Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers August 2011

In this issue

Medicare providers must revalidate enrollment by March 2013

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (Section 6401a). (Providers/suppliers who enrolled on or after Friday, March 25, 2011, have already been subject to this screening, and do not need to revalidate at this time.)

In the continued effort to reduce fraud, waste, and abuse, the Centers for Medicare & Medicaid Services (CMS) implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare administrative contractor (MAC) processing the enrollment application.

Between now and March 2013, Medicare administrative contractors (MACs) will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS), at *https://pecos.CMS.hhs.gov*.

Section 6401a of the Affordable Care Act requires institutional providers and suppliers to pay an application fee when enrolling or revalidating ("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 associated Internet-based PECOS enrollment applications); these fees may be paid via *www.Pay.gov*.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including *Internet-based PECOS*. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the *Medicare Learning Network*'s *special edition article SE1126*, titled "Further Details on the Revalidation of Provider Enrollment Information."

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

Source: CMS PERL 201108-19

Contents

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

Publication staff:
Terri Drury
Cindi Fox
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the *Medicare B Connection*

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

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

Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to FCSO Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

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

We use the same mailing address for all correspondence, and cannot designate that the Connection be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The Connection is arranged into distinct sections.

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

In addition to the above, other sections include:

- . **Educational Resources**, and
- **Contact information** for Florida and the U.S. Virgin Islands.

The Medicare B Connection represents formal notice of coverage policies

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

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

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

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

Patient liability notice

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

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/BNI/02_ABN.asp*.

ABN modifiers

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

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

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

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

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

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

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the Contact Information section of this publication for the address in which to send written appeals requests.

2012 annual update for the health professional shortage area bonus payments

Provider types affected

This article is for physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

What you need to know

Change request (CR) 7517, from which this article is taken, alerts providers that the annual HPSA bonus payment file for 2012 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2012, through December 31, 2012. These files will be posted to the Internet on or about December 1, 2011. Physician and other providers should review *https://www.cms.gov/hpsapsaphysicianbonuses/* each year to determine whether they need to add the modifier AQ to their claim in order to receive the bonus payment, or to see if the ZIP code area in which they rendered services will automatically receive the HPSA bonus payment.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors each year.

Additional information

The official instruction, CR 7517 issued to your carrier, A/B MAC, and FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2274CP.pdf*.
You will find annual HPSA files (as they become available) and other important HPSA information at *https://www.cms.gov/hpsapsaphysicianbonuses/*.

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

MLN Matters® Number: MM7517
Related Change Request (CR) #: 7517
Related CR Release Date: August 12, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2274CP
Implementation Date: January 3, 2012

October quarterly update to 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) 7511, 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 July 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.

continued on next page

October....(continued)

The latest package of CCI edits, version 17.3, is effective October 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 7511, issued to your carrier or A/B MAC regarding this change may be found at *http://www.cms.gov/Transmittals/downloads/R2265CP.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: MM7511
Related Change Request (CR) #: 7511
Related CR Release Date: July 29, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2265CP
Implementation Date: October 3, 2011

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

Get Ready for 5010 – Test now

Visit our new HIPAA 5010 section of the provider website at *http://medicare.fcso.com/Landing/199612*.asp, where you'll learn the latest news about HIPAA 5010, find out how to prepare for 5010 testing, and discover the resources you need to make your the transition to 5010 as smooth as possible. Don't wait – call FCSO's EDI to test now -- 888-670-0940, option-5.

Ambulance

Instructions to accept and process ambulance transportation codes

Provider types affected

This article is for ambulance providers and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for ambulance transportation services and transportation-related services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 1, 2012, you will be able to submit "no-pay claims" to Medicare for statutorily excluded ambulance transportation services and transportation-related services, in order to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

Caution – what you need to know

Change request (CR) 7489, from which this article is taken, announces that (effective January 1, 2012,) Medicare FIs, carriers, and A/B MACs will revise their claim processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily excluded ambulance transportation services and transportation-related services. Medicare will then deny claims containing these codes as "non-covered," which will allow you to submit the denied claim to a beneficiary's secondary insurance for coordination of benefits purposes.

Go – what you need to do

You should ensure that your billing staffs are aware of this change and the need to include the modifier GY to the HCPCS code identifying the excluded ambulance transportation service and transportation-related services.

Background

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare physician fee schedule database (MPFSDB), a status indicator of "I" or "X" is associated with these codes. The "I" shows the HCPCS code is "Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services." The "X" indicates a (statutory exclusion" of the code. (See the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), which you may find at *http://www.cms.gov/manuals/downloads/clm104c23.pdf*.)

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation-related services (HCPCS codes A0021 through A0424 and A0998) which are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit "no-pay claims" to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. Doing so will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary's secondary insurance for coordination of benefits purposes.

If you wish to bill for statutorily excluded ambulance transportation services and transportation-related services in order to obtain a "Medicare denial," you should bill for such services by attaching the modifier GY to the HCPCS code identifying the service according to long-standing CMS policy.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

- Claim adjustment reason code 96 – "Non-covered charge(s)"
- Remittance advice remark code N425 – "Statutorily excluded service(s)," and
- Group code PR – "Patient Responsibility."

Note: Make sure that you include the HCPCS code that accurately identifies the excluded ambulance transportation service and transportation-related services that the beneficiary was furnished.

continued on next page

Instructions.... (continued)

Additional information

You may find more information about instructions given to your carrier, FI, or A/B MAC to accept and process all ambulance transportation HCPCS codes by going to CR 7489, located at *http://www.cms.gov/Transmittals/downloads/R942OTN.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: MM7489
Related Change Request (CR) #: CR 7489
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R942OTN
Implementation Date: January 3, 2012

Submission of rural air ambulance service protocol for contractor review

According to Section 415 of the Medicare Modernization Act of 2003, the reasonable and necessary requirement for rural air ambulance transport may be "deemed" to be met when the service is provided pursuant to an established state or regional emergency medical services (EMS) agency protocol. The protocol must be recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through the Centers for Medicare & Medicaid Services (CMS).

CMS defines "established" to mean those protocols that have been reviewed and approved by the state EMS agencies or have been developed according to state EMS umbrella guidelines. Submission of protocols for review and subsequent approval will "deem" that the reasonable and necessary requirement for rural air ambulance transport has been met by the provider.

Providers that anticipate rural air ambulance transports pursuant to such a protocol may submit their written protocol to their fiscal intermediary for review and approval in advance. Providers may submit protocols for review as follow:

By email: *medicalpolicy@fcso.com*. Please include "Air Ambulance Protocol" in the subject line.

By U.S. Postal Service:
First Coast Service Options, Inc.
Medical Policy and Procedures ROC 19T
ATTN: Manager of Medical Policy and Procedures
P.O. Box 2078
Jacksonville, FL 32231-0048
By FAX: 1-904-791-8006

Providers will be notified of all protocol review decisions in writing within 30 days of receipt by FCSO.

Please include a contact name, telephone number and address with your submissions. Review decisions will be mailed to this address.

CMS has issued a *MLN Matters*® article pertaining to this requirement, which may be viewed at: *http://www.cms.gov/mlnmattersarticles/downloads/MM3571.pdf*.

Source: Pub. 100-09, Chapter 6, Section 6.4.2

Consolidated Billing

Reprocessing of customized prosthetic devices

Part B payment can be made for items of prosthetics, orthotics, and supplies (POS) when they are furnished to a beneficiary who is in a non-covered Part A stay at a hospital or skilled nursing facility (SNF). If these items are furnished to beneficiaries residing in a covered Part-A hospital or SNF stay, under inpatient prospective payment system or SNF consolidated billing (CB) payment rules, the items would be bundled into the global Part A payment for the covered stay itself. An exception to this policy is when certain customized prosthetic devices are furnished to beneficiaries residing in a covered Part A SNF stay as these items were carved out of the SNF CB provision by the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F, Section 103).

Since Monday, April 4, the claims processing system has been erroneously denying claims for certain custom prosthetic devices.

The Centers for Medicare & Medicaid Services (CMS) is issuing instructions to correct this processing error but the correction will not be implemented until Sunday, January 1, 2012. In the interim, the durable medical equipment Medicare administrative contractors (DME MACs) will reprocess any claims for custom prosthetic devices (identified by the "L" series of HCPCS codes) that were inappropriately denied when such claims are brought to their attention.

Source: CMS PERL 201107-52

Drugs and Biologicals

October 2011 quarterly average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7488, which instructs Medicare contractors to download and implement the October 2011 average sales price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

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

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

continued on next page

October.... (continued)

Additional information

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

The official instruction (CR 7488) issued to your Medicare MAC, carrier, and FI may be found at *http://www.cms.gov/Transmittals/downloads/R2264CP.pdf*.

MLN Matters® Number: MM7488
Related Change Request (CR) #: 7488
Related CR Release Date: July 29, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2264CP
Implementation Date: October 3, 2011

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

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

Note: This article was revised on August 9, 2011, to reflect the revised change request (CR) 7397 issued on August 5. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same.

Provider types affected

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

What you should know

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

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

Background

Pharmacies billing drugs

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

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

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

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

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

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

continued on next page

Pharmacy.... (continued)

Payment limits

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

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

Additional information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at *http://www.cms.gov/Transmittals/downloads/R2271CP.pdf*.

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

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

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

MLN Matters® Number: MM7397 *Revised*
Related Change Request (CR) #: 7397
Related CR Release Date: August 5, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2271CP
Implementation Date: October 1, 2011

Change request 7128 – carrier responsibility removed

The Centers for Medicare & Medicaid Services (CMS) has revised change request 7128 removing carrier responsibility. The related *MLN Matters* article MM7128, available at *https://www.cms.gov/MLNMattersArticles/downloads/MM7128.pdf*, has been revised but still indicates carriers in the "Provider Types Affected" section. This information was last published on *page 11 of the March 2011 Medicare B Update!*

Source: Publication 100-04, transmittal 2212, change request 7128

Durable Medical Equipment

Billing repair of codes listed in change requests 6573 and 5917

Note: This article was revised on August 8, 2011, to add a reference to MLN Matters® article MM7416 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7416.pdf*) that alerts DMEPOS providers that Medicare contractors may consider whether the accumulated costs of repairing an item exceed 60 percent of the purchase fee schedule amount for the item. This information was previously published in the May 2010 *Medicare B Update!* page 15.

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6914 in order to augment previously issued CR 6573. Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers may bill separately for any of the repair codes listed in the Key points section of this article in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME previously communicated in Attachment A of CR 6573. Your Medicare contractors will reprocess any claims submitted by DMEPOS suppliers for these separately billable repair codes listed below with dates of service of January 1, 2010, through the implementation date of CR 6914 (which is October 4, 2010), according to the guidelines established in CRs 5917 and 6573.

Key points of CR 6914

- The following is the list of the additional separately billable repair codes issued within CR 6914:

Code	Description
K0739	Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
L7500	Repair of prosthetic device, hourly rate
L7510	Repair of prosthetic device, repair or replace minor parts
L7520	Repair prosthetic device, labor component, per 15 minutes
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device
Q0506	Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only

- Medicare contractors will allow suppliers that are dually enrolled with the national supplier clearinghouse (NSC) and with their local carrier or A/B MAC as DMEPOS suppliers to bill separately for any of the above listed DMEPOS repair codes as well as those codes included in Attachment A of CR 6573 when billed under the guidelines established in CRs 5917 and 6573, including items/services furnished to beneficiaries who reside in other states.
- CR 5917 may be reviewed at *http://www.cms.gov/Transmittals/downloads/R1603CP.pdf* and CR 6573 *http://www.cms.gov/Transmittals/downloads/R531OTN.pdf*.

Additional information

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

continued on next page

Billing.... (continued)

associated with this CR 6914, issued to your Medicare MAC or carrier regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R695OTN.pdf*. You may review MM6573 (related to CR 6573) at *http://www.cms.gov/MLNMattersArticles/downloads/MM6573.pdf* and MM5917 (related to CR 5917) at *http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf*.

MLN Matters® Number: MM6914 *Revised*
Related Change Request (CR) #: 6914
Related CR Release Date: April 30, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R695OTN
Implementation Date: October 4, 2010

End-Stage Renal Disease

Clarification of payment for ESRD-related services under the monthly capitation payment

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7520 which clarifies payment for end-stage renal disease (ESRD) services under the monthly capitation payment (MCP).

Caution – what you need to know

CR 7520 instructs Medicare contractors to make payment for the home dialysis MCP service (codes *90951-90966*), even when a qualified non-physician practitioner furnishes the required monthly face-to-face visit(s), as described by the *Medicare Claims Processing Manual*, Chapter 8, Section 140 (included as an attachment to CR 7520).

Go – what you need to do

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

Background

In the calendar year (CY) 2004 physician fee schedule (PFS) final rule with comment period (68 FR 63216; see *http://www.gpoaccess.gov/fr/retrieve.html*), the Centers for Medicare & Medicaid Services (CMS) established new G codes for the ESRD MCP. For center-based patients, payment for the G codes varied based on the age of the beneficiary and the number of face to face visits furnished each month (e.g. one visit, two-three visits and four or more visits). Under this methodology, the lowest payment amount applies when a physician provides one visit per month, and a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would need to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that "we will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient."

Effective January 1, 2009, the *Current Procedural Terminology* (*CPT*) editorial panel created *CPT* codes to replace the G codes for monthly ESRD-related services, and CMS accepted the new codes. The clinical vignettes used for the valuation of the home dialysis MCP services (as described by *CPT* codes *90963-90966*) include scheduled and unscheduled examinations of the ESRD patient.

In the CY 2011 PFS final rule with comment period (75 FR 73295-73296), CMS required MCP physicians or practitioners to furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by *CPT* codes *90963, 90964, 90965*, and *90966* as listed in the following table:

continued on next page

Clarification.... *(continued)*

CPT code	Descriptor
90963	*End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents*
90964	*End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents*
90965	*End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents*
90966	*End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older*

Documentation by the MCP physician or practitioner should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.

CR 7520 clarifies Medicare policy to show that the MCP physician or practitioner may use other Medicare certified physicians or qualified non-physician practitioners to provide some of the visits during the month. Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide the visit(s). The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor.

When another physician is used to furnish some of the visits during the month, the physician who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management should bill for the MCP service.

When the qualified non-physician practitioner performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the national provider identifier of the qualified non-physician practitioner (i.e., the clinical nurse specialist, nurse practitioner, or physician assistant).

CR 7520 revises the *Medicare Claims Processing Manual*, Chapter 8, Section 140.1 (Payment for ESRD-Related Services Under the Monthly Capitation Payment [Center Based Patients]), which is included as an attachment to that CR.

Note: Medicare contractors will not search their files to adjust claims already processed, but will adjust claims brought to their attention within a timely filing period.

Additional information

The official instruction, CR 7520, issued to your carriers and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2269CP.pdf*.

If you have any questions, please contact your carriers 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: MM7520
Related Change Request (CR) #: CR 7520
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2269CP
Implementation Date: November 7, 2011

Laboratory/Pathology

Additional HCPCS codes subject to CLIA 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) 7513, which informs your Medicare carriers and MACs about the addition of four Healthcare Common Procedure Coding System (HCPCS) codes with modifiers that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits and were not mentioned in prior change requests. 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 & 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 listed in the chart that follows were new in 2011, are subject to CLIA edits and were not mentioned in 7277, transmittal 2156, "Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits". The HCPCS codes listed below require a facility to have either 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) must not be paid for these tests.

HCPCS	Modifier	Description
88120	TC	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual*
88120	*26*	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual*
88121	TC	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology*
88121	*26*	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology*

Additional information

The official instruction, CR 7513 issued to your carrier and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R915OTN.pdf*.

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

MLN Matters® Number: MM7513
Related Change Request (CR) #: 7513
Related CR Release Date: July 22, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R915OTN
Implementation Date: October 3, 2011

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

October changes to the laboratory national coverage determination edit software

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at *http://www.cms.gov/manuals/downloads/clm104c16.pdf*, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

Codes that are denied by Medicare for all 23 lab NCDs

- Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.
- Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.

Codes that do not support medical necessity for the blood counts

- Add ICD-9-CM code V54.82 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the blood counts (190.15) NCD.

Partial thromboplastin time

- Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

Prothrombin time

- Delete ICD-9-CM codes 286.5, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Add ICD-9-CM codes 286.52, 286.53, 286.59, 415.13, 444.01, 444.09, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.

Serum iron studies

- Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.
- Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

Blood glucose testing

- Add ICD-9-CM codes V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the blood glucose testing (190.20) NCD.

continued on next page

October.... (continued)

Glycated hemoglobin/glycated protein

- Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

Thyroid testing

- Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.
- Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

Lipids testing

- Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
- Add ICD-9-CM codes 444.01 and 444.09 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.

Human chorionic gonadotropin

- Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
- Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.

Gamma glutamyl transferase

- Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.
- Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, and 173.99 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Fecal occult blood test

- Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.
- Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.

Additional information

The official instruction, CR 7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2257CP.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: MM7507
Related Change Request (CR) #: 7507
Related CR Release Date: July 22, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2257CP
Implementation Date: October 3, 2011

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

Independent laboratory billing of AMCC organ disease panel laboratory tests for beneficiaries who are not receiving dialysis for treatment of ESRD

Provider types affected

This article is for laboratories billing Medicare contractors (carriers or Medicare administrative contractors [MACs]) for automated multi-channel chemistry (AMCC) end-stage renal disease (ESRD) related tests provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7497 which updates requirements regarding Independent laboratory (IL) billing of AMCC organ disease panel laboratory tests for beneficiaries who are not receiving dialysis for treatment of ESRD.

Caution – what you need to know

Effective for services on or after January 1, 2012, CR 7497 eliminates the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. Organ disease panels will be paid under the clinical laboratory fee schedule and will not be subject to the 50/50 rule payment calculation when billed by ILs.

Go – what you need to do

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

Background

Prior to January 2011, ILs were paid according to the 50/50 rule payment calculation for AMCC laboratory tests provided to beneficiaries who were eligible for Medicare under the ESRD benefit. Additionally, under the 50/50 rule, ILs were not allowed to bill organ disease panel codes listed in the following table because of the 50/50 rule payment calculation.

HCPCS/CPT code	Description
80047	*Metabolic panel ionized CA*
80048	*Metabolic panel total CA*
80051	*Electrolyte panel*
80053	*Comprehen metabolic panel*
80061	*Lipid panel*
80069	*Renal function panel*
80076	*Hepatic function panel*

ILs were required to bill for each individual laboratory test included in the organ disease panel and use the following modifiers with each code to identify which tests were included in the composite rate and which were separately payable:

- CD – AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
- CE – AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
- CF – AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

(See the *MLN Matters*® article corresponding to CR 6683 (Transmittal 661, issued April 5, 2010) at *http://www.cms.gov/MLNMattersArticles/downloads/MM6683.pdf*.)

Since the implementation of the ESRD prospective payment system (PPS) on January 1, 2011, ILs are no longer able to bill Medicare directly for any AMCC laboratory test that is related to the treatment of ESRD because payment for that test is already included in the bundled rate paid to the dialysis facility. Consequently, the 50/50 rule payment calculation was discontinued for ILs.

Claim editing was put in place that would allow ILs to bill (and be separately paid) for bundled laboratory tests performed on ESRD eligible patients so long as the service is not related to the treatment of ESRD.

If a Medicare beneficiary is not receiving dialysis treatment (for whatever reason), the IL may bill Medicare directly for any laboratory test it performs. However, while ILs can now be separately paid for individual laboratory tests performed on ESRD eligible patients who are not receiving dialysis, the editing that disallowed billing of organ

continued on next page

Independent.... (continued)

disease panel codes for ESRD eligible beneficiaries remains active.

CR 7497 eliminates the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries.

Organ disease panels:

- Will be paid under the clinical laboratory fee schedule, and
- Will not be subject to the 50/50 rule payment calculation when billed by ILs.

In summary, CR 7497 instructs that, effective January 1, 2012, your Medicare contractor(s) will:

- Allow organ disease panel codes (i.e., HCPCS codes *80047, 80048, 80051, 80053, 80061, 80069*, and *80076*) to be billed by ILs for ESRD eligible beneficiaries when the beneficiary is not receiving dialysis treatment for any reason (e.g., post-transplant beneficiaries), and
- Make payment for organ disease panels according to the clinical laboratory fee schedule and apply the normal ESRD PPS editing rules for IL claims described in CR 7064 (Transmittal 2134, issued January 14, 2011; see the *MLN Matters* article corresponding to CR 7064 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*).

Additional information

The official instruction, CR 7497, issued to your carriers or A/B MACS regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R939OTN.pdf*.

If you have any questions, please contact your carriers 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: MM7497
Related Change Request (CR) #: CR 7497
Related CR Release Date: August 1, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R939OTN
Implementation Date: January 3, 2012

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.

Codes subject to and excluded from CLIA edits

Note: This article was revised on August 8, 2011, to add a reference to *MLN Matters*® article MM7513 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7513.pdf*), to notify providers of four additional HCPCS codes (with modifiers) that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits and were not mentioned previously in MM7277. All other information is the same. This information was previously published in the March 2011 *Medicare B Update!* pages 23-25.

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 HCPCS codes for 2011 that are subject to 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 Healthcare Common Procedure Coding System (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.

continued on next page

Codes.... (continued)

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

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	*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)*
88749	*Unlisted in vivo (e.g., transcutaneous) laboratory service*

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

continued on next page

Codes.... (continued)

HCPCS	Description
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	*Gastric acid analysis, includes pH if performed, each specimen*
83861	*Microfluidic analysis utilizing an integrated collection and analysis device; tear osmolarity*
84112	*Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative*
85598	*Phospholipid neutralization; hexagonal phospholipid*
86481	*Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon producing T-cells in cell suspension*
86902	*Blood typing; antigen testing of donor blood using reagent serum, each antigen test*
87501	*Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype*
87502	*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*
87503	*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)*
87906	*Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (e.g., integrase, fusion)*
88120	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual*
88121	*Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology*
88363	*Examination and selection of retrieved archival (i.e., previously diagnosed) tissue(s) for molecular analysis (e.g., kras mutational analysis)*

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*.

MLN Matters® Number: MM7277 *Revised*
Related Change Request (CR) #: 7277
Related CR Release Date: February 11, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2156CP
Implementation Date: April 4, 2011

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

Radiology

Accreditation for supplying the technical component of advanced diagnostic imaging services

Note: This article was revised on August 8, 2011, to add a reference to *MLN Matters*® article SE1122 (*http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf*), which provides suppliers who furnish the technical component (TD) of advanced diagnostic imaging (ADI) services assistance in meeting the accreditation requirements. This information was previously published in the February 2011 *Medicare B Update!* page 24.

Provider types affected

This article is for physicians and non-physician practitioners who bill Medicare administrative contractors (MACs), and/or carriers for the TC of ADI services for Medicare beneficiaries. (Railroad Retirement Board is exempt from these requirements).

Provider action needed

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

Background

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

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

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

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

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended Section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and independent diagnostic testing facilities, that furnish the TC of advanced diagnostic imaging services.

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

Key points of CR 7176

- In order to furnish the TC of ADI services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.
- Provider's claims for the TC for ADI services will be denied:
- If the provider is not enrolled or accredited by a designated CMS accreditation organization (Denial code N290: "Missing/incomplete/invalid rendering provider primary identifier."), or
- If the code submitted is not listed on the provider's eligibility file (claim adjustment reason code185: "The rendering provider is not eligible to perform the service billed.").

Additional information

The official instruction, CR 7176 issued to your carrier, A/B MAC, and carrier regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R858OTN.pdf*.
If you have any questions, please contact your carrier, A/B MAC, or carrier at their toll-free number, which may be

continued on next page

Accreditation.... (continued)

found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7176 *Revised*
Related Change Request (CR) #:7176
Related CR Release Date: February 4, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: 858OTN
Implementation Date: July 5, 2011

General Coverage

Recovery audit program: Medicare administrative contractor-issued demand letters

Provider types affected

This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries (RHHIs), and Medicare administrative contractors [MACs]).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7436 which announces that Medicare's recovery auditors will no longer issue demand letters to you as of January 3, 2012.

Caution – what you need to know

Recovery auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the recovery auditor's review, and issue an automated demand letter to you.

Go – what you need to do

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

Background

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its recovery auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a recovery auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claim processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any recovery auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating recovery auditor and his/her contact information in the related demand letter. You should contact that recovery auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. To see the official instruction (CR 7436) issued to your Medicare contractor, see *http://www.cms.gov/Transmittals/downloads/R192FM.pdf*.

MLN Matters® Number: MM7436
Related Change Request (CR) #: 7436
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R192FM
Implementation Date: January 3, 2012

MREP and PC Print user guide update for version 5010A1

Provider types affected

This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors (carriers, fiscal intermediaries [FIs], durable medical equipment Medicare administrative contractors (DME MACs) and/or Part A/B Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

What you need to know

MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for Transaction 835 – Health Care Claim Payment/Advice. Specifically:

- The MREP user guide is being updated to reflect the changes in the software related to the HIPAA 5010A1, and
- The PC Print user guide is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 Transaction 835.

If you use MREP or PC Print, be sure to download the updated user guide for 835 version 5010A1 when they are available.

Background

The Centers for Medicare and Medicaid Services (CMS) is implementing the new standard for Transaction 835 (Health Care Claim Payment/Advice) version 5010A1 adopted under the Health Insurance Portability and Accountability Act (HIPAA). Providers/suppliers must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/print/download the electronic remittance advice in version 5010A1 in a human readable format.

Additional information

The official instruction, change request (CR) 7466 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R926OTN.pdf*. For more information on the Version 5010 transition and implementation, visit *http://www.cms.gov/Versions5010andD0/*.

MLN Matters® Number: MM7466
Related Change Request (CR) #: 7466
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R926OTN
Implementation Date: January 3, 2012

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

Medicare Remit Easy Print version 3.1 update

Medicare fee-for-service professional providers and suppliers:

Version 3.1 of the Medicare Remit Easy Print (MREP) software is available for download at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*. MREP now accepts remittances in the X12 835V4010A1 and X12 835V5010A1 formats. For other changes in this version of MREP, go to the "What's New" section of the *Medicare Remit Easy Print User Guide Version 3.1*.

MREP version 3.1 includes the claim adjustment reason code/remittance advice remark code list published March 8, 2011. Future lists will be made available individually and can be imported into MREP to keep the codes current.

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

Source: CMS PERL 201108-24

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

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

Announcements

The HIPAA 5010 compliance date is fast-approaching. There are only five months left until full implementation on January 1, 2012. Please contact your local Medicare administrative contractor (MAC) and test now.

Reminders

January 1, 2011, marked the beginning of the 5010/D.0. transition year.
Versions 5010 & D.0 FAQs Now Available!
National Testing Day Message Now Available!
5010/D.0 Errata requirements and testing schedule can be found here
Contact your MAC for their testing schedule

Readiness assessment

Have you done the following to be ready for 5010/D.0.?
What do you need to have in place to test with your Medicare administrative contactor (MAC)?
Do you know the implications of not being ready?

Implementation calendar

Upcoming events

September 2011
September 8: 5010 testing support – FCSO-hosted webcast
September 14: CMS-hosted Medicare fee-for-service national call – question & answer session

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

December 2011
December 31: End of the transition year, and the beginning of 5010 production environment

Past events

June 2010
June 15: *5010 national call – ICD-10/5010 national provider call*
June 30: *5010 national call – 837 institutional claim transaction*

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

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

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

October 2010
October 13: *5010/D.0. errata requirements and testing schedule released*
October 27: *5010 national call – NCPDP version D.0. transaction*

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

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

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

continued on next page

HIPAA....(continued)

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

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

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

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

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

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

August 2011
August 22-26: MAC hosted outreach and education session – troubleshooting with your MAC
August 31: CMS-hosted Medicare FFS national call – MAC panel questions & answers

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

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

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

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

Source: CMS PERL 201108-07

Reporting of recoupment for overpayment on the remittance advice with patient control number

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the health insurance claim (HIC) number being sent on the ASC X12 Transaction 835) with the patient control number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA)-compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR 6870 and CR 7068. The *MLN Matters* articles corresponding to CRs 6870 and 7068 may be reviewed at:

http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf
http://www.cms.gov/transmittals/downloads/R812OTN.pdf

continued on next page

Reporting....(continued)

CMS has determined that providing the patient control number as received on the original claim rather than the HIC number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR 7499 instructs the shared systems to replace the HIC number being sent on the ERA with the patient control number, received on the original claim. The ERA will continue to report the HIC number if the patient control number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the accounts receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR 7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the standard paper remit or the 004010A1 version of ASC X12 Transaction 835.

Additional information

The official instruction, CR 7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R940OTN.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: MM7499
Related Change Request (CR) #: CR 7499
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R940OTN
Implementation Date: April 2, 2012

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.

First National Version 5010 Testing Day results now available

The Centers for Medicare & Medicaid Services (CMS) version 5010 team held its first National Testing Day on June 15, 2011. On National Testing Day, 349 Medicare fee-for-service (FFS) trading partners conducted testing using the version 5010 format that all covered entities are required to use starting January 1, 2012.

From those 349 trading partners, 974 files were submitted, and there were no significant error scenarios reported. Sixty-eight trading partners responded to a follow-up survey about National Testing Day. Of those who responded to the survey, 32 percent stated that they feel ready to process version 5010 production transactions. In addition, 39 percent of the respondents stated that they were able to receive and process a 277CA while testing on National Testing Day.

The following metrics represent 5010 production transactions:

- Part B claims processed (May and June) – 59,778
- Coordination of benefits (COB) Part B claims (May and June) – 4,041
- Trading partners for Part B claims and COB (as of June) – Part A – 43, Part B – 84, COB – 24
- Eligibility inquiries (May and June) – 305,884 inquiries

CMS and the Medicare FFS program have scheduled a National 5010 Testing Week for August 22-26, 2011. National 5010 Testing Week provides an opportunity for trading partners to test compliance efforts that are already underway, with the support of a real-time help desk and access to Medicare administrative contractors. Check the *version 5010* section of the CMS website for more information about the transition to version 5010.

Keep up-to-date on version 5010 and ICD-10

Please visit *www.cms.gov/ICD10* for the latest news and resources to help you prepare.

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

Source: CMS PERL 201108-15

Populating REF segment - other claim related adjustment - for healthcare claim payment/advice or Transaction 835 version 5010A1

Provider types affected

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

Provider action needed

Stop – impact to you

The Centers for Medicare and Medicaid Services (CMS) has decided that populating the healthcare claim payment/advice or transaction 835 version 5010A1 REF segment (other claim related adjustment) at loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

Caution – what you need to know

Change request (CR) 7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (other claim related adjustment) at loop 2100 with qualifiers designated in the updated flat file attached to CR 7484. Note that CR also updates the 835 flat file by adding:

- PLB Code 90, and
- Qualifier "PQ" to be used in loop 1000B REF – payee additional information under some special situations where the national provider identifier (NPI) is not available.

Go – what you need to do

You should make sure that your billing staffs are aware of this change.

Background

Currently the healthcare claim payment/advice or transaction 835 REF segment (other claim related adjustment) at loop 2100 is not being populated for the Part B remittance advice, and the 835 flat file identifies this with a note: "N/U by Part B."

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR 7484, from which this article is taken, instructs the VIPS Medicare system (VMS) and the multi-carrier system (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated flat file that is an attachment to CR 7484.

Specifically, VMS and MCS will use one of the following reference identification qualifiers in REF01 as appropriate:

- 28: Employee identification number
- 6P: Group number

(When they use this 6P qualifier, they will also populate NM1 – corrected priority payer name segment at loop 2100 and REF02 with the other insured group number for the payer identified in NM1, and use claim status code 2 in CLP02 in CLP – claim payment information segment at loop 2100);

- EA: Medical record identification number
- F8: Original reference

Note: Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP remittance advice for version 5010A1.

Additional information

You may find the official instruction, CR 7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R927OTN.pdf*. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS's implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to *http://www.cms.gov/MFFS5010D0/01_Overview.asp*

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

MLN Matters® Number: MM7484
Related Change Request (CR) #: CR 7484
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R927OTN
Implementation Date: January 3, 2012

Provider Enrollment

Further details on the revalidation of provider enrollment information

Provider types affected

This *Medicare Learning Network* (*MLN*) *Matters*® special edition article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse [NSC]). These contractors are collectively referred to as MACs in this article.

Provider action needed

Stop – impact to you

In change request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, *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*. A related *MLN Matters*® article is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

Caution – what you need to know

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Go – what you need to do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based provider enrollment, chain and ownership System (PECOS) or complete the 855
- Sign the certification statement on the application
- If applicable, pay your fee thru *pay.gov*, and
- Mail your supporting documents and certification statement to your MAC.

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

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are not impacted. Between now and March 23, 2013, MACs will send out notices on a regular basis to begin the revalidation process for each provider and supplier. Providers and suppliers must wait to submit the revalidation only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov*. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, **you must** print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC IMMEDIATELY.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for calendar year (CY) 2011. 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 non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

continued on next page

Revalidation....(continued)

All institutional providers and suppliers who respond to a revalidation request must submit an enrollment fee via Pay.Gov (reference 42 CFR 424.514). You may submit your fee by electronic check, debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to *http://www.pay.gov* and 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. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt 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.

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.

Additional information

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

The *MLN*® fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and may be found at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

To access PECOS, your authorized official must register with the PECOS identification and authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment Web page at *http://www.cms.gov/MedicareProviderSupEnroll*.

If you have questions, contact your Medicare contractor. Medicare provider enrollment contact information for each state may be found at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

MLN Matters® Number: SE1126
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider enrollment revalidation – wait until you hear from your MAC

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to submit their enrollment information so they can be revalidated under new risk screening criteria required by the Affordable Care Act (Section 6401a). Providers and suppliers that enrolled on or after Friday, March 25, 2011, have already been subjected to this screening, and they are not required to revalidate at this time.

Do not submit your revalidation until you are notified to do so by your Medicare administrative contractor (MAC). You will receive a notice to revalidate between now and March 2013.

This will allow MACs to process revalidations in a timely fashion and allow providers to take advantage of innovative technologies and streamlined enrollment processes now under development. Updates will be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the *Medicare Learning Network's* *special edition article #SE1126*, titled "Further Details on the Revalidation of Provider Enrollment Information."

Source: CMS PERL 201108-38

Chiropractors not eligible to order and refer

In recent announcements and materials, the Centers for Medicare & Medicaid Services (CMS) incorrectly included chiropractors in the list of physician and practitioner types that may order and refer items or services to Medicare beneficiaries. In accordance with Section 1877(a)(1) and (5)(A), and Section 1861(r)(5) of the Social Security Act, and 42 CFR 410.21(b)(1) and (2), doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation; all other services furnished or ordered by chiropractors are not covered.

CMS is in the process of revising documents (including change requests) to reflect this correction.

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

Source: CMS PERL 201108-34

Edits on the ordering/referring providers in Medicare Part B claims

Note: This article was revised on August 15, 2011, to delete chiropractors from the list of providers who are eligible to order and refer items or services for Medicare beneficiaries. This article was revised on November 26, 2010, to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid. The automated edits will not be turned on effective January 3, 2011. This information was previously published in the April 2010 *Medicare B Update!* pages 29-32.

Provider types affected

Physicians, non-physician practitioners (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in PECOS, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

What providers need to know

Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

continued on next page

Edits....(continued)

Phase 2: Beginning January 3, 2011 (**See statement in the beginning of this article delaying implementation of phase 2**), Medicare will reject Part B claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.

Enrolled physicians and non-physician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the Web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the Ordering/Referring Provider edits, which is January 3, 2011.

Background

The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS, and
- Claims from specialists or specialty groups for referred services.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

Questions and answers relating to the edits

- **What will the edits do?**

The edits will determine if the ordering/referring provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the national provider identifier [NPI]), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

- **Why did Medicare implement these edits?**

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

- **How and when will these edits be implemented?**

These edits are being implemented in two phases:

- **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In phase 1, if the ordering/referring provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the billing provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message[1] from Medicare in the remittance advice[2].

  The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks

continued on next page

Edits....(continued)

information that is needed for adjudication.

Note: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

- **Phase 2** is scheduled to begin on January 3, 2011, and will continue thereafter. In phase 2, if the ordering/referring provider does not pass the edits, the claim will be rejected. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

CMS has taken actions to reduce the number of informational messages.
In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.[3]

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the report on a periodic basis. At any given time, only one report (the most current) will be available for downloading. To learn more about the report, and to download it, go to *http://www.cms.gov/MedicareProviderSupEnroll*; click on "Ordering Referring Report" (on the left). Information about the report will be displayed.

1 The informational messages vary depending on the claims processing system.
2 DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.
3 NPIs were added only when the matching criteria verified the NPI.

Effect of edits on providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you—the ordering/referring provider—need to ensure that:**

1. **You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).**
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. You need to take action to establish one. See the last bullet in this section.
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in PECOS:**
     - You need to submit an enrollment application to Medicare in one of two ways:
       1. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the certification statement and mail the certification statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to *http://www.cms.gov/MedicareProviderSupEnroll*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.

continued on next page

Edits....(continued)

Note for physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the Web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. **Obtain a paper enrollment application (CMS-855I)**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (*http://www.cms.gov/cmsforms*) or by contacting your designated Medicare enrollment contractor.

Note about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.** When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty and only the non-physician practitioner specialties listed in this article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

As the billing provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the ordering/referring provider so that you will not receive informational messages in phase 1 and so that your claims will be paid in phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the ordering/referring provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the ordering/referring provider edits. Keep in mind that this Ordering Referring Report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next report. You may resubmit a claim that did not initially pass the ordering/referring provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the ordering/referring provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

Billing providers should be aware that claims that are rejected because they failed the ordering/referring provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, an **advance beneficiary notice is not appropriate.**

Additional guidance

1. **Orders or referrals by interns or residents**. Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/

continued on next page

Edits....(continued)

she may not be identified in a Medicare claim as the ordering/referring provider. The teaching, admitting, or supervising physician is considered the ordering/referring provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the ordering/referring provider.

2. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare**. These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
3. **Orders or referrals by dentists**. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

You may want to review the following related CRs:

CR 6417 at *http://www.cms.gov/Transmittals/downloads/R825OTN.pdf*

CR 6421 at *http://www.cms.gov/Transmittals/downloads/R823OTN.pdf*, and

CR 6696 at *http://www.cms.gov/Transmittals/downloads/R328PI.pdf*.

If you have questions, please contact your Medicare carrier, Part A/B Medicare administrative contractor (A/B MAC), or durable medical equipment MAC, at their toll-free numbers, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters Number: SE1011 *Revised*
Related Change Request (CR) #: 6421, 6417, and 6696
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, and R328PI
Implementation Date: N/A

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

Note: This article was revised on August 15, 2011, to delete chiropractors from the list of providers who may order and/or refer. All other information remains the same. Change request 6417 will also be revised to remove chiropractors from that CR's list of providers who may order and/or refer. The Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a Medicare provider enrollment, chain and ownership system (PECOS) record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "to be announced" implementation and effective dates in this article are the correct dates. This information was previously published in the January 2011 *Medicare B Update!* pages 58-59.

Provider types affected

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

continued on next page

Expansion....(continued)

Provider action needed

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

Background

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

The providers who can order/refer are:

- Doctor of medicine or osteopathy
- Dental medicine
- Dental surgery
- Podiatric medicine
- Optometry
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

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

Key points

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

continued on next page

Expansion....(continued)

access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf. If no record is displayed, you do not have an enrollment record in PECOS.

- Checking the Ordering Referring Report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp.
- I don't have an enrollment record. What should I do? Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

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

Additional information

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

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

MLN Matters® Number: MM6417 *Revised*
Related Change Request (CR) #: 6417
Related CR Release Date: December 16, 2010
Effective Dates: Phase 1: October 5, 2009,
Related CR Transmittal #: R825OTN
Implementation Dates: Phase 1: October 5, 2009, Phase 2: To Be Announced

Eligible practitioners who need to enroll for the sole purpose of ordering and referring

Note: This article was revised on August 15, 2011, to delete chiropractors from the list of providers who may order and/or refer. All other information remains the same. In the near future, change request (CR) 7097 will be revised to remove chiropractors from that CR's list of providers who may order and/or refer. This information was previously published in the October 2010 *Medicare B Update!* pages 31-32.

Provider types affected

This article is for physicians and non-physician practitioners who are eligible to order and refer items and services for Medicare beneficiaries and who are enrolling in Medicare for the sole purpose of ordering or referring.

What you need to know

CR 7097, from which this article is taken, announces that physicians and non-physician practitioners will need to enroll in the Medicare program so they can order and refer items and services for Medicare beneficiaries.

The enrollment requirement is applicable to those physician and non-physician practitioners of a profession eligible to order and refer who are:

- Employed by the Department of Veterans Affairs (DVA), Public Health Service (PHS), Department of Defense (DOD) TRICARE, or by Medicare enrolled federally qualified health centers (FQHC), rural health clinics, (RHC), or critical access hospitals (CAH)
- Physicians in a fellowship
- Dentists, including oral surgeons
- Other employed eligible physicians and non-physician practitioners

Background

On May 5, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* an Interim Final Rule with Comment (IFC) regulation titled, "Medicare and Medicaid Programs; Changes in Provider

continued on next page

Eligible....(continued)

and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements." This IFC proposed requirements to implement several of the provisions of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) (Pub. L. 111-148) designed to support the Administration's efforts to prevent and detect fraud, waste and abuse in the Medicare and Medicaid programs, and to ensure quality care for beneficiaries.

Specifically, this regulation proposed requirements to implement section 6405 of the ACA, which (effective July 6, 2010) requires home health agencies and certain Part B suppliers to include, on a claim, the legal name and national provider identifier (NPI) of the physician or non-physician practitioner who ordered or referred the billed items or services for the beneficiary.

This action means that Medicare will reimburse claims from providers and suppliers who furnished, ordered, or referred items or services to Medicare beneficiaries only when the ordering/referring provider identified in those claims is of an eligible discipline as noted in the following list, and is also enrolled in the Medicare program (has an enrollment record in the provider enrollment, chain and ownership system [PECOS]) at the time of the service:

- Doctor of medicine or osteopathy
- Doctor of dental medicine
- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

Further, while most physicians and non-physician practitioners enroll in the Medicare program to furnish covered services to Medicare beneficiaries, in implementing this section of the ACA, the Centers for Medicare & Medicaid Services (CMS) has become aware of certain physicians and non-physician practitioners who only order or refer items and services for Medicare beneficiaries the services they furnish to Medicare beneficiaries are not reimbursable by the Medicare program. CR 7097 announces that such physicians and non-physician practitioners will need to enroll in the Medicare program in order to be able to continue to order or refer items or services for Medicare beneficiaries.

Specifically, if you order or refer items or services for Medicare beneficiaries and (1) you are employed by the Department of Veterans Affairs (DVA), the Public Health Service (PHS), the Department of Defense (DOD) TRICARE; or by a Medicare enrolled federally qualified health center (FQHC), rural health clinic (RHC), or critical access hospital (CAH), (2) you are in a fellowship, or (3) you are a dentist or oral surgeon, you will need to enroll in Medicare using the modified enrollment process described below. (Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.)

Modified enrollment process for physicians and non-physician practitioners who are enrolling solely to order and refer

To enroll in Medicare for the sole purpose of ordering or referring items or services, you must do the following:

1. Complete the following sections paper of form CMS-855I ("Medicare Enrollment Application for Physicians and Non-Physician Practitioners"):
   - Section 1 – Basic Information (you would be a new enrollee)
   - Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K)
   - Section 3 – Final Adverse Actions/Convictions
   - Section 13 – Contact Person, and
   - Section 15 – Certification Statement (must be signed and dated—blue ink recommended).
2. You must include a cover letter with this enrollment application stating that you are enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.

continued on next page

Eligible....(continued)

3. Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor, which you can find at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

Your designated Medicare enrollment contractor will verify that the information you provided on the application meets the Medicare requirements for your profession (supplier type) and, if approved, will enter the data into PECOS. This will place you on the ordering referring file that is available on the Medicare provider/supplier enrollment website (*http://www.cms.gov/MedicareProviderSupEnroll*) and the information will be in the Medicare claims system so that claims for the items or services you ordered or referred can be paid. The designated Medicare contractor will send you a letter notifying you that you are enrolled in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries.

Notes:

1) When enrolling, you do not have to complete the CMS-460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. Also, license information received from a physician or practitioner employed by DVA or DOD may be active in a state other than the DVA or DVA location.
2) Since the abbreviated application does not require you to complete Section 4 and CMS is requiring a cover letter, the Medicare enrollment contractors will reject your application if Section 4 is blank and a cover letter is not attached.
3) You are not permitted to be reimbursed by Medicare for services you may furnish to Medicare beneficiaries.
4) If, in the future, you wish to be reimbursed by Medicare for services performed, you must submit the full enrollment application via the paper application(s) (CMS-855) or Internet-based PECOS; the Medicare enrollment contractor will deactivate the current information.

Additional information

You may find more information about enrolling in Medicare for the sole purposes of ordering and referring by going to CR 7097, located at *http://www.cms.gov/Transmittals/downloads/R355PI.pdf*. You will find the updated *Medicare Program Integrity Manua*l, Chapter 15 (Medicare Provider/Supplier Enrollment), Section 16.1 (Ordering/Referring Providers Who Are Not Enrolled in Medicare) as an attachment to that CR.

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

MLN Matters® Number: MM7097 *Revised*
Related Change Request (CR) #: 7097
Related CR Release Date: September 17, 2010
Effective Date: October 18, 2010
Related CR Transmittal #: R355PI
Implementation Date: October 18, 2010

Advanced diagnostic imaging accreditation enrollment procedures

Note: This article was revised on August 5, 2011, to reflect the revised change request (CR) 7177 issued on August 3. In this article, the transmittal number, CR release date, and the Web address for accessing CR 7177 have been changed. Also, we have added a reference to *MLN Matters*® article SE1122 available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf* for further information about these accreditation requirements. This information was previously published in the March 2011 *Medicare B Update!* pages 66-67.

Provider types affected

Physicians, nonphysician 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 TC of advanced diagnostic imaging procedures.

continued on next page

Advanced....(continued)

The approved AOs are:

- The American College of Radiology
- The Intersocietal Accreditation Commission, and
- 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/R380PI.pdf*.

You may also want to review MM7176 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7176.pdf*) and SE1122 available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf* for further information about these accreditation requirements.

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 *Revised*
Related Change Request (CR) #: 7177
Related CR Release Date: August 3, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R380PI
Implementation Date: July 5, 2011

Incentive Programs

2009 Physician Quality Reporting System – report on top five measures submitted by specialty practice area available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a report on the 2009 Physician Quality Reporting System top five measures submitted by specialty practice area is now available on the Physician Quality Reporting System Web page.

The report provides information on the measures most frequently submitted by each specialty type. The report includes data for services rendered in calendar year 2009 and processed into national claims history by February 26, 2010.

To view this report, visit *http://www.cms.gov/PQRS* and select the Analysis and Payment page tab. Once on the Analysis and Payment page, scroll down to the "Downloads" section and select the publication titled *2009 PQRS Report of Top 5 Measures Submitted by Provider Specialty [PDF 564KB].*

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

Source: CMS PERL 201108-18

Differences between the Medicare and Medicaid EHR incentive programs

With the exception of dually-eligible hospitals, providers can only participate in one of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs (Medicare or Medicaid) each year. The Centers for Medicare & Medicaid Services (CMS) outlines key differences between the Medicare and Medicaid EHR incentive programs to help you determine which EHR incentive program is right for you.

Who is eligible?

For the **Medicare** EHR incentive program, eligible participants include:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Chiropractors
- "Subsection (d) hospitals" in the 50 states or District of Columbia (D.C.) that are paid under the inpatient prospective payment system (IPPS)
- Critical access hospitals (CAHs)
- Medicare advantage (MA-affiliated) hospitals

For the **Medicaid** EHR incentive program, eligible participants include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a federally qualified health center or rural health clinic that is led by a physician assistant
- Acute care hospitals (including CAHs and cancer hospitals) with at least 10 percent Medicaid patient volume
- Children's hospitals (no Medicaid patient volume requirements)

Dually-eligible hospitals

If you represent a hospital that meets all of the following qualifications, you are dually-eligible for the **Medicare and Medicaid** EHR incentive programs:

- You are a Subsection (d) hospital in the 50 states or D.C., or you are a CAH
- You have a CMS certification number ending in 0001-0879 or 1300-1399
- You have 10 percent of your patient volume derived from Medicaid encounters

CMS encourages potential participants to review *CMS's comparison chart* to learn more about the differences

continued on next page

Differences....(continued)

between the two EHR incentive programs, and use the *eligibility wizard application* (i.e., *EHR EP Decision Tool*) to determine for which program they may be eligible.

Want more information about the EHR incentive programs?

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

Source: CMS PERL 201108-09

2010 Medicare eRx incentive program payment update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2010 Medicare electronic prescribing (eRx) incentive program has begun for eligible professionals who met the criteria for successful reporting. Distribution of 2010 Medicare eRx incentive payments is scheduled to be completed by August 31, 2011.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of "LE" to indicate incentive payments instead of "LS." LE will appear on the electronic remit. In an effort to further clarify the type of incentive payment issued (either physician quality reporting system or eRx incentive), CMS created a four-digit code to indicate the type of incentive and reporting year. For the 2010 eRx incentive payments, the four-digit code is "RX10." This code will be displayed on the electronic remittance advice along with the LE indicator. For example, eligible professionals will see LE to indicate an incentive payment, along with RX10 to identify that payment as the 2010 eRx incentive payment. Additionally, the paper remittance advice will read, "This is an eRx incentive payment." The year will not be included in the paper remittance.

Who to contact for questions?

If you have questions about the status of your eRx incentive payment (during the distribution timeframe), please contact your provider contact center. The contact center directory is available at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

The QualityNet help desk is available Monday through Friday from 7:00 a.m.-7:00 p.m. CST at 866-288-8912 or via *qnetsupport@sdps.org*. The help desk can also assist with program and measure-specific questions.

The following CMS resource is available to help eligible professionals understand the 2010 eRx Incentive Payments; view *A Guide for Understanding the 2010 eRx Incentive Payment [PDF 57 KB]*.

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

Source: CMS PERL 201108-17

Certified EHR technology and the EHR incentive programs

Eligible professionals (EPs) and eligible hospitals participating in the Medicare and Medicaid electronic health record (EHR) incentive programs are required to use certified EHR technology in order to receive incentive payments. To get an incentive payment, you must use an EHR that is certified specifically for the EHR incentive programs. EHRs certified or qualified for other Medicare or Medicaid incentive programs may not be certified for this program.

To qualify as certified EHR technology for the EHR incentive programs, an EHR needs to be tested by one of the Office of the National Coordinator for Health Information Technology-Authorized Testing and Certification Bodies (otherwise known as the ONC-ATCBs). If an EHR technology has been certified by an ONC-ATCB, it indicates to EPs and eligible hospitals that it has the capacities necessary to support their efforts to meet meaningful use goals and objectives.

Note that you do not need to already have certified EHR technology in place when you register for the EHR incentive programs. However, you will need to have meaningfully used your certified EHR technology to receive your first year Medicare incentive payment. Under the Medicaid EHR incentive program, you will need to have at least adopted (i.e., purchased or acquired) certified EHR technology in order to receive your first year incentive payment.

For more details on certified EHR technology, visit the *EHR section* of the Centers for Medicare & Medicaid Services (CMS) website. For a list of certified EHR technologies, visit the *ONC's Certified Health IT Product List*.

Want more information about the EHR Incentive Programs? Visit the *CMS EHR incentive programs website* for the latest news and updates on the EHR incentive programs; also sign up for the *EHR incentive programs email update Listserv*.

Source: CMS PERL 201108-21

General Information

Fraud prevention initiative

If you help people with Medicare, Medicaid and the Children's Health Insurance Program (CHIP), you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

Significant progress in the fight against health care fraud has already been made as shown by the federal government's recovery of a record $4 billion last year from people who attempted to defraud seniors and taxpayers. The Affordable Care Act provides additional resources and tools to enable the Centers for Medicare & Medicaid Services (CMS) to expand efforts to prevent and fight fraud, waste and abuse. The CMS fraud prevention initiative aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former "pay and chase" recovery operations to a more proactive "prevention and detection" model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Yet, as important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available in the CMS fraud prevention toolkit on the Web at *https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp*.

The website contains materials to help you inform Medicare beneficiaries about how to protect themselves from becoming a victim of fraud and how to report it.

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

Source: CMS PERL 201108-27

New information to improve patient safety at America's hospitals

Provider types affected

This article is informational in nature and of interest to all providers who serve Medicare beneficiaries.

What you need to know

This article alerts providers that they may review and share data about hospital acquired conditions (HACs) with their Medicare patients. The Centers for Medicare & Medicaid Services (CMS) is making this important new data about the safety of care in America's hospitals available on the "Hospital Compare" website at *http://www.healthcare.gov/compare*. This site contains information on more than 4,700 hospitals across the nation.

Background

HACs are serious conditions that often result from improper procedures during inpatient care.
The data released on the "Hospital Compare" website shows the number of times an HAC occurred for Medicare fee-for-service patients between October 2008 and June 2010. The numbers are reported as number of HACs per 1,000 discharges, and are not adjusted for hospitals' patient populations or case-mix.

Independent data from the Institute of Medicine (IOM) show that as many as 98,000 people die in hospitals each year from medical errors that could have been prevented through proper care. Although not every HAC represents a medical error, the HAC rates provide important clues about the state of patient safety in America's hospitals. In particular, HACs show how often the following potentially life-threatening events take place:

- Blood infections from a catheter placed incorrectly in a patient or from a catheter that is not kept clean properly
- Urinary tract infections caused by a urinary catheter
- Falls and injuries during a hospital stay
- Transfusions through mismatched blood types
- Severe pressure ulcers (or bed sores that develop while a patient is in the hospital

continued on next page

New....(continued)

- Air bubbles in the bloodstream
- Objects accidentally left in the body after surgery (such as a sponge, gauze, or a surgical instrument), and
- Signs of uncontrolled blood sugar for patients with diabetes.

CMS reports HAC rates for these eight measures because they incur high costs to the Medicare program or because they occur frequently during inpatient stays for Medicare patients. Furthermore, HACs usually result in higher reimbursement rates when they occur as complications for an inpatient stay because they require more resources to care for the patient with the complication. Lastly, CMS considers HACs to be conditions that could have reasonably been prevented through the use of evidence-based guidelines for appropriate hospital inpatient care.

CMS has gathered data on HAC rates from hospitals since 2007. Since 2008, Medicare has denied additional reimbursement for cases for which HACs were presented as secondary diagnoses during a patient's hospital stay.

Rates for the eight HAC rates reported on "Hospital Compare" vary among hospitals. The most common HAC reported was injury from a fall or some other type of trauma. Over 70 percent of hospitals reported at least one fall or trauma, and more than 50 percent reported at least two occurrences. The rarest HACs reported were transfusions through mismatched blood types and air bubbles in the bloodstream. More than 95 percent of the hospitals had no occurrences of these HACs.

Rates for infection were also relatively common, with more than 45 percent of hospitals reporting at least one occurrence of blood or urinary tract infection developed during a hospital stay.

Although HACs were rare, there is still room for improvement. While 19 percent of hospitals had no occurrences of HACs, 81 percent had at least one HAC; 62 percent had two different types of HACs.

In addition to information about HACs, "Hospital Compare" reports 25 inpatient and five outpatient process of care measures, readmission and mortality rates for certain conditions, three children's asthma care measures, and 10 measures that gauge patient satisfaction with hospital care. The site also features information about the volume of certain hospital procedures and conditions treated for Medicare patients and what Medicare pays for those services.

Additional information

- To review the HAC data please visit *http://www.healthcare.gov/compare*. Select *Visit the Website* next to *Compare Hospitals*. Then click the link in the *Hospital Spotlight* section.
- CMS is working with the members of the Hospital Quality Alliance – a national private-public partnership of hospitals, consumers, providers, employers, payers, and government agencies – to make HAC data accessible to the public in meaningful, relevant, and easily understood ways to encourage healthcare quality improvement. CMS is working with the Alliance and consumers about how to include HAC data in the main report of "Hospital Compare". For now, HAC data are available through a downloadable file linked to the "Hospital Compare" website and on *data.medicare.gov* (*http://data.medicare.gov/dataset/Hospital-Acquired-Condition-Calculations/sjdk-f65s*).
- You can also view archived data on the CMS Hospital Compare website at *http://www.cms.gov/HospitalQualityInits/11_HospitalCompare.asp*.

CMS is also working with its Quality Improvement Organization (QIO) contractors to give hospitals the resources to eliminate HACs as much as possible. QIOs have been working with providers across the country since 2008 to reduce rates of hospital-associated infections, slow rates of pressure ulcers in nursing homes and hospitals, and improve safety and reduce infections for surgical patients. More information about QIOs' efforts is online at *http://www.cms.gov/qualityimprovementorgs*.

MLN Matters® Number: SE1114
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: May 6, 2011
Related CR Transmittal #: NA
Implementation Date: May 6, 2011

Comparative billing report on outpatient physical therapy services

On Tuesday, August 2, 2011, CMS released a national provider comparative billing report (CBR) centered on independent physical therapy providers who practice in the outpatient setting and bill Medicare with modifier KX. The CBR is similar to the original study distributed last summer except this current study will focus on 2010 billing data and is being sent to 5000 additional or different providers.

The CBRs are produced by Safeguard Services under contract with CMS and contain actual data-driven tables and graphs with an explanation of findings that compare a provider's billing and payment patterns to those of their peers located in the state and across the nation. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs.

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

For more information and to review a sample of the outpatient physical therapy services CBR, please visit the CBR Services website at *http://www.CBRservices.com* or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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

Source: CMS PERL 201108-10

Medicare Part B secondary payer deductible issues resulting from change request 7335

Effective Friday, April 1, 2011, CMS implemented CR 7335 – Allowing the Common Working File (CWF) to accept both Medicare Secondary Payer (MSP) and Non-MSP Lines on MSP Claims and MSP Adjustment Claims. This change request (CR) rescinds and fully replaces CR 7026.

Medicare Part B claims processed after Friday, April 1, 2011, for which the beneficiary has a Medicare deductible remaining and Medicare is the secondary payer, are erroneously issuing payment despite the beneficiary's deductible not being satisfied or despite the total Medicare allowed amount being applied towards the deductible.

The recovery of overpayments made during this time will be performed systematically. The recovery process has not yet been scheduled for implementation.

In addition to these overpayments, physical therapy and occupational therapy claims processed after Friday, April 1, 2011, where Medicare is the secondary payer and a deductible is not met are being held up by the system and are not being paid.

The Centers for Medicare & Medicaid Services (CMS) anticipates both of these issues to be resolved in November 2011.

Source: CMS PERL 201108-35

FY 2012 ICD-9-CM code titles available

The full and abbreviated fiscal year (FY) 2012 ICD-9-CM code titles effective Saturday, October 1, 2011 (version 29), are now available in both Microsoft Excel and text formats at *http://www.CMS.gov/ICD9ProviderDiagnosticCodes/06_codes.asp*.

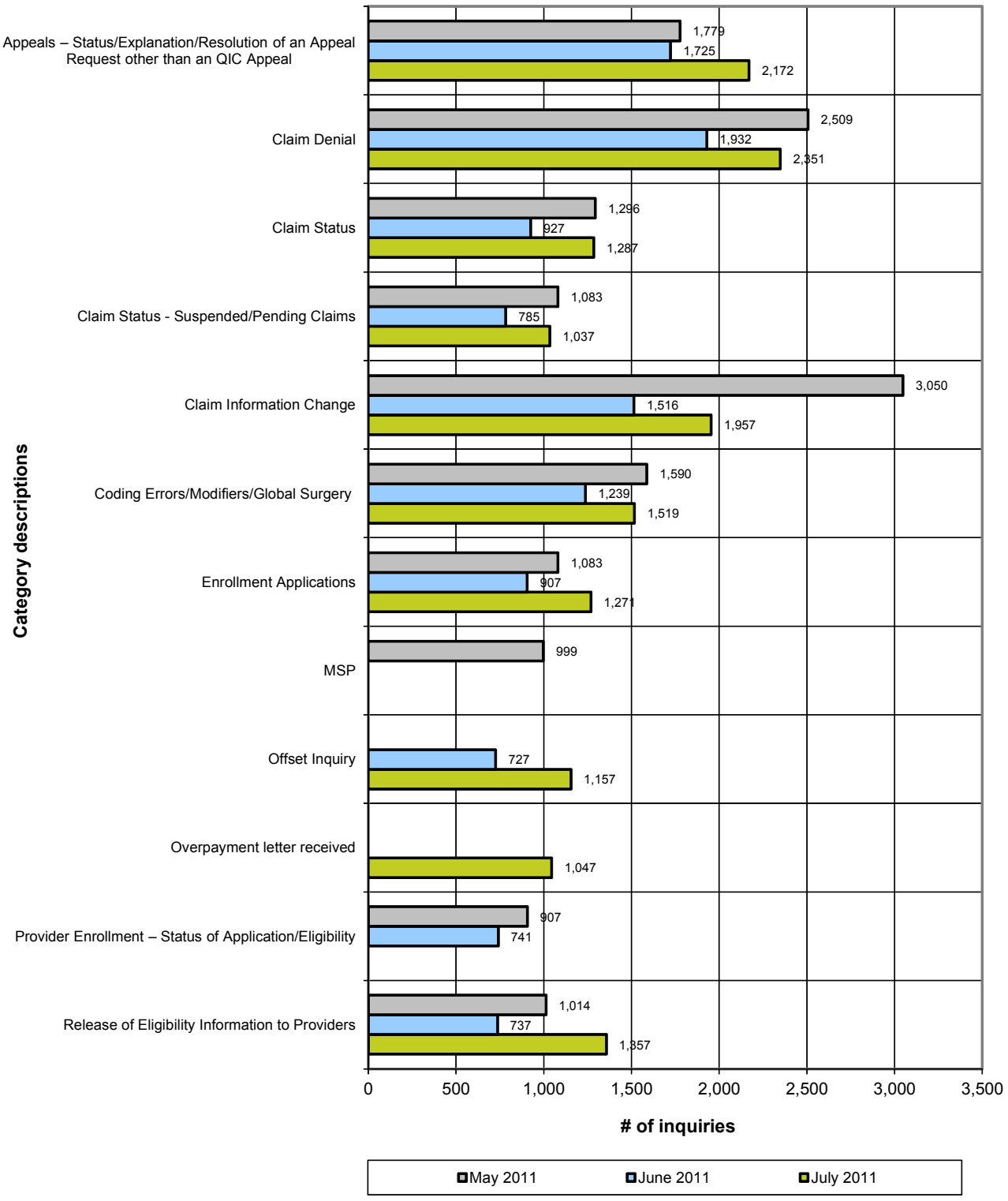
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201108-06

Top inquiries, denials, and return unprocessable claims

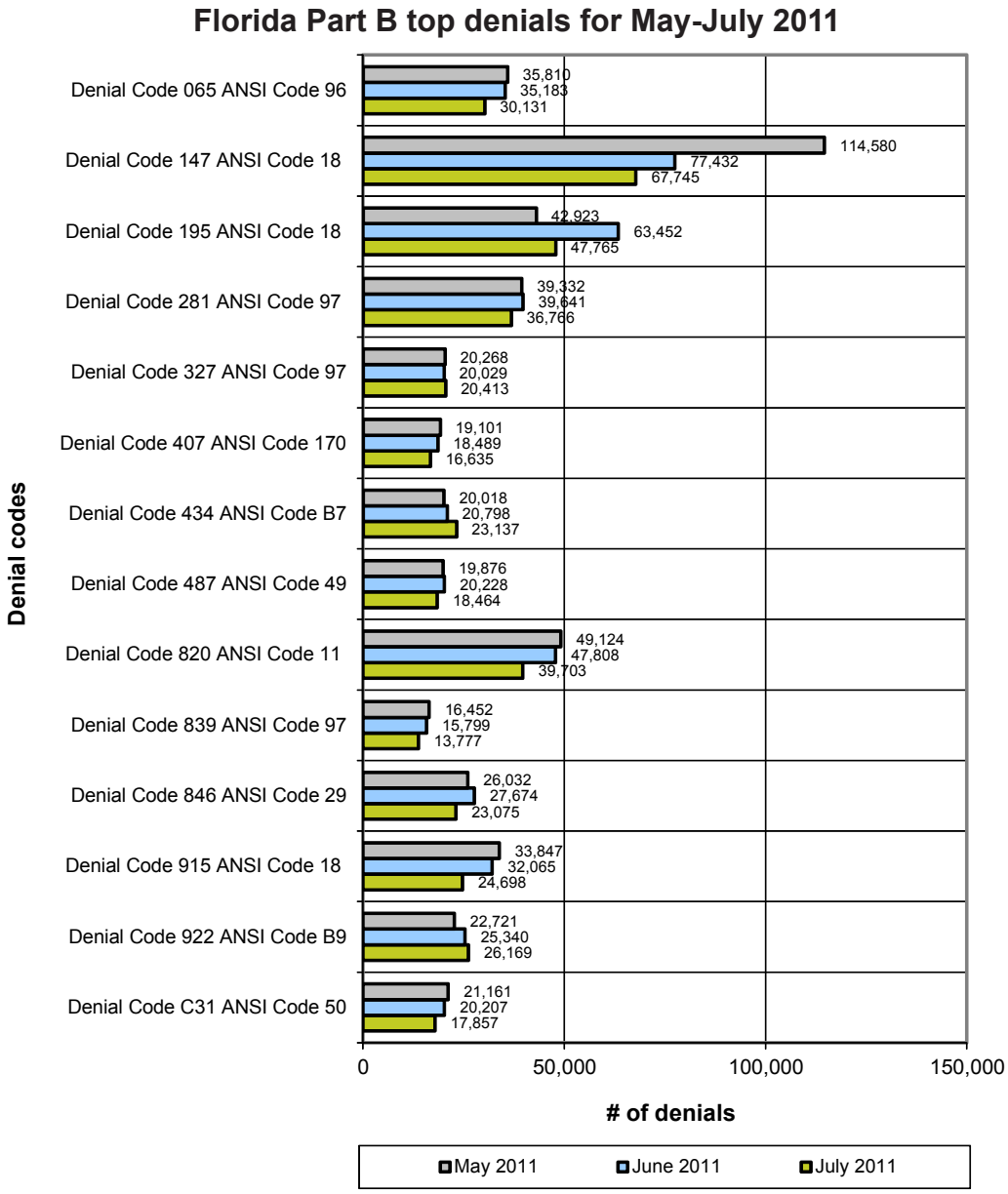
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during May-July 2011. For tips and resources to help you avoid or reduce the amount of time spent on many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



continued on next page

Top....(continued)



What to do when your claim is denied

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

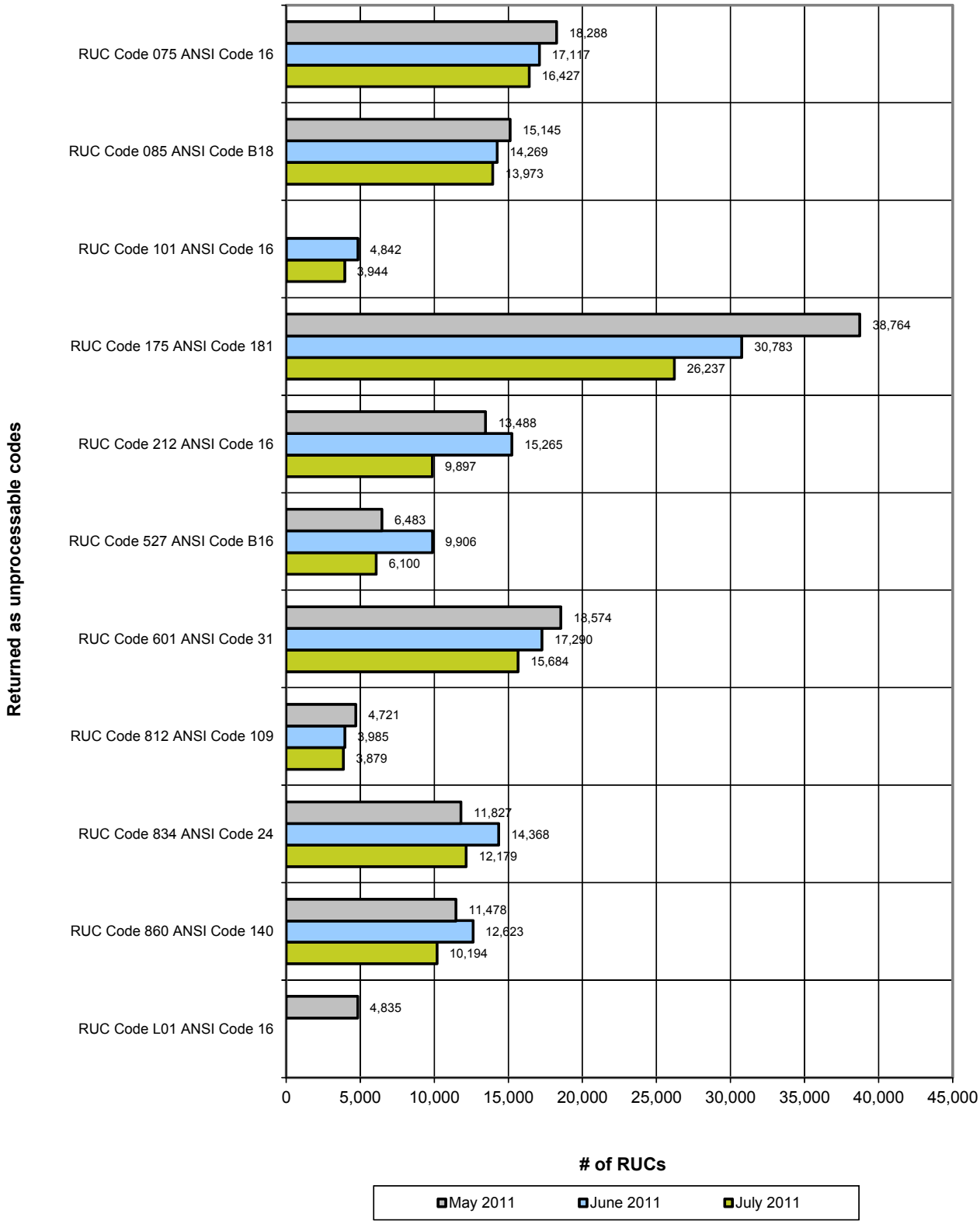
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top....(continued)

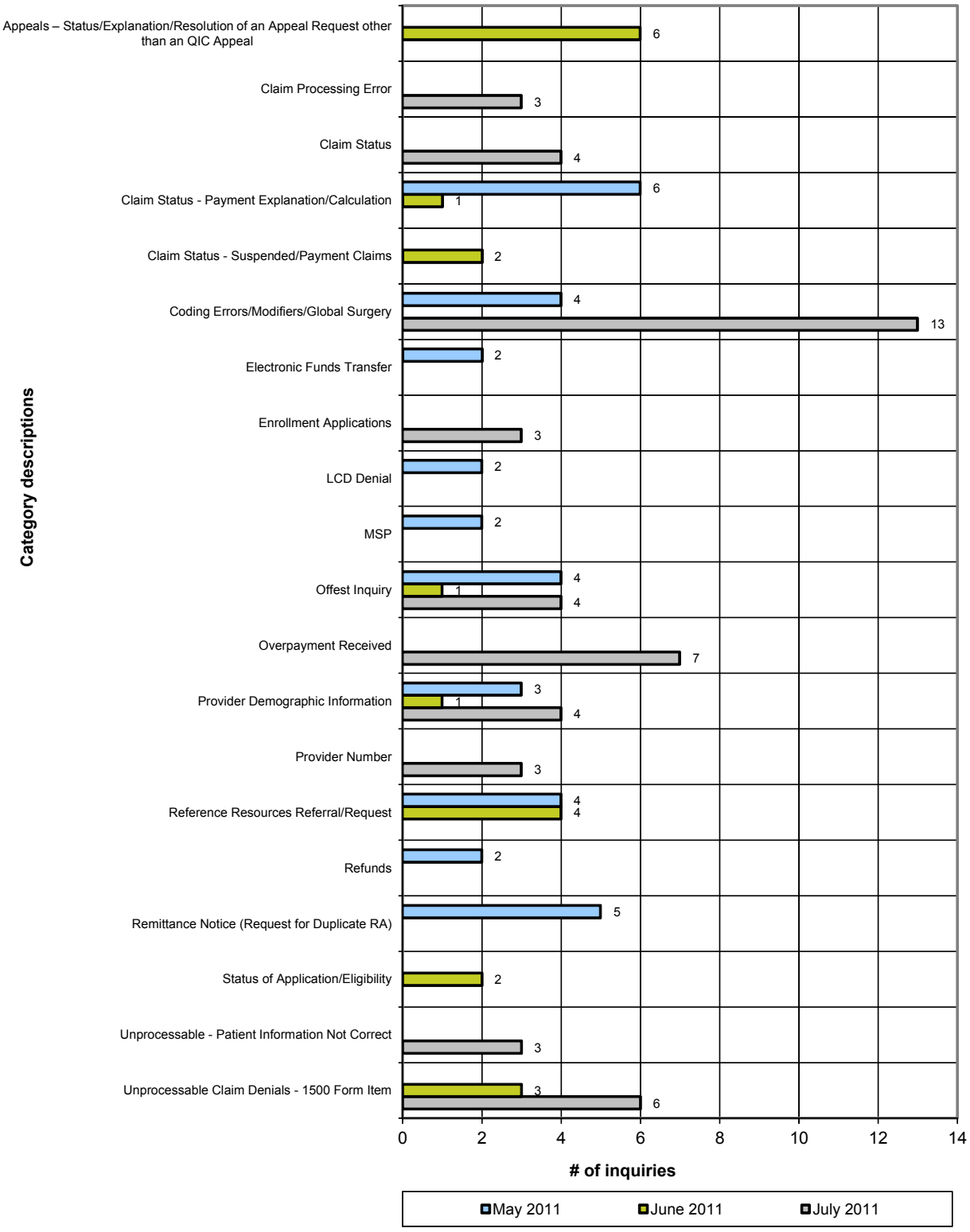
Florida Part B top return as unprocessable claims for May-July 2011



continued on next page

Top....(continued)

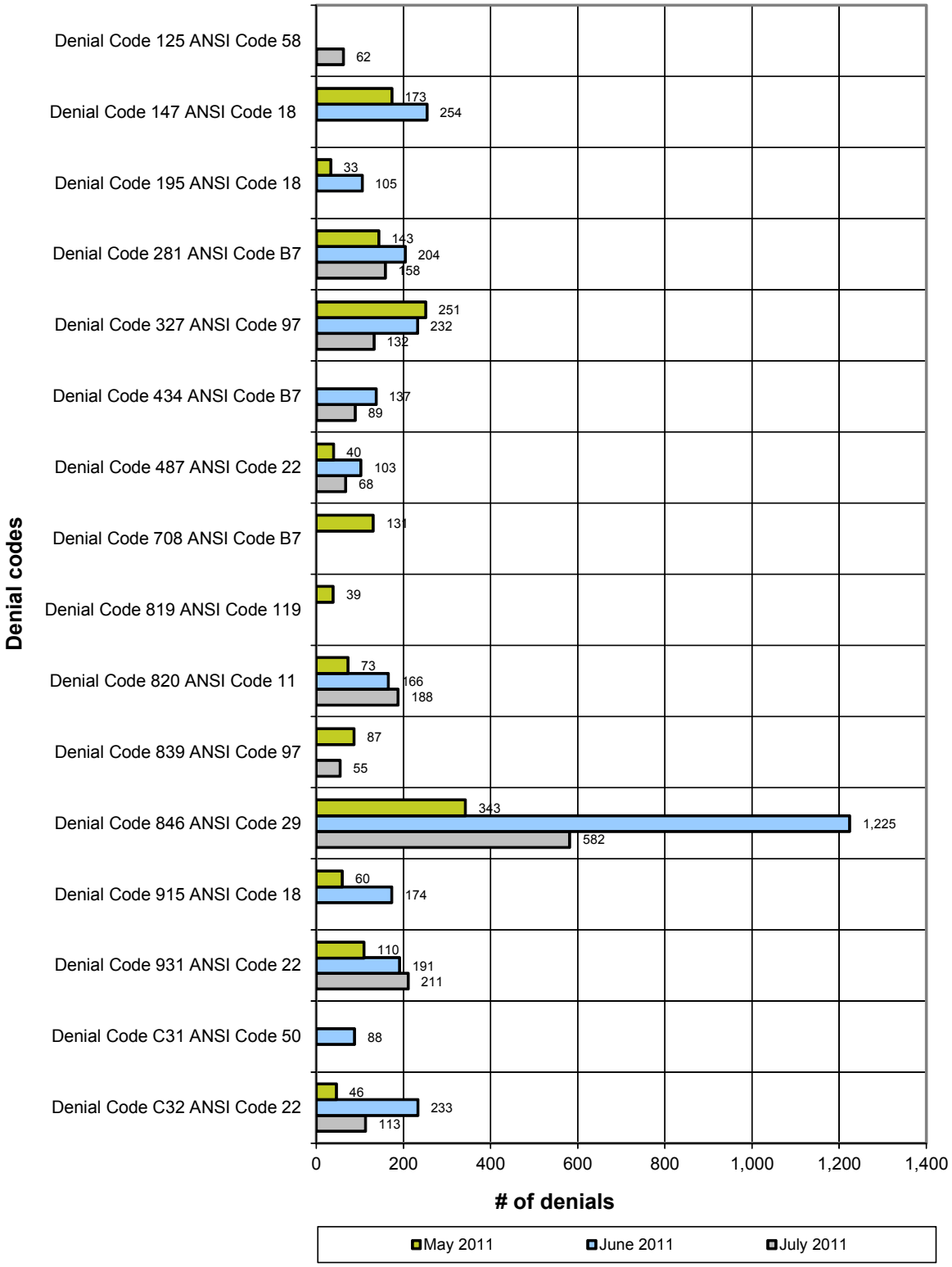
U.S. Virgin Islands Part B top inquiries for May-July 2011



continued on next page

Top....(continued)

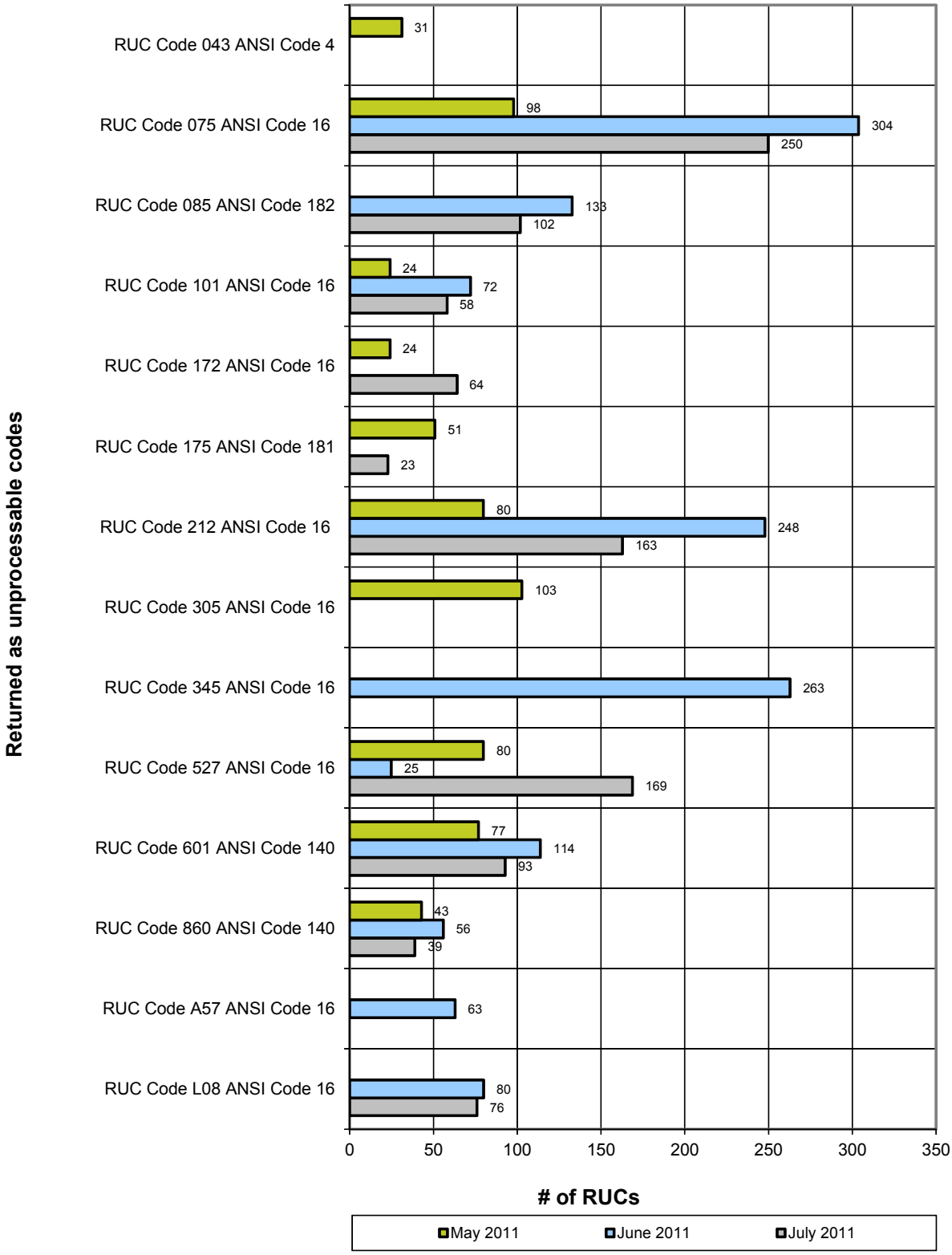
U.S. Virgin Islands Part B top denials for May-July 2011



continued on next page

Top....(continued)

U.S. Virgin Islands Part B top return as unprocessable claims for May-July 2011



This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

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

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

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

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

Contents

Advance beneficiary notice

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

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

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

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

Looking for LCDs?

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

Revisions to LCDs

J0881: Erythropoiesis stimulating agents – revision to the LCD

LCD ID number: L29168 (Florida)
LCD ID number: L29339 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for erythropoiesis stimulating agents was most recently revised on October 1, 2010. Since that time, the LCD has been revised. On June 24, 2011, the Food and Drug Administration (FDA) issued a revised drug label for epoetin alfa (Procrit® and Epogen®) and darbepoetin alfa (Aranesp®). These revisions required that the LCD be updated to reflect the new language surrounding the indications, black box warning, and dosage and administration for these drugs. Therefore, the "Indications and Limitations of Coverage and/or Medical Necessity," "Utilization Guidelines," "Documentation Requirements," and "Sources of Information and Basis for Decision" sections of the LCD have been revised accordingly to read in-line with the revised drugs labels.

Effective date

This LCD revision is effective for claims processed **on or after August 23, 2011**, for services rendered **on or after June 24, 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.

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
September 2011

Transition to HIPAA version 5010 technical seminar
When: Monday, September 12
Time: 10:00-11:30 a.m. **Type of Event:** Face-to-face

Transition to HIPAA version 5010 technical seminar
When: Monday, September 12
Time: 2:00-3:30 p.m. **Type of Event:** Face-to-face

Medifest Jacksonville 2011
When: September 13-15
Time: 8:00-4:30 p.m. **Type of Event:** Face-to-face

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

Two easy ways to register

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

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

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

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Preventive Services

New preventive services FAQs available

The Centers for Medicare & Medicaid Services (CMS) has posted 27 frequently asked questions (FAQs) regarding preventive services for Medicare fee-for-service providers/suppliers to the "Medicare Learning Network® Products Preventive Services" Web page; to access the entire list of 27 FAQs, scroll to the "Related Links Inside CMS" section at *http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp* and select "Preventive Services FAQs." You may also find the answer to each individual FAQ below.

Annual wellness visit

- Who can perform the Annual wellness visit (AWV)? *Read the answer*.
- Is the AWV the same as a beneficiary's yearly physical? *Read the answer*.
- Are clinical laboratory tests part of the AWV? *Read the answer*.
- Is there a deductible or coinsurance/copayment for the AWV? *Read the answer*.
- Can a separate evaluation and management (E/M) service be billed at the same visit as the AWV? *Read the answer*.
- Are the "new" preventive services codes for the annual Medicare wellness visit included in applicable 2011 Physician Quality Reporting System measures? *Read the answer*.

Initial preventive physical examination

- Is the initial preventive physical examination (IPPE) the same as a beneficiary's yearly physical? *Read the answer*.
- Who can perform the IPPE? *Read the answer*.
- Are clinical laboratory tests part of the IPPE? *Read the answer*.
- Is there a deductible or coinsurance/copayment for the IPPE? *Read the answer*.
- If a beneficiary enrolled in Medicare in 2010, can he or she have the IPPE in 2011 if it was not performed in 2010? *Read the answer*.
- Can a separate evaluation and management (E/M) service be billed at the same visit as the IPPE? *Read the answer*.

Medicare immunization billing (seasonal influenza virus, pneumococcal, and hepatitis B)

- Does a Part B deductible or coinsurance apply to adult immunizations covered by Medicare? *Read the answer*.
- If a beneficiary receives a seasonal influenza virus vaccination more than once in a 12-month period, will Medicare still pay for it? *Read the answer*.
- Are HCPCS codes Q2035 and Q2039 payable by Medicare? *Read the answer*.
- Will Medicare pay for the pneumococcal vaccination if a beneficiary is uncertain of his or her vaccination history? *Read the answer*.
- Does Medicare cover the hepatitis B vaccine for all Medicare beneficiaries? *Read the answer*.
- When a beneficiary receives both the seasonal influenza virus and pneumococcal vaccines on the same visit, would a provider continue to report separate administration codes for each type of vaccine? *Read the answer*.
- Can the seasonal influenza virus, pneumococcal, and hepatitis B vaccines all be roster billed? *Read the answer*.
- What is a mass immunizer? *Read the answer*.
- Do providers that only provide immunizations need to enroll in the Medicare program? *Read the answer*.
- May a single roster claim be submitted containing information for both the pneumococcal and seasonal influenza virus vaccines when the vaccines are administered on the same visit? *Read the answer*.
- End-stage renal disease (ESRD) dialysis facilities currently bill for the flu, pneumonia, and hepatitis B vaccines. Will the administration of these vaccines also remain separately payable after January 1, 2011? *Read the answer*.

continued on next page

New....(continued)

- How should a provider that is not enrolled in Medicare bill for the flu vaccine? *Read the answer*.
- How should the Physician Quality Reporting Initiative influenza immunization measure #110 (Preventive Care and
- Screening: Influenza Immunization for Patients ≥ 50 Years Old) be reported for patients seen outside of the flu season (September through February)? What if the flu immunization was administered by another provider? *Read the answer*.

Colorectal cancer screening

- Do the Medicare deductible and standard coinsurance apply for colorectal cancer screening services under the revised ambulatory surgical center payment system? *Read the answer*.

Smoking cessation counseling

- What are the two *Current Procedural Terminology* (*CPT*) codes for smoking and tobacco use cessation counseling services that replace the temporary Healthcare Common Procedure Coding System (HCPCS) G codes (G0375 and G0376) previously used for billing these services? *Read the answer*.

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

Source: CMS PERL 201108-25

August is National Immunization Awareness Month

This national health observance presents a great opportunity to educate seniors and other people with Medicare on the importance of disease control and prevention through immunization. Vaccine-preventable disease levels are at or near record lows, yet many adults remain under-immunized, missing opportunities to protect themselves against diseases such as hepatitis B, seasonal influenza, and pneumococcal disease.

What can you do?

The Centers for Medicare & Medicaid Services (CMS) asks health care providers who provide care to seniors and others with Medicare to join it during National Immunization Awareness Month to help protect your Medicare patients from vaccine-preventable diseases. This can be done by ensuring their immunizations are up-to-date, educating them on risk factors, and encouraging their use of appropriate Medicare-covered immunizations.

(Note that if you provide the Medicare annual wellness visit to your eligible Medicare patients, please ensure that a written screening schedule for immunizations is reflected on their personalized preventive service plan.)

Medicare Part B immunization benefits

Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration for qualified beneficiaries as preventive immunizations. Providers who accept the Medicare-approved payment amount for the following services are paid under Medicare Part B:

- **Seasonal influenza immunization** – Medicare provides payment for the seasonal influenza vaccine and its administration for all people with Medicare, once per influenza season. Medicare may cover additional influenza vaccinations, if medically necessary. You may visit the *Centers for Disease Control and Prevention (CDC) website* for the latest 2011-2012 seasonal flu recommendations and alerts.
- **Pneumococcal immunization** – Medicare provides payment for the pneumococcal vaccine and its administration for all beneficiaries, generally once in a lifetime. Medicare may cover additional vaccinations based on risk.
- **Hepatitis B immunization** – Medicare provides payment for the hepatitis B vaccine and its administration for beneficiaries at medium to high risk of contracting hepatitis B.

continued on next page

August....(continued)

For more information

- *The CMS Guide to Medicare Preventive Services*
- *Medicare Immunizations Billing Quick Reference Chart*
- *CMS Adult Immunizations Brochure*
- *CMS Adult Immunizations Web page*
- *CMS Medicare Learning Network® (MLN) Preventive Services Educational Products Web page* – This site provides access to MLN educational resources developed by CMS for fee-for-service providers and suppliers related to preventive services covered by Medicare, including immunizations covered by Part B
- *The CDC Vaccines and Immunizations Web page*
- *National Immunization Awareness Month 2011 Toolkit*
- *Annual Wellness Visit Brochure* – A brochure for health care professionals.
- *The ABCs of Providing the Annual Wellness Visit Quick Reference Chart*

Source: CMS PERL 201108-11

Other Educational Resources

Updates from the Medicare Learning Network®

Medicare Learning Network Catalog of Products updated

The Medicare Learning Network® Catalog of Products has been updated and is available as a free interactive downloadable document at *http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf*. The catalog lists all MLN products available to the Medicare fee-for-service provider community. In the catalog, click on the title of a product to go directly to a downloadable copy or, if the product is available in hard copy, click on "Hard Copy" next to "Formats Available," to link to the MLN Product Ordering Page.

MLN Provider Exhibit Program schedule

The *Medicare Learning Network®* (MLN) *Provider Exhibit Program* is an educational and marketing resource within the Centers for Medicare & Medicaid Services (CMS). The mission of the MLN Provider Exhibit Program is to reach the Medicare fee-for-service (FFS) provider community by providing a formal and consistent CMS presence at national and regional provider association meetings and conferences to promote awareness and use of the MLN products.

The MLN will be exhibiting at the following healthcare provider conferences in the coming weeks:

Healthcare Billing & Management Association – 2011 Annual Fall Conference
Wednesday, September 14 through Friday, September 16
Bellagio Hotel – Las Vegas, NV
Booth #217

American Academy of Family Physicians Scientific Assembly
Wednesday, September 14 through Saturday, September 17
Orange County Convention Center – Orlando, FL
Booth #249

Please make a note of these dates and locations and add them to your calendar! If you are interested in having a MLN exhibit at your event, please contact CMS at *MLNexhibits@cms.hhs.gov*.

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

Source: CMS PERL 201108-26

Registration now open for second ACO accelerated development learning session

Thursday, September 15, 2011, through Friday, September 16, 2011
San Francisco, CA

The *Center for Medicare and Medicaid Innovation* is offering free *accelerated development learning sessions* for providers interested in learning more about how to coordinate patient care through accountable care organizations (ACOs). The second of four accelerated development learning sessions in 2011 will be held in San Francisco, CA on Thursday, September 15, 2011, and Friday, September 16, 2011. Registration is free and open for teams of between two and four senior leaders from health care delivery organizations interested in forming an ACO or from an existing ACO.

The accelerated development learning sessions are designed to help existing or emerging ACOs understand the steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care. The content at each ACO learning session is repetitive and is not part of an ongoing series.

For more information, to register, or to view the plenary sessions from the first learning session, please visit *http://ACOregister.rti.org*. For more information, please visit the *Frequently Asked Questions 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 201108-37

New podcasts available from four popular CMS ICD-10 national provider calls

Limited on time? The Centers for Medicare & Medicaid Services (CMS) has created podcasts from four popular national provider calls on ICD-10. These podcasts are perfect for use in the office, on the go in your car, or on your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs.

- *"CMS ICD-10 Conversion Activities"* – Wednesday, May 18, 2011
- *"Preparing for ICD-10 Implementation in 2011"* – Wednesday, January 12, 2011
- *"Basic Introduction to ICD-10-CM"* – Tuesday, March 23, 2010
- *"ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks)"* – Tuesday, May 19, 2009

To access these podcasts, select the links above or visit the CMS-sponsored ICD-10 teleconferences Web page at *http://www.CMS.gov/ICD10/Tel10/list.asp*; select a call date from the list of previous national provider calls to access related presentation materials, audio recordings, and written transcripts.

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

Source: CMS PERL 201108-22

Medicare Quarterly Provider Compliance Newsletter available

The July 2011 issue of the *Medicare Quarterly Provider Compliance Newsletter* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903687.pdf*. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. In this issue, several recovery audit findings that affect inpatient hospitals and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers are presented. Please visit *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf* to download, print, and search newsletters from previous quarters.

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

Source: CMS PERL 201108-12

New 'Fast Fact' posted on MLN® provider compliance Web page

The Centers for Medicare & Medicaid Services (CMS) has posted a new "Fast Fact" to the *Medicare Learning Network® (MLN) provider compliance Web page*. This page features educational fee-for-service (FFS) provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions. Bookmark the page and check back often as a new "Fast Fact" is added each month.

Source: CMS PERL 201108-12

Medicare Physician Guide revised

The revised *Medicare Physician Guide*, which is designed to provide education on the Medicare program, is now available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/MedicarePhysicianGuide_ICN005933.pdf*. The guide includes information on an introduction to the Medicare program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare services, protecting the Medicare trust fund, Medicare overpayments and fee-for-service appeals, and provider outreach and education.

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

Source: CMS PERL 201108-12

Introduction to the Medicare Program booklet available in hard copy

The *Medicare Learning Network*'s (MLN's) *Introduction to the Medicare Program booklet* is now available in print format. This booklet is designed to provide education on the Medicare program and includes information about the four parts of the Medicare program, other health insurance plans, and organizations of interest to providers and beneficiaries. 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 201108-12

2011 Physician Quality Reporting System Maintenance of Certification Program fact sheet released

The *2011 Physician Quality Reporting System Maintenance of Certification Program* fact sheet is available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/PQRSMOCMadeSimple.pdf*. This fact sheet provides education regarding the incentive payment program to identified eligible professionals who satisfactorily report data on quality measures for covered physician fee schedule services furnished to Medicare Part B fee-for-service beneficiaries. It also includes information on the additional 0.5 percent incentive payment when those providers meet Maintenance of Certification Program Incentive requirements.

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

Source: CMS PERL 201108-12

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

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

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

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

Phone numbers

Providers

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

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

email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Order form for Medicare Part B materials

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

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

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

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

Medicare B Connection

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

Attention Billing Manager