and/or regional home health intermediary (RHHI), at their toll-free number which may be found at: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters Number: MM7267
Related Change Request (CR) #: 7267
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Related CR Transmittal #: R2152CP
Implementation Date: July 5, 2011

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Primary Care Incentive Payment eligibility data updated on contractor websites

Practitioners wishing to confirm Primary Care Incentive Payment (PCIP) eligibility for incentive payment year 2011 may now refer to the updated "Primary Care Incentive Payment eligibility" data files from CMS, available on contractor websites. For additional practitioner eligibility inquiries, practitioners should call their Medicare claims processing contractor contact centers.

Source: CMS PERL 201103-19

Physician Compare Initiative Web page is now available

The Physician Compare Initiative Web page is a resource related to the Physician Compare Website specifically for physicians and eligible professionals. The Web page will contain information that is deemed of interest to the healthcare professional community, including CMS sponsored forums and links to other applicable resources.

The Physician Compare Website was launched December 30, 2010, to meet requirements set forth by Section 10331 of the Patient Protection and Affordable Care Act of 2010. For more information on the Physician Compare Website visit <http://www.medicare.gov/find-a-doctor/provider-search.aspx>.

For more information on the Physician Compare Initiative, visit http://www.cms.gov/physician-compare-initiative/01_overview.asp.

This newly established Web page will be updated regularly, so check it often for timely and reliable information from CMS.

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

Source: CMS PERL 201103-36

2011 electronic prescribing incentive program update – future payment adjustments

Provider types affected

This article is for physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing (eRx) Incentive Program.

Provider action needed

Stop – impact to you

CMS announced that, beginning in 2011, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment on their future Medicare Part B physician fee schedule (PFS) covered professional services.

Caution – what you need to know

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.

Go – what you need to do

Certain eligible professionals can avoid the 2012 eRx payment adjustment by becoming a successful electronic prescriber (completing the required claims-based reporting in the required timeframe). Group practices participating in the eRx group practice reporting option (GPRO) I or II during 2011 **must** become a successful electronic prescriber and complete the required reporting. See the *Background* section for more details. Be sure to inform your staffs of this update.

Background

From 2012 through 2014, the eRx 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 amount for covered professional services for not being a successful electronic prescriber in 2011 or as defined in future rule making.
- In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98 percent of their Medicare Part B PFS amount for covered professional services.

The 2012 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. The payment adjustment also does not apply if the eligible professional has less than 100

cases containing an encounter code in the measure's denominator for the same January 1, 2011, through June 30, 2011, reporting period.

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 – but it will exempt an eligible professional or GPRO from a 2013 payment adjustment.

Avoiding the 2012 eRx payment adjustment

An eligible professional can avoid the 2012 eRx payment adjustment if he or 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 the National Plan and Provider Enumeration System (NPPES)
- Does not have prescribing privileges and reports G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim prior to June 30, 2011
- Does not have at least 100 cases containing an encounter code in the measure's denominator
- Becomes a successful electronic prescriber (submits required number of electronic prescriptions (10 for individual) via claims and reports this to CMS before June 30, 2011), or
- Claims a hardship as described below.

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

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

If an eligible professional or selected group practice wishes to request an exemption to the eRx incentive program and the payment adjustment, there are two "hardship codes" that can be reported via claims if one of the following situations apply:

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

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2011 electronic prescribing incentive program update – future payment adjustments (continued)**Additional information**

For additional information, please visit the “How to Get Started” and “Payment Adjustment Information” sections at <http://www.cms.gov/erx incentive>.

You may wish to download *Medicare’s Practical Guide to the Electronic Prescribing (eRx) Incentive Program* publication, available at <http://www.cms.gov/partnerships/downloads/11399-P.pdf>.

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 Related CR Release Date: N/A
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 Implementation Date: N/A

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Program reminder: 2011 electronic prescribing incentive – 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, 2011-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.

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 201103-37

Internet-based PECOS even more user-friendly

Health care providers who use or plan to use the Provider Enrollment, Chain, and Ownership System (PECOS) to file and track their Medicare enrollment record and specialty status have even more reason to enjoy the convenience of Internet-based PECOS. The Internet-based system received a series of enhancements during the month of January, including:

- An improved submission process, including simpler directions for signing up and a clearer process for follow-up
- A tracking bar for the application process, indicating progress through the system, and
- A new application status module on the website for checking whether enrollment applications have been:
 - Received by the MAC (Medicare administrative contractor)
 - Reviewed by the MAC
 - Returned for additional information, or
 - Approved or rejected.

Additionally, providers now have 15 days to submit signed paperwork required to complete the enrollment process.

To access Internet-based PECOS, visit <https://pecos.CMS.hhs.gov/pecos/login.do>. To learn more about Medicare enrollment for providers and suppliers, visit <http://www.CMS.gov/MedicareProviderSupEnroll>. Additional informative fact sheets from the *Medicare Learning Network* about Internet-based PECOS are available for physicians and nonphysician practitioners, provider and supplier organizations, and DMEPOS suppliers.

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

Source: CMS PERL 201103-21

Update on health information technology and EHR incentive program ONC explains how 2011 marks age of meaningful use

The latest public letter from Dr. David Blumenthal, National Coordinator for Health Information Technology, marks 2011 as the year when medical care entered a new era – the age of meaningful use of health information. The letter highlights the programs the Office of National Coordinator (ONC) has implemented in order to build an infrastructure to support meaningful use, and it also examines the role of meaningful use as a vision of how information can be used in innovative ways to revolutionize the work of health professionals and health care institutions.

Visit the ONC website (at <http://HealthIT.HHS.gov/portal/server.pt?open=512&mode=2&objID=3541>) to read the letter and learn more about the age of meaningful use.

Strong interest in Medicare and Medicaid EHR incentive programs

In a press release earlier this week, the Center for Medicare & Medicaid Services (CMS) announced that there has been strong interest in early registration for the Medicare and Medicaid EHR (electronic health record) incentive programs.

In January, more than 21,000 providers initiated registration for the programs, and four states began issuing Medicaid incentive payments, totaling \$20,425,550. In particular, the press release highlighted the following successes:

- The Office of the National Coordinator for Health Information Technology announced that as of Friday, February 11, more than 45,000 providers requested information or registration help from 62 regional extension centers.
- On Wednesday, January 5, Kentucky made an initial payment of \$2.86-million to a teaching hospital, University of Kentucky Healthcare. On the same day, Kentucky disbursed an incentive payment of \$1.3-million to Central Baptist Hospital, and Oklahoma issued incentive payments to two physicians at the Gastorf Family Clinic of Durant, Oklahoma, totaling \$42,500 (\$21,250 each), for having adopted certified EHRs.
- On Wednesday, January 12, Louisiana announced a payment of \$63,750 to Winn Community Health Center, the first federally-qualified health center in the nation to receive an incentive payment. The incentive payment consisted of \$21,250 for each of three eligible professionals at the clinic.
- During the week of Monday, January 17, Iowa issued its first Medicaid EHR incentive payments in the amount of \$21,250 each for two eligible professionals.

CMS Administrator Donald Berwick, M.D., said, "This strong early interest in the Medicare and Medicaid EHR

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Update on health information technology and EHR incentive program (continued)

incentive programs among providers and state Medicaid programs is most welcome and very encouraging. We encourage early adoption, and we're seeing the registration numbers continue on an upward trajectory. The valuable feedback we've seen in these early weeks of the program helps us to fine-tune our list of frequently-asked-questions and other resources to increase providers' understanding of the incentive programs and help them in getting signed up."

Want more information about the EHR incentive programs? Visit the EHR incentive programs website at <http://www.cms.gov/EHRIncentivePrograms/> for the latest news and updates on the EHR incentive programs, and join the CMS EHR Listserv at http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp to stay up-to-date.

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

Source: CMS PERL 201102-47

Advanced diagnostic imaging accreditation enrollment procedures**Provider types affected**

Physicians, non-physician practitioners, and independent diagnostic testing facilities (IDTF) submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MAC]) are affected by this article.

Provider action needed**Stop – impact to you**

The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations (AOs) to provide accreditation services for suppliers of the technical component (TC) of advanced diagnostic imaging procedures. The approved AOs are:

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

The accreditation will apply only to the suppliers of the images themselves, and not to the physician's interpretation of the image. The accreditation only applies to those who are paid under the Medicare physician fee schedule.

Caution – what you need to know

If you are a provider submitting claims for the TC of advanced diagnostic imaging services for Medicare beneficiaries, you must be accredited by January 1, 2012, to be reimbursed for the claim if the service is performed on or after that date.

Go – what you need to do

Physicians, non-physician practitioners, and IDTFs submitting claims for the TC of advanced diagnostic imaging services for Medicare beneficiaries must:

- Complete Internet-based provider enrollment, chain and ownership system (PECOS) or the appropriate CMS-855 enrollment application and the attachment for advanced diagnostic imaging (ADI).
- Mail the completed form to the designated Medicare enrollment contractor.
- You must be accredited by January 1, 2012, to be reimbursed for the claim if the service is performed on or after that date.

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act and required the Secretary, Department of Health and Human Services (DHHS) to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and IDTFs, who furnish the TC of advanced diagnostic imaging services. MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, such as positron emission tomography (PET).

In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.

Additional information

The official instruction, CR 7177, issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R373PI.pdf>.

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Advanced diagnostic imaging accreditation enrollment procedures (continued)

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

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

MLN Matters® Number: MM7177
 Related Change Request (CR) #: 7177
 Related CR Release Date: April 7, 2011
 Effective Date: July 1, 2011
 Related CR Transmittal #: R373PI
 Implementation Date: July 5, 2011

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

Reporting of recoupment for overpayment on the remittance advice

Note: This article was revised on March 4, 2011, to reflect changes made to change request (CR) 6870. The CR was changed to amend the implementation date to October 3, 2011, for claims processed by Medicare contractors using the Fiscal Intermediary Shared System (FISS). The article was changed accordingly. All other information is the same. This information was previously published in the April 2010 *Medicare B Update!* pages 41-42.

Provider types affected

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

Provider action needed

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

Background

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

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

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

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

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

Step II: Report the actual recoupment.

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

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

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

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter

Continued on next page

Reporting of recoupment for overpayment on the remittance advice (continued)

includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:**Claim level:**

The original payment is taken back and the new payment is established

Provider level:

PLB03-1 – PLB reason code FB (forward balance)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

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

Step II:**Claim level:**

No additional information at this step

Provider level:

PLB03-1 – PLB reason code WO (overpayment recovery)

PLB 03-2 shows the detail:

Part A: PLB-03-2

1-2: CS

3-19: Adjustment DCN#

20:30: HIC#

Part B: PLB-03-2

1-2: 00

3-19: Adjustment ICN#

20-30: HIC#

PLB04 shows the actual amount being recouped.

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

Additional information

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

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

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

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

MLN Matters[®] Number: MM6870 *Revised*

Related Change Request (CR) #: 6870

Related CR Release Date: March 4, 2011

Effective Date: July 1, 2010

Related CR Transmittal #: R866OTN

Implementation Date: July 6, 2010, except October 3, 2011, for claims processed by the FISS system used by FIs and A/B MACs

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The 2011 Medicare Contractor Provider Satisfaction Survey

In case you've forgotten or haven't heard, the Centers for Medicare & Medicaid Services (CMS) launched its Annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This is a friendly reminder to encourage selected providers to take the survey. The survey offers Medicare fee-for-service (FFS) providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. As a result of past survey responses, Medicare FFS contractors have implemented changes to improve their communication processes and education and training of their staff.

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

If you have received a survey letter, then you have been selected to participate. Please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes.

CMS is listening and wants to hear from you. To learn more about the MCPSS, please visit the CMS website at www.cms.hhs.gov/MCPSS. If you have any questions or concerns, please call our toll-free MCPSS provider helpline number at 800-654-1431 or send an email to MCPSS_survey@scimetrika.com.

If you've already completed and submitted your survey, we thank you for your feedback.

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

Source: CMS PERL 201103-02

ICD-10 MS-DRG conversion project website – new information now available

The *ICD-10 Medicare Code Editor v27* and a text version of the *ICD-10-CM/PCS Medicare Severity-Diagnosis Related Group (MS-DRG) v28 Definitions Manual* are 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 "Downloads" section. There are also links to order the MS Grouper with Medicare Code Editor ICD-10 Pilot Software Version 28 on CD-ROM from National Technical Information Service (NTIS) in the "Related Links Outside CMS" section of the Web page.

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 final ICD-10 MS-DRGs will be subject to formal rulemaking.

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

Source: CMS PERL 201103-33

New frequently asked questions about ICD-10 implementation

The Centers for Medicare & Medicaid Services (CMS) has posted two new frequently asked questions (FAQs) about ICD-10 national provider teleconferences and the partial code freeze.

To access these FAQs, please visit the CMS ICD-10 Web page at <http://www.cms.gov/ICD10>, select the Medicare Fee-for-Service Provider Resources link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section, and select "ICD-10 FAQs."

Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

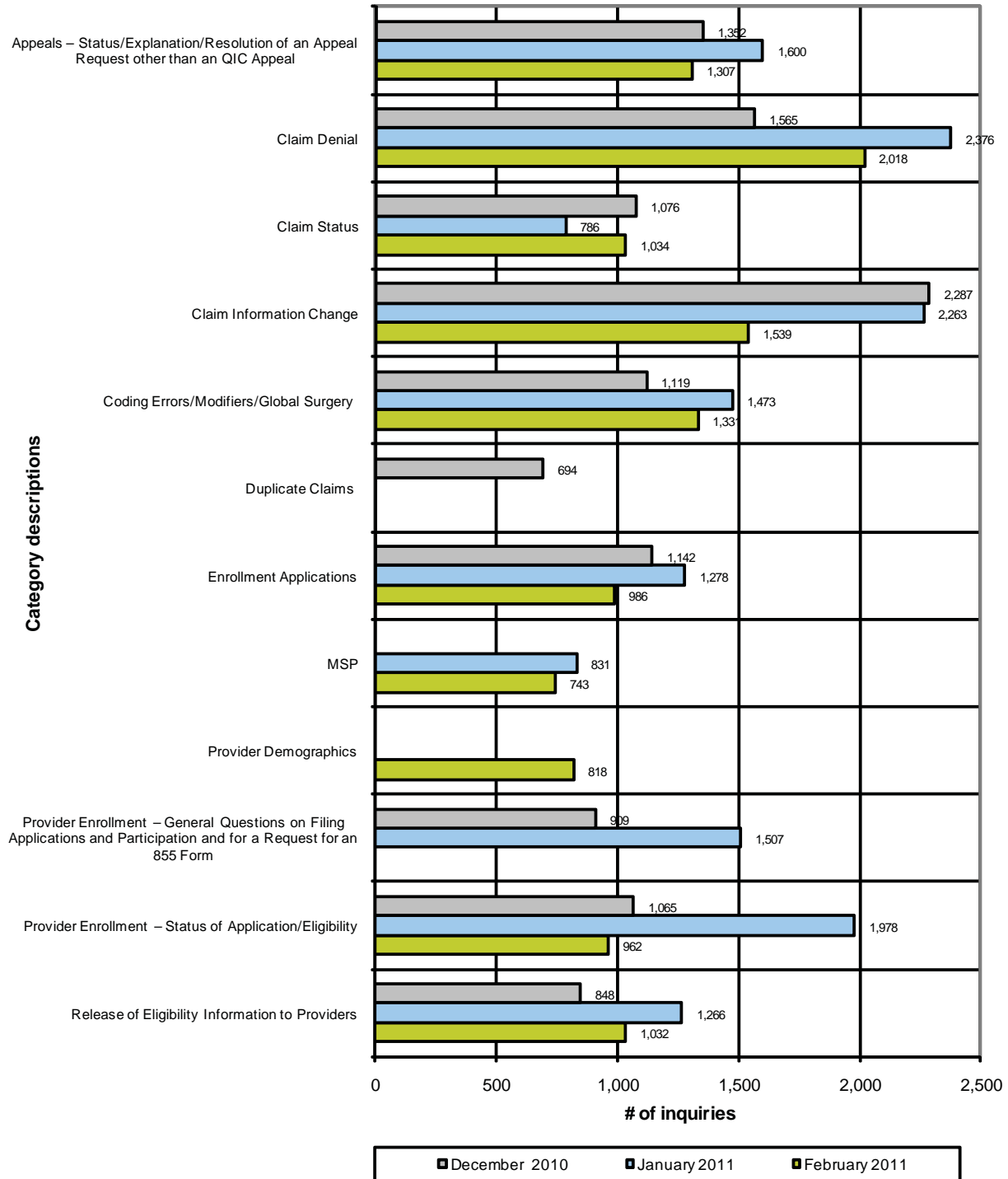
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201103-10

Top inquiries, denials, and return unprocessable claims for December 2010-February 2011

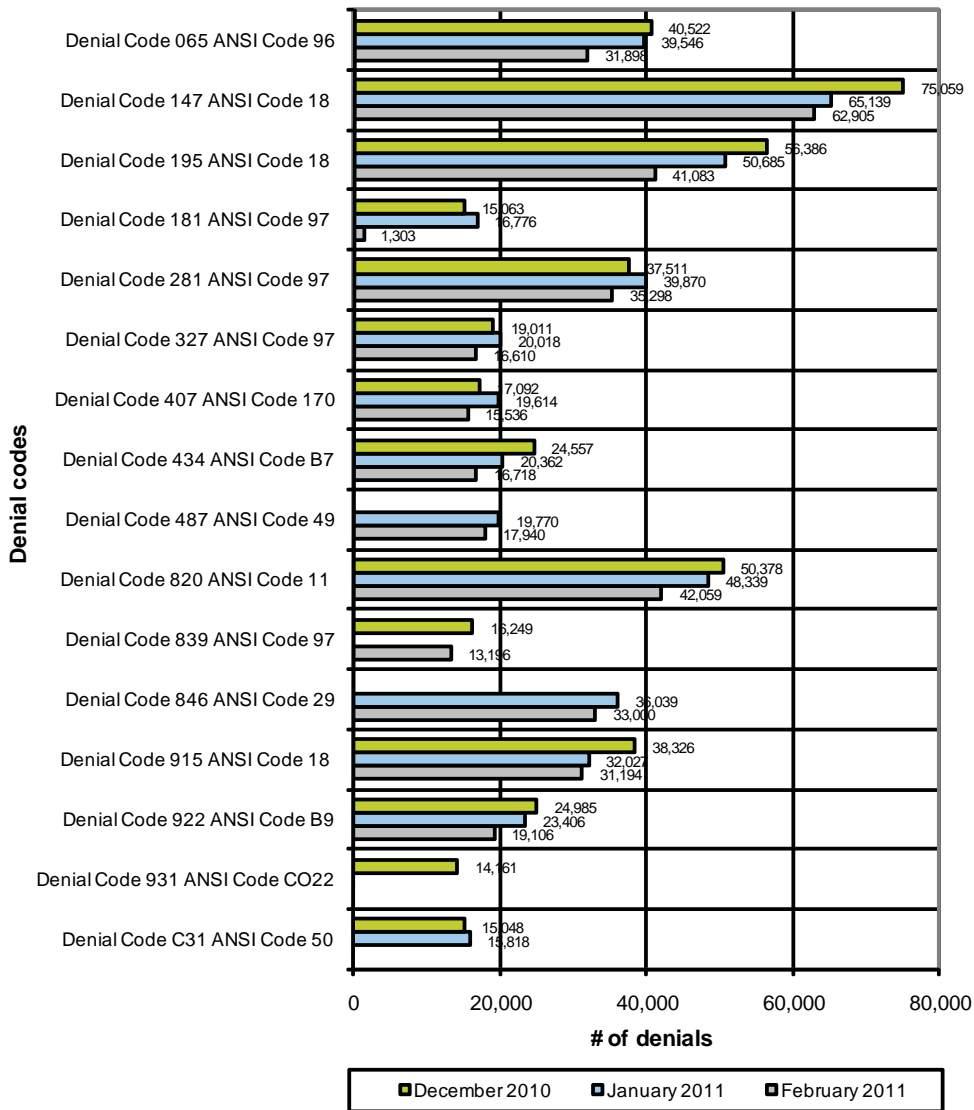
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during December 2010-February 2011. For tips and resources to help you avoid or reduce the amount of time 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 December 2010-February 2011



Top inquiries, denials, and return unprocessable claims for December 2010-February 2011 (continued)

Florida Part B top denials for December 2010-February 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.

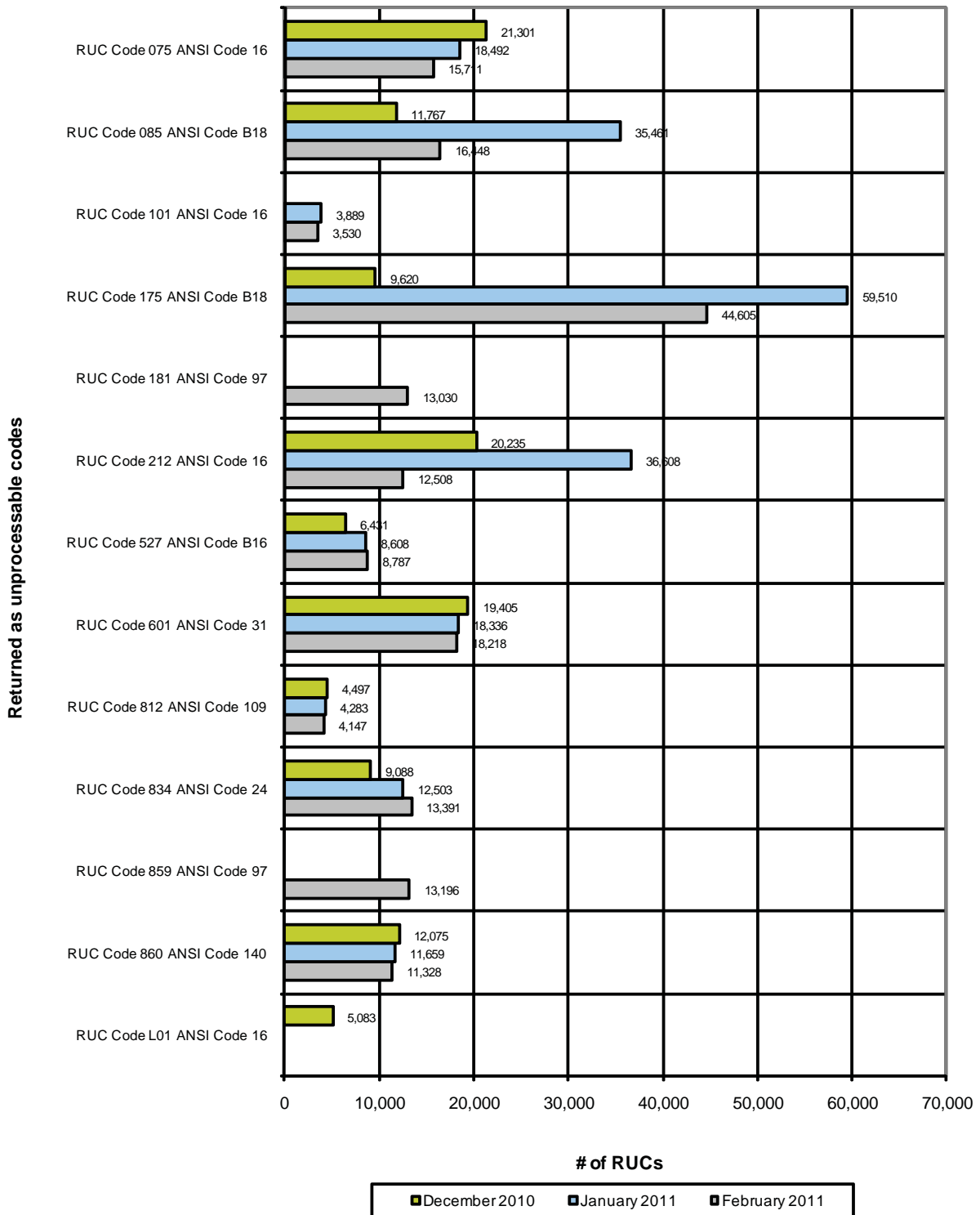
Did you know you can now create an account and receive your personalized Provider Data Summary report?

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.

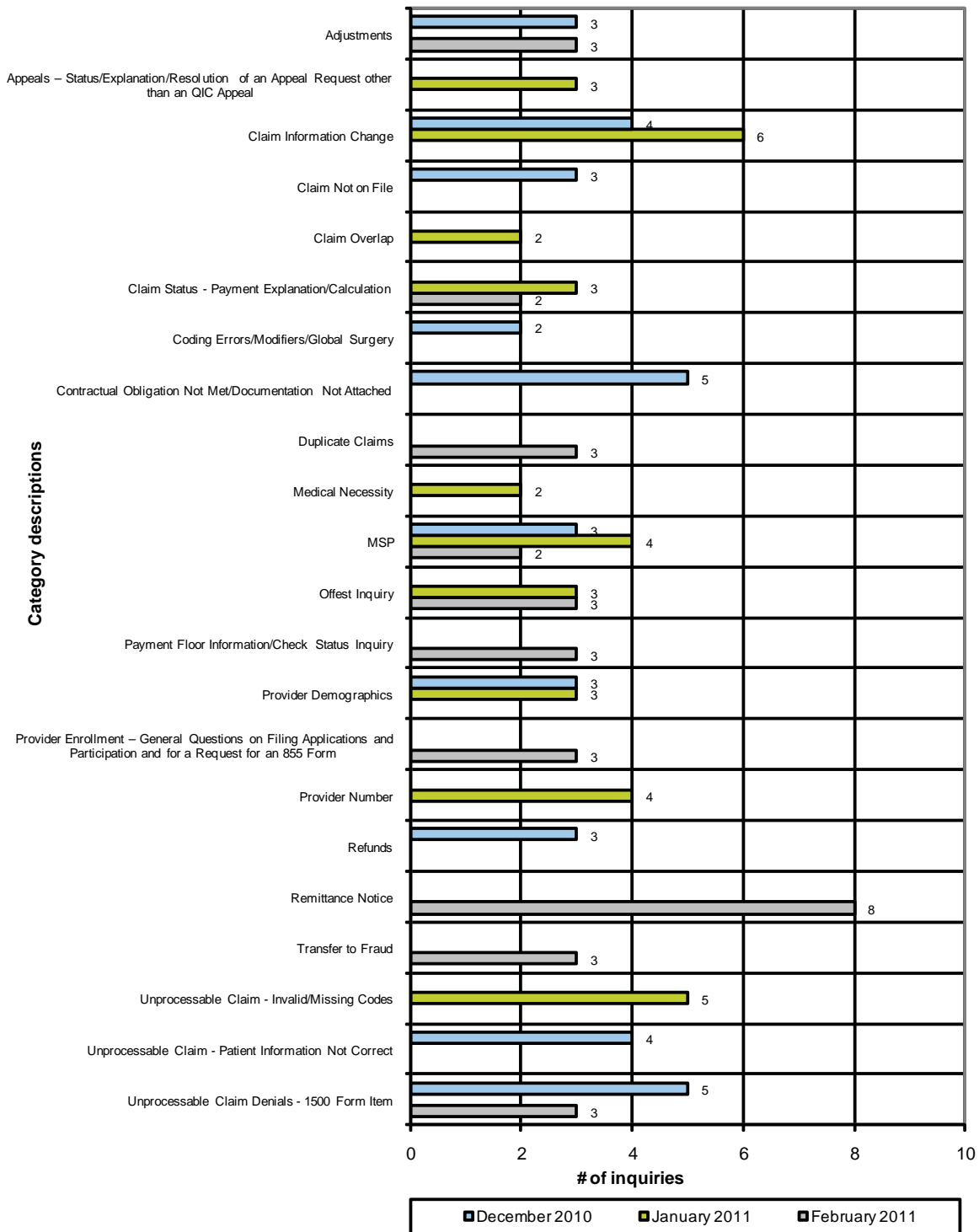
Top inquiries, denials, and return unprocessable claims for December 2010-February 2011 (continued)

Florida Part B top return as unprocessable claims for December 2010-February 2011



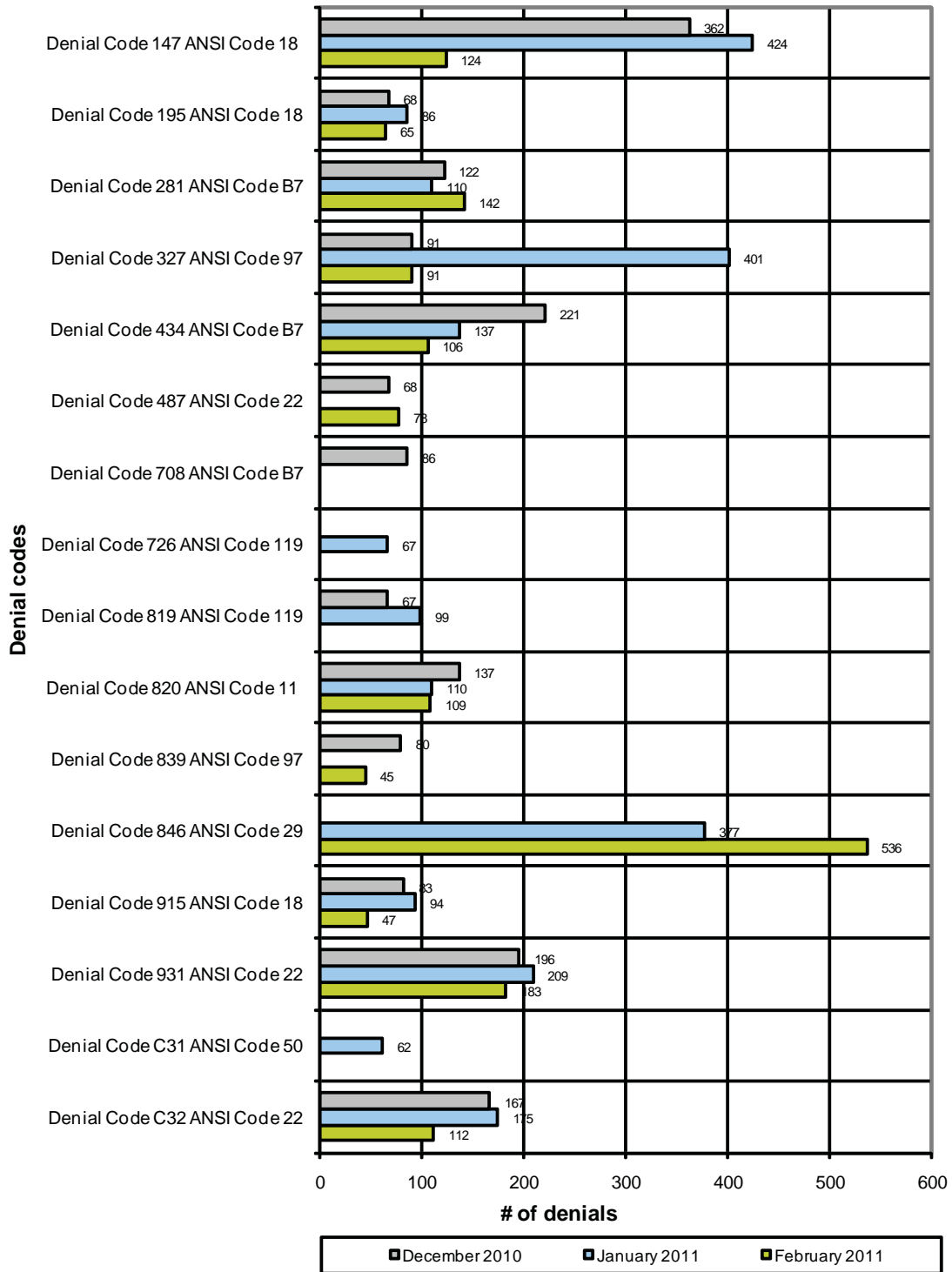
Top inquiries, denials, and return unprocessable claims for December 2010-February 2011 (continued)

U.S. Virgin Islands Part B top inquiries for December 2010-February 2011



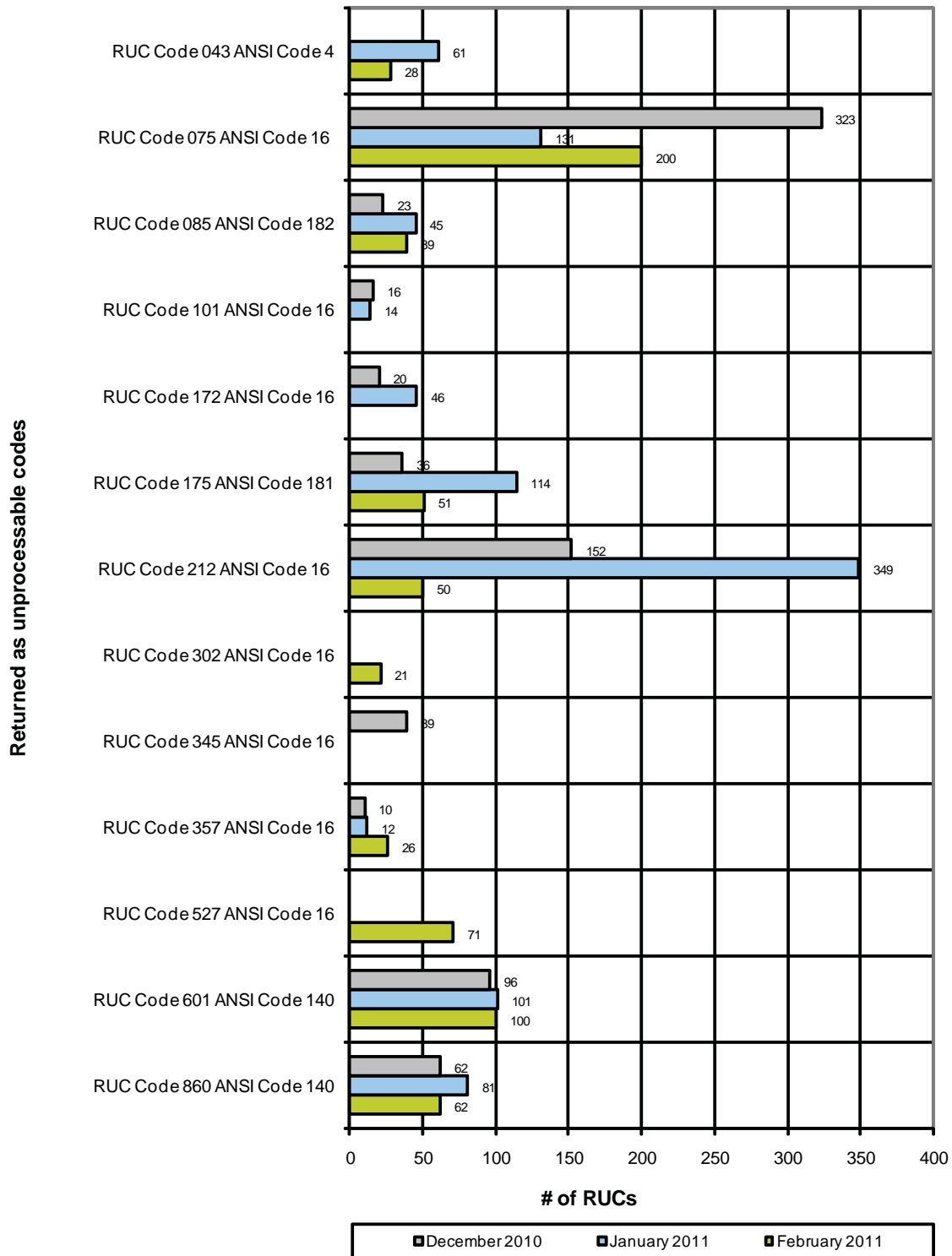
Top inquiries, denials, and return unprocessable claims for December 2010-February 2011 (continued)

U.S. Virgin Islands Part B top denials for December 2010-February 2011



Top inquiries, denials, and return unprocessable claims for December 2010-February 2011 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims for December 2010-February 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/medicare-coverage-database/>.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our website <http://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
 PO Box 2078
 Jacksonville, FL 32231-0048

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Advance beneficiary notice

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

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

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

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at <http://www.cms.gov/medicare-coverage-database/>, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Revisions to LCDs

BOTULINUM TOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L29088 (Florida)

LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised on September 13, 2010. Since that time, there have been several revisions to this LCD.

- The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised in the “Food and Drug Administration (FDA) Indications for Botox®” section to add: prophylaxis of headaches in adult patients with chronic migraine (> 15 days per month with headache lasting four hours a day or longer). The “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised in the section “Procedure Code J0585-Injection, onabotulinumtoxin, 1 unit” to add ICD-9-CM codes 346.71 and 346.73, and the “Documentation Requirements” section of the LCD has also been revised in relation to this new FDA approved indication for Botox®.

Effective date

The **above revisions** to the LCD are effective for claims processed **on or after March 3, 2011**, for services rendered **on or after October 15, 2010**.

- The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has also been revised to add language regarding incobotulinumtoxin (Xeomin®) and a new section was added, “FDA Indications for Xeomin®”. The “CPT/HCPCS Codes” section of the LCD has been revised to add HCPCS code J3590 – Unclassified biologics and HCPCS code C9278 - Injection, incobotulinumtoxin A, 1 unit (for ASCs only). The “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised to add a new section, “HCPCS code J3590 – incobotulinumtoxin (Xeomin®)-effective 07/30/10 and HCPCS code C9278 - Injection, incobotulinumtoxin a, 1 unit (ASCs only)-effective 01/01/11”. In addition, the “Sources of Information and Basis for Decision” section of the LCD has been updated. The LCD “Coding Guidelines” attachment has also been revised to add coding and billing information for incobotulinumtoxin (Xeomin®).

Effective date

The **above revisions** to the LCD are effective for claims processed **on or after March 3, 2011**, for services rendered **on or after July 30, 2010**, for HCPCS code J3590 and claims processed **on or after March 3, 2011**, for services rendered **on or after January 1, 2011**, for HCPCS code C9278. 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.

G0431: Qualitative drug screening – revision to the LCD coding guidelines

LCD ID number: L30574 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) “Coding Guidelines” attachment for qualitative drug screening was most recently revised on February 13, 2011. Since that time, the “Coding Guidelines” attachment was updated to include the Centers for Medicare & Medicaid Services (CMS) information regarding HCPCS codes G0431QW and G0434QW based on Joint Signature Memorandum/Technical Direction Letter (JSM/TDL) 11194 and change request 7266, transmittal 2155. The following information was added:

Effective for claims processed on or after March 3, 2011, for dates of service on or after January 1, 2011, HCPCS code G0431QW was deleted from the Clinical Laboratory Fee Schedule (CLFS). HCPCS code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a Clinical Laboratory Improvement Amendments (CLIA) waived test.

Also,

Effective for claims processed on or after March 3, 2011, for dates of service on or after January 1, 2011, HCPCS code G0434QW was added to the CLFS. HCPCS code G0434 can describe a CLIA waived test. The use of the QW modifier to indicate a CLIA waived test is necessary for accurate claims processing. Both HCPCS codes G0431 and G0434 will remain on the CLFS.

Continued on next page

G0431: Qualitative drug screening – revision to the LCD coding guidelines (continued)**Effective date**

This revision to the LCD “coding guidelines” attachment is effective for claims processed **on or after March 3, 2011**, for services rendered **on or after January 1, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

IDTF: Independent diagnostic testing facility (IDTF) – revision to the LCD**LCD ID number: L29195 (Florida)****LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) and the LCD “Coding Guidelines” attachment were last revised on January 1, 2011. Since that time, the “Coding Guidelines” have been revised in the ‘Credentialing Matrix’ table. Revisions include the following:

- The “Technician qualification requirements” for CPT codes 76376 and 76377 have been revised to add: ARRT: MR or ARMRI: MRI or ARDMS: RDMS or ARRT: R.T.-S (as applicable).
- The “Supervising physician and interpreting physician qualification requirements” have been revised for CPT codes 77080, 77081, 77082 and HCPCS code G0130 to add: orthopaedic surgeon.
- The “Supervising physician and interpreting physician qualification requirements” have been revised for CPT codes 93875, 93880 and 93882 to add: ABPN: Neurologist with ASN or UCNS: neuroimaging subspecialty certification.
- The “Technician qualification requirements” have been revised for CPT codes 95900, 95903, 95904 and 95905 to add ABEM: CNCT.

The “Key for IDTF table abbreviations” section of the “Coding Guidelines” has also been updated to include:

The American Board of Electrodiagnostic Medicine (ABEM).

The LCD “Coding Guidelines” attachment has also been revised for the “Level of physician supervision” in the “Credentialing matrix” in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 5459, dated January 11, 2007, to revise the level of physician supervision to level “3” for CPT codes 76813 and 76814, and in accordance with CMS change request 6351, dated January 2, 2009, to revise the level of physician supervision to level “1” for CPT code 93293.

Effective date

This revision to the LCD “Coding Guidelines” attachment is effective for services rendered **on or after March 22, 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.

J1459: Intravenous immune globulin – revision to the LCD**LCD ID number: L29205 (Florida)****LCD ID number: L29356 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for intravenous immune globulin was most recently revised on October 1, 2010. Since that time, the LCD has been revised to add a dual diagnosis requirement for ICD-9-CM codes 279.00 (Hypogammaglobulinemia, unspecified) and V87.41 (Personal history of antineoplastic chemotherapy) under the ICD-9 Codes that ‘Support Medical Necessity’ section of the LCD. The “Coding Guidelines” attachment was also updated to include the new dual diagnosis requirement. In addition, under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD new off label indications for patients with Hypogammaglobulinemia and NNI (non neutropenic infection) induced by certain chemotherapy agents were added.

All the following criteria must be met:

1. Recent treatment with rituximab in combination with cytotoxic chemotherapy.
2. Laboratory proven hypogammaglobulinemia and an absolute neutrophil count over 1,000.
3. Acute infection requiring hospitalization or an infection lasting over 2 weeks in spite of antibiotics or an infection relapsing immediately after discontinuation of antibiotics.

Continued on next page

J1459: Intravenous immune globulin – revision to the LCD (continued)

4. Dose: 400-600 mg/kg one time that can be repeated at a standard interval based on laboratory assessment of IG levels and persistence of non neutropenic infection.

Effective date

This LCD revision is effective for services rendered **on or after April 7, 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.

NCSVCS: Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)

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

The local coverage determination (LCD) for noncovered services was most recently revised on February 13, 2011. Since that time, a revision was made to the LCD. *CPT* codes 95980, 95981, and 95982 were removed from the ‘*CPT*/HCPCS Codes, Local Noncoverage Decisions-Procedures’ section of the LCD. *CPT* codes 95980-95982 represent the initial and subsequent programming of a gastric stimulator. These codes are used for the electronic analysis of the implanted gastric stimulator. Enterra™ Therapy can be considered for coverage if documentation supports that the device is for the treatment of chronic nausea and vomiting associated with severe chronic gastroparesis that is refractory to standard medical management and meets all humanitarian device exemption (HDE) requirements. Claims for humanitarian use device (HUD) may be reviewed pre or post payment. Documentation when requested should include details about the specific device, including a copy of the institution’s institutional review board (IRB) approval letter for each individual patient, the device number and documentation that the device is classified by the Food and Drug Administration (FDA) as a HUD, and has been approved by the FDA under a HDE. Supporting documentation should also include a description of the clinical indications for the patient and why the device is needed. The medical record should document why the benefits of the use of the device outweigh the risks, considering other available devices and other available therapies.

Effective date

This LCD revision is effective for claims processed **on or after April 12, 2011**, for services rendered **on or after January 1, 2009**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

SKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L29279 (Florida)

LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for skin substitutes was most recently revised on January 1, 2011. Since that time, under the “*CPT*/HCPCS Codes” section of the LCD, language was revised/added to clarify that new services must be evaluated by First Coast Service Options Inc. (FCSO) Medicare administrative contractor (MAC) jurisdiction 9 (J9) to determine if they are medically reasonable and necessary, and that the not separately payable HCPCS codes are considered “not medically reasonable and necessary products.”

In addition, information was added regarding an advance beneficiary notice (ABN).

Effective date

This LCD revision is effective for claims processed **on or after March 8, 2011**, for services rendered **on or after February 13, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

Additional Information

J0600: Injection, edetate calcium disodium, up to 1000 mg

The comprehensive data analysis department evaluated HCPCS code J0600: Injection, edetate calcium disodium, up to 1000 mg. HCPCS code J0600 was identified as aberrant based on Medicare Part B extract and summary system (BESS) data January-June 2010. The data revealed a carrier- to-nation ratio of 4.64 with Florida representing 31.28 percent of the total dollars allowed in the nation. The utilization of HCPCS code J0600 has increased significantly and the billing pattern identified during the analysis of current Florida Part B claims data indicates a pattern of utilization that suggests a high risk exists for improper billing or payment. First Coast Service Options Inc. (FCSO), will implement a prepayment edit to prevent payment of services for non-covered and/or inaccurately coded services.

The local coverage determination (LCD) for chelation therapy (L29098) is available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section..." drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

J1740: Boniva® (ibandronate sodium) injection program vulnerability

The Centers for Medicare & Medicaid Services (CMS) Miami field office recently identified a program vulnerability related to the use of Boniva® injection administered intravenously to male patients for the prevention and treatment of osteoporosis. Patients reported receiving Boniva® injection (intravenous - IV) instead of oral drugs for the treatment of osteoporosis even though there were no contraindications to the administration of oral medications, including oral Boniva®. Reportedly, patients were given Boniva® IV as prophylaxis for osteoporosis. Some patients who received Boniva® IV reported they had normal bone mineral density test results, while others were told they were being given Boniva® IV for osteopenia, rather than for osteoporosis. Patients also reported that they were not offered other treatment alternatives that are approved by the Food and Drug Administration (FDA) for males with osteoporosis.

Boniva® (ibandronate sodium) injection is a nitrogen-containing bisphosphonate that inhibits osteoclast-mediated bone resorption. Boniva® injection is administered intravenously and is approved by the FDA for the treatment of osteoporosis in postmenopausal women.

In order to be covered by Medicare, a drug or biological must be safe and effective and otherwise reasonable and medically necessary. Drugs and biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the FDA labeling. The labeling lists the safe and effective indications, dosage, and frequency of the agents.

The CMS *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50 indicates the following:

The Medicare program provides limited benefits for

outpatient drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met:

- *They meet the definition of drugs or biologicals*
- *They are of the type that are not usually self-administered*
- *They meet all the general requirements for coverage of items as incident to a physician's services*
- *They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice*
- *They are not excluded as noncovered immunizations, and*
- *They have not been determined by the FDA to be less than effective.*

Section 50.2 of the above chapter provides guidance on determining self-administration of a drug or biological and assists with interpretation of Medicare's requirement that the drug is "not usually self-administered by the patient." This section further reflects the following:

Contractors must continue to apply the policy that not only the drug is medically reasonable and necessary for any individual claim, but also that the route of administration is medically reasonable and necessary. That is, if a drug is available in both oral and injectable forms, the injectable form of the drug must be medically reasonable and necessary as compared to using the oral form.

The following excerpt from the *Medicare Program Integrity Manual*, Pub. 100-08, Chapter 13, Section 13.5.1 indicates the following:

Continued on next page

J1740: Boniva® (ibandronate sodium) injection program vulnerability (continued)

In order to be covered under Medicare, a service shall be reasonable and necessary. Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is all of the following:

- Safe and effective
- Not experimental or investigational
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member
 2. Furnished in a setting appropriate to the patient's medical needs and condition
 3. Ordered and furnished by qualified personnel
 4. One that meets, but does not exceed, the patient's medical need, and
 5. At least as beneficial as an existing and available medically appropriate alternative.

In addition to FDA approved indications, Medicare may consider coverage of off-label uses based on guidance provided in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.4.2. This manual section indicates the following:

Unlabeled Use of Drug

FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.

These decisions are made by the contractor on a

case-by-case basis.

The Clinical Pharmacology Compendia lists the following off-label indications for Boniva® injection:

- Paget's disease
- Osteolytic metastases in patients with prostate cancer
- Hypercalcemia of malignancy
- Corticosteroid-induced osteoporosis

Based on the CMS Miami field office findings which indicate Medicare is making payment for claims for male patients who are receiving Boniva® IV which does not meet FDA label or approved compendia off-label indications, a prepayment edit will be implemented in the near future. The prepayment edit will result in requests for medical records for Boniva® IV claims to allow review of the medical record documentation prior to payment for male patients. First Coast Service Options Inc. (FCSO) anticipates the publication of a draft local coverage determination (LCD) later this year for drugs used in the treatment of osteoporosis which will define FCSO's coverage indications and limitations for these medications. In the interim, Medicare providers should ensure that claims submitted to Medicare for Boniva® IV meet CMS' requirements related to intravenous versus oral administration and that patients meet FDA label or CMS approved compendia off-label indications.

Providers may have recently received requests for records for Boniva® IV claims submitted for both male and female patients. The provider must respond to these requests for documentation and submit medical records that support the services billed to the Medicare program.

64999: Blood brain barrier osmotic disruption for treatment of brain tumors – national coverage determination

The national coverage determination (NCD) for blood brain barrier osmotic disruption for treatment of brain tumors (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, Section 110.20) was effective for services provided on or after March 20, 2007. According to the NCD, the Centers for Medicare & Medicaid Services (CMS) determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors. First Coast Service Options Inc. has identified the following diagnoses as not reasonable and necessary based on this NCD.

191.0-191.9 (Malignant neoplasm of brain)

198.3 (Secondary malignant neoplasm of brain and spinal cord)

Effective date

This article serves as a 45-day notice that blood brain barrier osmotic disruption is considered not reasonable and necessary when billed with diagnoses 191.0-191.9 or 198.3 effective for services rendered **on or after April 22, 2011**.

96521: Refilling and maintenance of portable pump

Data analysis at First Coast Service Options Inc. (FCSO) previously identified an increase in utilization of CPT code 96521 (*Refilling and maintenance of portable pump*). FCSO had also determined that, in many cases, external infusion pumps are being used for the administration of intravenous antibiotics outside of the physician's office. FCSO published an educational article October 2009, detailing the nationally covered indications for external infusion pumps (see below). This pattern of utilization remains evident in current Florida Part B claims data. Due to the high risk of improper claim payment, FCSO will implement a prepayment edit to prevent payment of services for noncovered and/or inaccurately coded services.

The Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) for infusion pumps, located in CMS Publication 100-03, Chapter 1, Part 4, Section 280.14, does not include the administration of intravenous antibiotics as a covered indication for external infusion pumps.

Nationally-covered indications for external infusion pumps are limited to the following:

- Administration of deferoxamine for the treatment of acute iron poisoning and iron overload.
- Administration of heparin for thromboembolic disease and/or pulmonary embolism (in an institutional setting only).
- Chemotherapy infusion pump in the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor.
- Administration of morphine in the treatment of intractable pain caused by cancer (in either an inpatient or outpatient setting, including a hospice).
- Continuous subcutaneous insulin infusion in the home setting for the treatment of diabetic patients when specified criteria are met.
- Other uses of external infusion pumps are covered if the contractor's medical staff verifies the appropriateness of the therapy and the prescribed pump for the individual patient.

In addition, it must be noted that the Medicare program provides limited benefits for outpatient prescription drugs. Medicare covers medically necessary drugs that are administered incident-to the physician's professional services if the drugs are not usually self-administered by the patient. Per CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.3, "In order to meet the general requirements for coverage under the "incident to" provision, a Food and Drug Administration approved drug or biologic must be:

- of a form that is not usually self-administered
- furnished by a physician, and
- administered by the physician or by auxiliary personnel employed by the physician and under the physician's personal supervision." (Please note that "personal supervision" means that the physician must be in attendance during the performance of the procedure.)

Medicare does not provide reimbursement for outpatient injectable drugs unless incident-to requirements are met. When patients utilize external infusion pumps to self-administer intravenous antibiotics at home, incident-to requirements are not met. Therefore, both the infusion pump and the associated antibiotic or other injectable drug cannot be billed to Medicare.

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

April 2011

Medicare's documentation and coding errors: What could it cost you?

When: Tuesday, April 19
Time: 11:30 a.m.-1:00 p.m.

Part B claim edits for ordering/referring providers

When: Tuesday, April 27
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

National Native HIV/AIDS Awareness Day and American Diabetes Alert Day Sunday, March 20 is National Native HIV/AIDS Awareness Day

Sunday, March 20, marks the fifth annual National Native HIV/AIDS Awareness Day. The HIV/AIDS epidemic is a serious health threat to Native communities, and this national health observance recognizes the mounting impact of HIV/AIDS on our country's Native peoples – American Indians, Alaska Natives, and Native Hawaiians. The Centers for Medicare & Medicaid Services (CMS) ask that you join in this national effort to raise awareness of the risks of the disease to Native peoples and help them understand the dynamics contributing to those risks.

Medicare coverage

Screenings for HIV are covered by Medicare, for eligible beneficiaries:

- Who are categorized as grade A (strongly recommended) or grade B (recommended) ratings by the U.S. Preventive Services Task Force (USPSTF) and who meet certain other requirements. (Please refer to the CMS "NCD for Screening for HIV" and the USPSTF "Screening for HIV Recommendation Statement" listed below for additional details.)
- For both standard and Food and Drug Administration (FDA) approved HIV rapid screening tests.
- If screening is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

What can you do?

As a provider of health care services to Native populations, CMS asks that you help promote HIV/AIDS prevention and early detection by talking with your patients about the risks of HIV/AIDS and the importance of prevention, and encourage them to get screened for HIV. Your support can help further the efforts to decrease the occurrence of HIV/AIDS among Native people.

For more information

- CMS National Coverage Determination – NCD for screening for HIV [http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=229&ver=19&NcaName=Screening+for+the+HUMAN+Immunodeficiency+Virus+\(HIV\)+Infection&=BEAAAAAAAAAA&](http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=229&ver=19&NcaName=Screening+for+the+HUMAN+Immunodeficiency+Virus+(HIV)+Infection&=BEAAAAAAAAAA&)
- U.S. Preventive Services Task Force (USPSTF) – screening for HIV recommendation <http://www.uspreventiveservicestaskforce.org/uspstf05/hiv/hivrs.htm#clinical>

- Indian Health Service HIV/AIDS Program – <http://www.IHS.gov/MedicalPrograms/HIVAIDS>
- CDC National Native HIV/AIDS Awareness Day – <http://www.CDC.gov/Features/NativeHIVAIDS>
- National Native American AIDS Prevention Center – <http://www.NNAAPC.org/news/awareness-day.htm>

We have the ability to make a difference! Thank you for your support.

Tuesday, March 22 is American Diabetes Alert Day

Please join with CMS during American Diabetes Alert Day to help inform seniors and other people with Medicare about the seriousness of diabetes. Currently, 25.8 million Americans are living with diabetes and an additional 79 million (or one in three American adults) are at risk for developing type 2 diabetes. If left undiagnosed and untreated, diabetes may increase the risk for complications such as heart disease, stroke, blindness, kidney damage, amputations, and death related to pneumonia and flu.

Medicare coverage

Medicare provides coverage of the following diabetes-related services for qualified Medicare beneficiaries:

- Diabetes screening tests
- Diabetes self-management training (DSMT)
- Diabetes supplies
- Dilated eye exam (for diabetic retinopathy)
- Foot care
- Glaucoma screening
- Hemoglobin A1c tests
- Influenza and pneumococcal immunizations
- Medical nutrition therapy (MNT)

What can you do?

As a health care professional who provides services to seniors and other people with Medicare, CMS needs your help to ensure that all eligible Medicare beneficiaries take advantage of the diabetes screening tests as well as all of the other diabetes-related services they may be eligible to receive.

For more information

- *Diabetes-Related Services* brochure – this brochure provides Medicare fee-for-service providers with an overview of Medicare-covered diabetes screening tests, DSMT, MNT, supplies

Continued on next page

National Native HIV/AIDS Awareness Day and American Diabetes Alert Day (continued)

and other services for Medicare beneficiaries.
<http://www.CMS.gov/MLNProducts/downloads/DiabetesSvc.pdf>

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including diabetes-related services. http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – this comprehensive resource provides coverage and coding information on the array of Medicare-covered preventive services and screenings, including diabetes-related services. http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- The CMS Prevention website – provides health care providers with information on Medicare's coverage of diabetes-related services and

screening tests.

<http://www.CMS.gov/home/Medicare.asp>

- National Diabetes Education Program (NDEP) – NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations. NDEP has a number of resources including PowerPoint slides; fact sheets; public service announcements for print, television, and radio; logos; feature articles; and Web banners. <http://www.YourDiabetesInfo.org/AlertDay2011>
- American Diabetes Alert Day – visit the American Diabetes Association's website at <http://www.Diabetes.org/in-my-community/programs/alert-day> to learn more about American Diabetes Alert Day.

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

Source: CMS PERL 201103-28

Updated Quick Reference Information: Medicare Immunization Billing chart

The *Quick Reference Information: Medicare Immunization Billing* chart, which provides Medicare fee-for-service physicians, providers, suppliers, and other healthcare professionals quick information to assist with filing claims for influenza vaccine, pneumococcal vaccine, and hepatitis V virus (HBV) vaccine and the administration, has been updated and is available to download, free of charge, from the *Medicare Learning Network*. You may view the chart at http://www.CMS.gov/MLNProducts/downloads/qr_immun_bill.pdf. Hardcopies will be available at a later date.

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

Source: CMS PERL 201103-32

March is National Nutrition Month

More than 16.8-million Americans, 65 years or older, are diagnosed with diabetes or renal disease. Medical nutrition therapy (MNT) that is provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management, along with other health outcomes that may help delay these diseases. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that March is National Nutrition Month[®], focusing on the importance of making informed food choices, developing sound eating and physical activity habits in order to promote a healthy lifestyle and improve good health.

Medicare coverage – Medicare provides MNT-coverage for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) and post-renal transplant when referred by the treating physician and provided by a registered dietitian or nutrition professional. (The treating physician must indicate a diagnosis of diabetes or renal disease in order to receive this benefit.)

Medicare provides coverage for three hours of MNT in the first year, two hours in subsequent years, and additional hours in certain situations.

Note that for the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate 13-50 ml/min/1.73m²).

What can you do? – CMS needs your help to ensure that all eligible people with Medicare take full advantage of the MNT benefit. MNT provided by a registered dietitian or nutrition professional can be an integral component of diabetes and renal disease management, which may result in improved health outcomes and delay in disease progression. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT. As the treating physician, provide a written referral

Continued on next page

March is National Nutrition Month (continued)

and encourage them to make an appointment with a registered dietitian or nutrition professional.

For more information

Diabetes-Related Services brochure – this resource provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, MNT, and supplies and other diabetes-related services. Read at <http://www.CMS.gov/MLNProducts/downloads/DiabetesSvc.pdf>.

The CMS MNT website – provides health care professionals with information about Medicare coverage of MNT provided by a registered dietitian or nutrition professional. Read at <http://www.CMS.gov/MedicalNutritionTherapy>.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – this comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including MNT and other services for Medicare beneficiaries with diabetes. Read at http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.

National Nutrition Month* – visit the American Dietetic Association's website at <http://www.EatRight.org/NNM> to learn more about National Nutrition Month 2011.

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

Source: CMS PERL 201103-14

March is National Colorectal Cancer Awareness Month

Of cancers that affect both men and women, colorectal cancer is the second leading cancer killer in the United States, affecting men and women of all racial and ethnic groups. Colorectal cancer is most often found in people aged 50 years or older, and its risk of developing increases with age. Screening tests can find precancerous polyps, so that they can be removed before they turn into cancer; screening tests also can find colorectal cancer early, when treatment works best. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of certain colorectal cancer screenings for the early detection of colorectal cancer.

Medicare coverage – Medicare defines those at a high risk of developing colorectal cancer as someone who has one or more of the following risk factors: close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp, family history of familial adenomatous polyposis, family history of hereditary nonpolyposis colorectal cancer, personal history of adenomatous polyps, personal history of colorectal cancer, or personal history of inflammatory bowel disease (including Crohn's Disease and ulcerative colitis).

All Medicare beneficiaries age 50 and older who are not at high risk for colorectal cancer are covered for the following screening services:

- Fecal occult blood test (FOBT) every year
- Flexible sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed, in which case Medicare may cover a screening sigmoidoscopy after at least 119 months)
- Screening colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed, in which case Medicare may cover

a screening colonoscopy only after at least 47 months), and

- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy)

All Medicare beneficiaries age 50 and older who are at high risk for colorectal cancer are covered for the following screening services:

- FOBT every year
- Flexible sigmoidoscopy once every 4 years
- Screening colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has been performed, in which case Medicare may cover a screening colonoscopy only after at least 47 months), and
- Barium enema (as an alternative to a covered screening colonoscopy)

What can you do? – CMS needs your help to promote early detection and prevention of colorectal cancer. As a provider of health care services to seniors and other people with Medicare, providers can help increase awareness and educate patients about risk factors, what they can do to reduce their risk, and prevention and early detection through colorectal cancer screening, as appropriate. Your recommendation can help save lives! Colorectal cancer is preventable, treatable, and beatable.

For more information – educate yourself with the following resources:

- Cancer screenings brochure – this tri-fold brochure provides health care professionals with an overview of Medicare-covered cancer screenings, including colorectal cancer screening. Download at http://www.CMS.gov/MLNProducts/downloads/Cancer_Screening.pdf.
- *Quick Reference Information: Medicare Preventive Services* – this double-sided chart contains coverage, coding, and payment information for the many Medicare-covered preventive services,

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March is National Colorectal Cancer Awareness Month (continued)

including colorectal cancer screening. View at http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

- The *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health care Professionals* --this comprehensive resource contains coverage, coding, and payment information for the many Medicare-covered preventive services, including colorectal cancer screening. Visit http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.

- The National Colorectal Cancer Roundtable website is available at <http://www.NCCRT.org>.
- Visit the Prevent Cancer Foundation website for National Colorectal Cancer Awareness Month at <http://www.PreventCancer.org/colorectal>.

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

Source: CMS PERL 201103-01

Other Educational Resources

Electronic health record incentive programs frequently asked questions

The Centers for Medicare & Medicaid Services (CMS) wants to help you find the answers you need about the electronic health record (EHR) incentive programs. Take a minute and review the new frequently asked questions (FAQs) about topics including eligibility, registration, meaningful use and attestation that have been posted to the FAQ section of the EHR incentive programs website.

A few of the new FAQs include:

Q1. What is the definition of “reasonable cost” for critical access hospitals (CAHs) under the Medicare and Medicaid EHR incentive programs?

A1. The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Read the full answer at http://questions.cms.hhs.gov/app/answers/detail/a_id/10163/kw/10163.

Q2. How is hospital-based status determined for eligible professionals (EPs) in the Medicare and Medicaid EHR incentive programs?

A2. A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of their covered professional services in either the inpatient (place of service 21) or emergency department (place of service 23) of a hospital. Read the full answer at http://questions.cms.hhs.gov/app/answers/detail/a_id/10464/kw/10464.

Q3. For large practices, will there be a method to register all of the EPs at one time for the Medicare or Medicaid EHR incentive programs? Can EPs allow another person to register or attest for them?

A3. At this time there is no method available for a third party to register multiple EPs for the Medicare

and Medicaid EHR incentive programs. Read the full answer at

http://questions.cms.hhs.gov/app/answers/detail/a_id/10141/kw/10141.

FAQ highlights: Registration questions

To help ensure that your registration process goes smoothly and for your easy reference, we have provided answers below to two of the most common registration questions from our FAQs found on the CMS website at https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage.

Q1. How will EPs and eligible hospitals apply for incentives under the Medicare and Medicaid EHR incentive program?

A1. Registration for the Medicare and Medicaid EHR incentive programs began on January 3, 2011. However, the Medicaid incentive program is rolled out on a state-by-state basis. An updated schedule of state-planned Medicaid incentive program start dates can be found on the CMS website.

Q2. If a hospital is eligible to participate in both the Medicare and Medicaid EHR incentive programs, how should they register?

A2. If a hospital meets all of the following qualifications, it is dually-eligible for the Medicare and Medicaid EHR incentive programs:

- It is a subsection(d) hospital in the 50 U.S. states or the District of Columbia, or it is a critical access hospital (CAH)
- It has a CMS certification number ending in 0001-0879 or 1300-1399
- It has 10 percent of patient volume derived from Medicaid encounters

Any hospitals that meet these three qualifications, must register for “Both Medicare & Medicaid” when registering for the programs.

Continued on next page

Electronic health record incentive programs frequently asked questions (continued)

Want more information about the EHR incentive programs? Keep up to date! Visit http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp to join the CMS EHR incentive programs Listserv. Visit <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 201103-44

**Revised resources from the Medicare Learning Network
Medicare Learning Network Products Catalog**

The March 2011 version of the *Medicare Learning Network*[®] Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that lists all MLN products by media format. Access the catalog at <http://www.CMS.gov/MLNGenInfo> and select the “MLN Products Catalog” in the Downloads section. Once you have opened the catalog, you may either click on the title of a product or the type of “Formats Available.”

Section 1011 fact sheet revised

The revised publication titled *Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens* (revised February 2011) is now available in downloadable format from the *Medicare Learning Network*[®] at http://www.CMS.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf. This factsheet is designed to provide education on available funding, eligibility, and program enrollment requirements to undocumented aliens, as detailed in Section 1011 of the Medicare Modernization Act of 2003 (MMA). It also includes information about which states have exhausted payment under Section 1011 and what services are reimbursable under the program.

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

Source: CMS PERL 201103-32

**The National Provider Identifier: What You Need to Know booklet
revised**

The booklet titled *The National Provider Identifier (NPI): What You Need to Know* (revised February 2011) has been revised and is available in downloadable format. This booklet was created to help you become more familiar with the national provider identifier (NPI) (established by final rule on January 23, 2004). Covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are required by regulation to use NPIs to identify health care providers in HIPAA standard transactions. This publication may be downloaded at <http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.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 201103-32

Medicare Contractor Provider Satisfaction Survey fact sheet

The *Medicare Learning Network* has released a new fact sheet on the Medicare Contractor Provider Satisfaction Survey (MCPSS). The MCPSS offers Medicare fee-for-services providers and suppliers the opportunity to provide feedback on their interactions with Medicare contractors. The fact sheet is available in downloadable format and may be viewed at http://www.CMS.gov/MLNProducts/Downloads/MCPSS_FactSheet.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 201103-50

Revised ‘Clinical Laboratory Fee Schedule’ fact sheet

The revised publication titled *Clinical Laboratory Fee Schedule* (revised February 2011), is now available in downloadable format from the *Medicare Learning Network* at http://www.CMS.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf. This fact sheet is designed to provide education on the clinical laboratory fee schedule, including background information, coverage of clinical laboratory services, and how payment rates are set.

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

Source: CMS PERL 201103-50

Revised ‘Ambulatory Surgical Center Fee Schedule’ fact sheet available in print

The revised publication titled “Ambulatory Surgical Center Fee Schedule” (revised January 2011) is now available in print format. 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. To place your order, visit <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201103-32

Revised Medicare Physician Fee Schedule fact sheet

The revised publication titled *Medicare Physician Fee Schedule* (revised February 2011) is now available in downloadable format from the Medicare Learning Network* at <http://www.CMS.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsh.pdf>. This fact sheet is designed to provide education on the Medicare physician fee schedule (MPFS), including physician services, therapy services, MPFS payment rates, and the MPFS rates formula.

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

Source: CMS PERL 201103-32

Medicare Learning Network opinion page and revised fact sheet on dual eligibles

Medicare Learning Network Opinion Page

The Medicare Learning Network® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded.

If you don't have an MLN account or don't want to log in, don't worry; the MLN offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the *MLN Opinion Page* (http://www.CMS.gov/MLNProducts/85_Opinion.asp) and click on "MLN Opinion Page" in the "Related Links Inside CMS" section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the "Take the anonymous evaluation for this product" link that will appear on the right-hand side. A new window will open containing the product evaluation.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services, and activities and to develop products, services, and activities that better meet your educational needs. If you have any suggestions related to MLN product topics or formats, please send them to MLN@cms.hhs.gov.

Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance factsheet revised

The revised publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance* (revised December 2011) is now available from the Medicare Learning Network at http://www.CMS.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.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 201103-16

February 2011 Quarterly Provider Compliance Newsletter released

The Medicare Learning Network® (MLN) has released the February 2011 issue of the *Medicare Quarterly Provider Compliance Newsletter*, which is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. In this issue, a number of recovery audit findings that affect inpatient hospitals, physicians, and durable medical equipment (DME) suppliers are presented. This publication is issued on a quarterly basis and highlights the top issues of that particular quarter, as identified through a variety of sources. The current issue may be downloaded at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf. An archive and searchable index of previously-issued newsletters are also now available at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf.

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

Source: CMS PERL 201102-49

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

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