

C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

December 2011



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The Obama administration has expanded its efforts to fight fraud

On Tuesday, December 13, the Obama administration announced recovery of over 5.6 billion in fraudulent payments in fiscal year 2011, a 167 percent increase from 2008. President Obama's health care reform law includes new resources and tools to help fight fraud in Medicare and Medicaid and to protect taxpayer dollars. In addition, the Centers for Medicare & Medicaid Services (CMS) is taking steps to strengthen controls to identify and prevent prescription drug fraud and abuse in the Medicare Part D program.

CMS released a notice to Part D prescription drug plan sponsors that contains information and guidance to immediately take steps to stop prescription drug misuse and fraud. Pain killers (e.g., OxyContin™) are the fifth most filled classes of drugs in Medicare, with spending in 2009 totaling 3.9 billion. The Government Accountability Office identified evidence of fraud and drug abuse in Medicare for these types of drugs, which pose a threat to public health as well as the federal budget. Among the messages conveyed to the plans:

- Investigate and stop payment for suspect claims
- Use tools to help manage proper utilization of drugs
- Limit prescriptions to 30-day doses

These efforts build on significant progress already made by the Obama administration to fight fraud across the health care sector – progress that has been sped up by resources from the Affordable Care Act, the health care law of 2010. This progress has contributed to the 167 percent increase in fraud recoveries since 2008.

In addition, under a demonstration announced in November, Medicare will implement a prior authorization process for all power mobility device claims in seven high-risk states, guaranteeing that beneficiaries receive access to the services they need but preventing payment in cases where medical need has not been established. This will make it more difficult to get fraudulent claims through Medicare's claims payment systems.

You may read the full CMS fact sheet at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4217>.

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

Source: CMS PERL 201112-28



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

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

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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.fcsso.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 (waiver of liability statement on file).

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

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

Consolidated Billing

Claims processing issue affects claims for physician's services excluded from SNF CB stay

The Centers for Medicare & Medicaid Services (CMS) has identified a claims processing issue that has affected payment of some Part B claims for skilled nursing facility (SNF) patients for dates of service during the time period: Saturday, October 1 through Monday, November 21.

Some Part B claims for SNF patients submitted to Medicare during October and November have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system has paid and then identified a "Medicare overpayment" on these claims in error.

If you submitted a Part B claim for a SNF patient, you may receive a system-generated demand letter from Medicare, or you may see a notification for a payment offset on your remittance advice.

If you receive a system-generated demand letter related to this issue, the specific "Reason for Overpayment" will be listed as shown in the highlighted area of the graphic below:

Invoice Number: [REDACTED]

Claim No.	Beneficiary Name	HIC No.	Service Date From	Service Date To	Amount Overpaid	Paid Date	Performing Provider No.
[REDACTED]	[REDACTED]	[REDACTED]	09/30/2011	09/30/2011	\$17.61	10/19/2011	[REDACTED]

Reason for Overpayment: Based on Medicare Policy, services within a Skilled Nursing Facility period are subject to consolidated billing and should not be paid separately. Our records indicate that this claim is subject to Skilled Nursing Facility consolidated billing. Therefore, payment was made to you in error.

Your Medicare claims administration contractor (MAC) is working with the Centers for Medicare & Medicaid Services (CMS) to resolve this problem in the claims processing system, so appropriate payment adjustments can be made.

CMS is asking providers not to appeal these claims at this time. Because these are erroneous adjustments in Medicare's claims processing system, submitting an appeal may slow down the correct adjustment of your claim.

Your MAC will notify you when the adjustment process for these claims has been initiated, so you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted. CMS apologizes for any inconvenience this issue may have caused.

Source: CMS PERL 201112-09

Drugs and Biologicals

January 2012 average sales price files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the January 2012 average sales price (ASP) and not otherwise classified (NOC) pricing files, crosswalks, and updated pricing files for October 2011 and July 2011. All are available for download at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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

Source: CMS PERL 201112-25

Revised average sales price template now available

The revised average sales price (ASP) template is now available at <http://www.cms.gov/McrPartBDrugAvgSalesPrice/>. Manufacturers should use this template for submitting ASP to the Centers for Medicare & Medicaid Services (CMS) beginning January 2012.

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

Source: CMS PERL 201112-41

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

Note: This article was revised on December 16, 2011, to reflect the revised change request (CR) 7397 issued on December 15. 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. This information was previously published in the October 2011 *Medicare B Connection*, pages 7-8.

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 change request (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 durable medical equipment Medicare administrative contractor (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/R2368CP.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> and
- *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: December 15, 2011

Effective Date: January 1, 2013

Related CR Transmittal #: R2368CP

Implementation Date: January 1, 2013

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Durable Medical Equipment

‘The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements’ fact sheet revised

On Monday, December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) announced a revised repairs and replacement policy for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The revised policy continues to allow any Medicare enrolled supplier to repair medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable. The policy now considers repair parts to include components that are needed to repair the base equipment, including batteries and tires. Additionally, the revised fact sheet provides guidance on billing the labor component and parts for the repair for beneficiaries who reside in competitive bid areas.

The revised “*The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements*” fact sheet (ICN 905283) is designed to provide education on repairs and replacements under the DMEPOS competitive bidding program. It includes information on which items and services can be provided by contract versus non-contract suppliers.

Source: CMS PERL 201112-34

Reasonable charge update for 2012 for splints, casts, and certain intraocular lenses

Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs)) for splints, casts, and certain intraocular lenses.

What providers need to know

Change request (CR) 7628, on which this article is based, announces that payment of claims for splints, casts, and for intraocular lenses implanted in a physician's office (codes V2630, V2631, V2632) continues to be made on a reasonable charge basis subject to certain payment limits. CR 7628 also announces that the update factor for the inflation indexed charge (IIC) for 2012 is 3.6 percent.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, and intraocular lenses (codes V2630, V2631, and V2632) implanted in a physician's office. For splints and casts, the Q codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

CR 7628 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2012. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501.

The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 30, 2011. The 2012 payment limits for splints and casts will be based on the 2011 limits that were announced in CR 7225 last year, increased by 3.6 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2011. (You can read the *MLN Matters*® article associated with CR 7225 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7225.pdf>.) The IIC update factor for 2012 is 3.6 percent.

A list of the 2012 payment limits for splints and casts are listed in the table that follows.

2012 payment limits for splints and casts							
A4565	\$8.12	Q4013	\$14.88	Q4026	\$111.41	Q4039	\$7.78
Q4001	\$46.21	Q4014	\$25.08	Q4027	\$17.85	Q4040	\$19.44
Q4002	\$174.65	Q4015	\$7.44	Q4028	\$55.72	Q4041	\$18.88
Q4003	\$33.19	Q4016	\$12.54	Q4029	\$27.29	Q4042	\$32.23
Q4004	\$114.91	Q4017	\$8.60	Q4030	\$71.83	Q4043	\$9.45
Q4005	\$12.24	Q4018	\$13.71	Q4031	\$13.64	Q4044	\$16.12
Q4006	\$27.58	Q4019	\$4.31	Q4032	\$35.91	Q4045	\$10.96
Q4007	\$6.13	Q4020	\$6.86	Q4033	\$25.45	Q4046	\$17.63
Q4008	\$13.79	Q4021	\$6.36	Q4034	\$63.30	Q4047	\$5.47
Q4009	\$8.17	Q4022	\$11.48	Q4035	\$12.72	Q4048	\$8.82
Q4010	\$18.39	Q4023	\$3.20	Q4036	\$31.66	Q4049	\$2.00
Q4011	\$4.08	Q4024	\$5.74	Q4037	\$15.53	Q4012	\$9.20
Q4025	\$35.68	Q4038	\$38.90				

Additional information

You can find the official instruction, CR 7628, issued to your carrier, FI, MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2349CP.pdf>.

Detailed instructions for calculating:

1. **Reasonable charges** are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);

continued on next page

Reasonable ... (continued)

2. **Customary and prevailing charges** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
3. The **IIC** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

Chapter 23 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>.

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

MLN Matters® Number: MM7628

Related Change Request (CR) #: CR 7628

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2349CP

Implementation Date: January 3, 2012

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Registration reminder for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) like to remind all suppliers interested in participating in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program that registration for user IDs and passwords is open. If you are interested in bidding, you must designate one authorized official (AO) (from those listed on your CMS-855S enrollment form) to act as your AO for registration purposes, and your AO must register.

CMS strongly urged all AOs to register no later than December 22, 2011, to ensure that AOs have time to designate other supplier employees to use the DMEPOS online bidding system (DBidS).

When bidding opens, suppliers will need to submit their bids using DBidS. To help ensure bid security and privacy, suppliers interested in bidding must first register all employees that will enter information in DBidS, and those employees must obtain a user ID and password through the individuals authorized access to CMS computer services (IACS) system. Only suppliers' employees that have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as backup authorized officials (BAO). The AO and BAOs can designate other supplier employees as end users (EU). BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name, date of birth, and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the national supplier clearinghouse (NSC) to register successfully.

Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with the NSC. CMS recommends that BAOs register no later than January 12, 2012, so that they will be able to assist AOs with approving EU registration.

Registration will close **February 9, 2012, at 9 p.m. ET** – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, www.dmecompetitivebid.com and click on "Registration is Open" above the registration clock on the home page. Please review the *IACS Reference Guide* posted on the website for step-by-step instructions on registration. You will also find a registration checklist and quick step guides on the CBIC website. If you have any questions about the registration process, please contact the CBIC customer service center at 1-877-577-5331.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the home page of the CBIC website. For information about round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under "Bidding Suppliers: Round 2 & National Mail-Order" on the CBIC website.

Source: CMS PERL 201112-40

Now available: New webcast for round 2 and national mail-order bidders

The first in a series of educational webcasts for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program is now available on the Competitive Bidding Implementation Contractor (CBIC) website. This webcast, “Welcome to Round 2 and National Mail-Order,” provides background information on the program and information about the educational resources available to assist you in participating.

The webcast is available on demand to view at your convenience—24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please go to the CBIC website at www.dmecompetitivebid.com and select “Bidding Suppliers: Round 2 & National Mail-Order” and then choose “Education Events.”

The Centers for Medicare & Medicaid Services (CMS) will be issuing more webcasts later in the bidder education program. The upcoming webcasts will address topics such as financial documentation requirements, the national mail-order competition, general bidding requirements, and how to submit a bid in the online system, DBidS. As each webcast is posted, CMS will announce its availability through an email update. If you have not already done so, please register on the CBIC website to receive these announcements and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9 a.m. to 9 p.m. ET, Monday through Friday, throughout the registration and bidding periods.

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

Source: CMS PERL 201112-43

Bidding timeline and education efforts for DMEPOS competitive bidding program

Bidding timeline

The Centers for Medicare & Medicaid Services (CMS) has announced the bidding timeline for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program. To view the timeline, visit the Competitive Bidding Implementation Contractor (CBIC) website at www.dmecompetitivebid.com.

Education program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner. The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website, www.dmecompetitivebid.com, features a comprehensive array of important information for suppliers, including bidding rules, user guides, policy fact sheets, checklists, and bidding information charts. The education program will also include webcasts that cover all the essential topics suppliers need to know in order to bid. These webcasts will be posted on the CBIC website and will be available 24 hours a day/7 days a week. When a webcast is posted, the CBIC will announce its availability through a CBIC email update announcement. To sign up to receive webcast announcements and other key registration and bidding information, visit the CBIC website at www.dmecompetitivebid.com and subscribe to email updates.

In addition to viewing the information on the CBIC website, DMEPOS suppliers are encouraged to call the CBIC toll-free help desk, 1-877-577-5331, with their questions and concerns.

To view the press release, please click: www.cms.gov/apps/media/press_releases.asp.

To view the fact sheet, please click: www.cms.gov/apps/media/fact_sheets.asp.

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

Source: CMS PERL 201111-72

Get ready for DMEPOS competitive bidding

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

Fall 2011

- The Centers for Medicare & Medicaid Services (CMS) announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

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

Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up-to-date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
- The correspondence address.

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

- **Get licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a competitive bidding area (CBA), you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is very important that you make sure that current versions of all required licenses are in your enrollment file with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.
- **Get accredited:** Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

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

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

Each office visit is an opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that flu seasons are unpredictable and can be severe. Each year, it is estimated that 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get the flu vaccine – not the flu.

continued on next page

Competitive ... (continued)

Remember – the flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is not a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and <http://www.cms.gov/immunizations>.

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

Source: CMS PERL 201111-55

Evaluation and Management

Expansion of Medicare telehealth services for CY 2012

Provider types affected

Physicians, hospitals (including critical access hospitals [CAH]), and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for providing telehealth services to Medicare beneficiaries will be affected by this article.

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

Effective January 1, 2012, you may begin billing your FI, carrier, or A/B MAC for CPT codes 99406-99407 and HCPCS codes G0436-G0437 for smoking cessation services furnished as Medicare telehealth services when all other Medicare telehealth qualifications have been met. Change request (CR) 7504 also announces that the initial telehealth consultation codes (G0425-G0427) used for hospital inpatients may also be billed for telehealth services with a place of service (POS) code for the emergency department when all other Medicare telehealth qualifications have been met.

Caution – what you need to know

CR 7504, from which this article is taken, announces that (effective January 1, 2012) the Centers for Medicare & Medicaid Services (CMS) is adding four smoking cessation services codes to the list of Medicare telehealth services for CY 2012.

Go – what you need to do

You should make sure that your billing staffs are aware of these additional smoking cessation codes for Medicare telehealth services for CY 2012.

Background

In the calendar year 2012 physician fee schedule final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is adding four smoking cessation services codes to the list of Medicare distant site telehealth services. The additional codes, effective January 1, 2012, are:

- CPT codes 99406 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*); and 99407 (*Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*); and
- HCPCS codes G0436 (*Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes*); and G0437 (*Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes*).

CMS is also revising the initial inpatient telehealth consultation code descriptors to allow practitioners to report these services furnished to emergency department patients. The code descriptors, effective January 1, 2012, are:

- HCPCS code G0425 (*Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth*)

continued on next page

Telehealth ... (continued)

- HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth)
- HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth)

For your claims with dates of service on or after January 1, 2012:

- Your carrier or A/B MAC will accept and pay these codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ modifier (Via asynchronous telecommunications system) or GT modifier (Via interactive audio and video telecommunications system);
- Your FI or A/B MAC will accept and pay such claims when submitted with a GQ or GT modifier by CAHs that have elected method II on type of bill (TOB) 85x; and
- Your carrier or A/B MAC will pay initial inpatient telehealth consultation codes G0425-G0427 with the GT or GQ modifier when billed with place of service (POS) emergency department in addition to inpatient hospital or skilled nursing facility.

Additional information

Further information regarding telehealth is available in the *Telehealth Services Fact Sheet* at <http://www.cms.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>.

You can find more information about the new smoking cessation codes for telehealth services by going to CR 7504, which was issued via two transmittals. The first transmittal revises the *Medicare Benefit Policy Manual* and is at <http://www.cms.gov/Transmittals/downloads/R151BP.pdf> and the second updates the *Medicare Claims Processing Manual* and is at <http://www.cms.gov/Transmittals/downloads/R2354CP.pdf>.

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

MLN Matters® Number: MM7504

Related Change Request (CR) #: CR 7504

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R151BP and R2354CP

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.

Laboratory/Pathology

CY 2012 annual update for clinical laboratory fee schedule and services subject to reasonable charge payment

Provider types affected

Clinical diagnostic laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) are affected.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7654, which provides instructions to Medicare contractors for the calendar year (CY) 2012 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your staffs are aware of these updates.

continued on next page

Clinical lab ... (continued)**Background****Annual updates to fees**

The annual update to the local clinical laboratory fees for CY 2012 is 0.65 percent. The annual update to local clinical laboratory fees for CY 2012 reflects an additional multi-factor productivity adjustment and a -1.75 percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2012 is 3.6 percent (See 42 Code of Federal Regulations (CFR) 405.509(b)(1)).

The Social Security Act (the Act), Section 1833(a)(1)(D) provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

This update is in accordance with Section 1833(h)(2)(A)(i) of the Act, as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2012 national minimum payment amount is \$14.97 (\$14.87 plus 0.65 percent update for CY 2012). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	G0123
G0144	G0145	G0147	G0148	P3000

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Public comments

On July 18, 2011, CMS hosted a public meeting to solicit input on the payment relationship between CY 2011 codes and new CY 2012 *CPT* codes. Notice of the meeting was published in the *Federal Register* on February 25, 2011, and on the CMS website on or about June 15, 2011. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSchd>. Additional written comments from the public were accepted until October 28, 2011. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Molecular pathology procedure test codes

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure test codes released by the American Medical Association. For payment purposes under the clinical laboratory fee schedule, these test codes will be assigned a "B" indicator – "Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient)."

However, each of these new molecular pathology Procedure test codes represents a test that is currently being used and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understands that existing *Current Procedural Terminology (CPT)* test codes are "stacked" to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare as follows in order to represent the

continued on next page

Clinical lab ... (continued)

performance of the entire test:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time).

If the new *CPT* test coding structure were active, Laboratory A would bill Medicare the new, single *CPT* test code that corresponds to the test represented by the “stacked” codes in the example above rather than billing each component of the test separately.

As of January 1, 2012, Medicare requests that Medicare claims for Molecular Pathology Procedures reflect both the existing *CPT* “stacked” test codes that are required for payment and the new single *CPT* test code that would be used for payment purposes if the new *CPT* test codes were active.

Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment, as follows:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) along with the new, single *CPT* test code that corresponds to the test represented by the “stacked” test codes.

While the allowed charge amount will be \$0.00 for the new molecular pathology procedure test codes that carry the “B” indicator, Medicare requests that Medicare claims also reflect a charge for the non-payable service.

The table below contains the CY 2012 molecular pathology procedure test codes:

81200	81205	81206	81207	81208
81209	81210	81211	81212	81213
81214	81215	81216	81217	81220
81221	81222	81223	81224	81225
81226	81227	81228	81229	81240
81241	81242	81243	81244	81245
81250	81251	81255	81256	81257
81260	81261	81262	81263	81264
81265	81266	81267	81268	81270
81275	81280	81281	81282	81290
81291	81292	81293	81294	81295
81296	81297	81298	81299	81300
81301	81302	81303	81304	81310
81315	81316	81317	81318	81319
81330	81331	81332	81340	81341
81342	81350	81355	81370	81371
81372	81373	81374	81375	81376
81377	81378	81379	81380	81381
81382	81383	81400	81401	81402
81403	81404	81405	81406	81407
81408				

Access to data file

Internet access to the CY 2012 clinical laboratory fee schedule data file will be available after November 21, 2011, at <http://www.cms.hhs.gov/ClinicalLabFeeSched>. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2012 clinical laboratory fee schedule, which will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CY 2012 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

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Clinical lab... (continued)

The fees for clinical laboratory travel codes, P9603 and P9604, are updated annually. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2012, CMS will issue a separate instruction on the clinical laboratory travel fees.



The CY 2012 clinical laboratory fee schedule also includes codes that have a “QW” modifier, defined as CLIA waived test, to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

As in to prior years, the CY 2012 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

- New code 86386 is priced at the same rate as code 82487.
- New code 87389 is priced at the same rate as code 86703 plus 50 percent of code 87390.
- Reconsidered code G0434 is priced at the same rate as code G0430.
- Reconsidered code G0435 is priced at the same rate as code 87804.
- Reconsidered code 83861 is priced at the same rate as code 84081.
- Reconsidered code 87906 is priced at the same rate as 50 percent of code 87901.
- Reconsidered code 86481 is priced at the same rate as code 86480 plus code 83520.
- For CY 2012, there are no new test codes that need to be gap filled.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2012 is 3.6 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. **Note:** The Medicare manuals noted in this article are available at <http://www.cms.gov/Manuals/IOM/list.asp>.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

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Clinical lab ... (continued)
Blood product codes

These codes are:

P9010	P9011	P9012	P9016	P9017
P9019	P9020	P9021	P9022	P9023
P9031	P9032	P9033	P9034	P9035
P9036	P9037	P9038	P9039	P9040
P9044	P9050	P9051	P9052	P9053
P9054	P9055	P9056	P9057	P9058
P9059	P9060			

Also, payment for the following codes are applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Sections 20.5 through 20.5.4:

P9010	P9016	P9021	P9022	P9038
P9039	P9040	P9051	P9054	P9056
P9057	P9058			

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine codes

86850	86860	86870	86880	86885
86866	86890	86891	86900	86901
86903	86904	86905	86906	89920
86921	86922	86923	86927	86930
86931	86932	86945	86950	86960
86965	86970	86971	86972	86975
86976	86977	86978	86985	

Reproductive medicine procedure codes

89250	89251	89253	89254	89255
89257	89258	89259	89260	89261
89264	89268	89272	89280	89281
89290	89291	89335	89342	89343
89344	89346	89352	89353	89354
89356				

Additional information

The official instruction, CR 7654, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2365CP.pdf>.

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

MLN Matters® Number: MM7654

Related Change Request (CR) #: 7654

Related CR Release Date: December 9, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2365CP

Implementation Date: January 3, 2012

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Medicare Physician Fee Schedule Database

Summary of policies in the CY 2012 MPFS final rule and the telehealth originating site facility fee payment amount

Provider types affected

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

What you need to know

This article is based on change request (CR) 7671, which summarizes the policies in the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount for CY 2012. Please be sure that your staffs are aware of these changes.

Background

The purpose of this article is to inform you about the CR 7671, which summarizes the policies in the CY 2012 Medicare physician fee schedule (MPFS) and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year.

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2012.
- The final rule (published in the *Federal Register* on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate proposed notices earlier this year:
 - The Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule (published in the *Federal Register* on June 6, 2011), and
 - The Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 (published in the *Federal Register* on July 19, 2011).
- The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the *Federal Register* on November 29, 2010).
- Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

Updated policies

Summary of policies in the CY 2012 MPFS

Misvalued codes under the physician fee schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services that have been identified as misvalued, reducing payments for these services by approximately \$100 million. CMS also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years.

Multiple procedure payment reduction policy

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based

continued on next page

Final rule ... (continued)

on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The MPPR currently applies only to the technical component (TC). The procedure with the highest PC and TC payment would be paid in full. Beginning CY 2012, the PC payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations.

Revisions to the practice expense geographic adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 types of physician services. The Affordable Care Act revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent components of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average while CMS studied the changes that are being undertaken in the 2012 physician fee schedule final rule.

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with section 3102 (b) of the Affordable Care Act and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to the offices of physicians industry to calculate the PE employee wage index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the “all other services” and “other professional expenses” Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of statutory provisions, including a floor of 1.0 for the work GPCI and the limited recognition of cost differences for employee wage and office rent in the PE GPCI, will result in some payment reductions in the areas that benefitted from them in 2010 and 2011. Congress may choose to extend one or both of these provisions for CY 2012 subsequent to the release of this CR. In the event that Congress decides to extend either of these provisions for CY 2012, CMS will update the GPCIs for all impacted areas appropriately.

CMS is additionally basing the GPCI cost share weights on the revised and rebased 2006 MEI finalized by OACT in the CY 2011 final rule with comment period. CMS opted not to adopt the 2006-based MEI for GPCI cost share weights in the 2011 final rule in response to public comments. CMS subsequently addressed many of these commenters concerns in the CY 2012 final rule through the changes that are described above.

The Institute of Medicine (IOM) also has been evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment. Their first report released in full in September includes an evaluation of the accuracy of geographic adjustment factors for the hospital wage index and the GPCIs and the methodology and data used to calculate them. CMS already is implementing many of the IOMs recommendations through the revisions to the GPCIs adopted in the CY 2012 final rule with comment period. Some IOM recommended revisions to the GPCIs will require a change in law.

Implementation of the 3-day payment window policy in wholly-owned or wholly-operated entities

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) was enacted. Section 102 of this Act, entitled “Clarification of 3-Day Payment Window,” clarified when certain non-diagnostic services furnished to Medicare beneficiaries in the three days (or, in the case of a hospital that is not a subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the one day) preceding an inpatient admission should be considered “operating costs of inpatient hospital services” and therefore included in the hospital’s payment under the Hospital Inpatient Prospective Payment System (IPPS). This policy is generally known as the “3-day payment window,” and a hospital must include on the inpatient claim for a Medicare beneficiary’s inpatient stay, the technical portion of all outpatient diagnostic

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Final rule ... (continued)

services and admission-related non-diagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

When a physician's office or clinic that is wholly owned or wholly operated by a hospital furnishes a service subject to the three day payment window policy, Medicare will pay the Professional Component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once a physician's office or practice has received confirmation of a beneficiary's inpatient admission from the admitting hospital, it should, for services furnished during the three day payment window, append CMS payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days) to all claim lines for diagnostic services and for those non-diagnostic services that have been identified as related to the inpatient stay. The new modifier will be available for use on January 1, 2012, and CMS encourages wholly owned or wholly operated physician offices and entities to begin to use the modifier when services are subject to the three day payment window policy. CMS will delay implementation of the policy until July 1, 2012, so that physician's offices and entities may coordinate their internal claims and payment practices. Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

Annual wellness visit providing a personalized prevention plan

The Affordable Care Act provided for Medicare coverage for an annual wellness visits (AWV) providing personalized prevention plan services. The statute required that a health risk assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published "A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries." This framework includes sections on:

- History of health risk assessments,
- Defining the HRA framework and rationale for its use
- Use of HRAs and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

As discussed in the preamble to the CY 2012 physician fee schedule final rule, we believe it is important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

CMS is providing payment for the AWV through the same Level II HCPCS codes as were used in CY 2011 and is adjusting the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.

Molecular pathology procedure codes

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure codes released by the American Medical Association (AMA). However, each of these new molecular pathology procedure codes represents a test that is currently being furnished and which may be billed to Medicare. When these types of tests are billed to Medicare, the existing *CPT* codes are "stacked", or billed in combination with each other, to represent one given test. Under the new *CPT* coding structure for these molecular pathology services, a physician or laboratory would bill Medicare the new, single *CPT* procedure code that corresponds to the test represented by the "stacked" codes rather than billing each component of the test separately. CMS notes that not all of the current "stacked" molecular pathology *CPT* codes represent physicians' services paid on the physician fee schedule (PFS); many are only payable on the clinical laboratory fee schedule (CLFS).

For payment purposes under the PFS and CLFS, these 101 new molecular pathology procedure codes will be assigned a MPFS procedure status indicator of "B" (Bundled Code). Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which

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Final rule ... (continued)

they are incident (for example, a telephone call from a hospital nurse regarding care of a patient)). While these services would traditionally be assigned a procedure status indicator of “I” (Not Valid for Medicare purposes Medicare uses another code for the reporting of, and the payment for these services.), assigning these *CPT* codes a procedure status of B will allow CMS to gather claims information important to evaluating eventual pricing of these new molecular pathology *CPT* codes.

To that end, as of January 1, 2012, Medicare requests that Medicare claims for molecular pathology procedures reflect both the existing “stacked” *CPT* codes that are required for payment and the new single *CPT* code that would be used for payment purposes if the new *CPT* codes were active. While the allowed charge amount will be \$0.00 for the new molecular pathology procedure codes that carry the procedure status indicator of B, Medicare requests that Medicare claims also reflect a charge for the non-payable service. Please note that these *CPT* codes are listed in the CY 2012 PFS final rule as having a procedure status indicator of I—the CY 2012 final rule text and accompanying files will be corrected to reflect the procedure status indicator of B for these 101 molecular pathology *CPT* codes.

Telehealth services

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as kidney disease education (KDE) counseling services and medical nutrition therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the List of Medicare Telehealth services under the “category 2” methodology (“category 1” are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

Telehealth originating site facility fee payment amount

Section 1834(m) of the Social Security Act established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased, as of the first day of the year, by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for CY 2012 is 0.6 percent.

For CY 2012, the **payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or \$24.24.** The beneficiary is responsible for any unmet deductible amount or coinsurance.

Additional information

For more information and access to the CY 2012 final rule, go to the “Physician Fee Schedule” available at http://www.cms.gov/PhysicianFeeSched/01_Overview.asp. The official instruction, CR 7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2371CP.pdf>.

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

MLN Matters® Number: MM7671

Related Change Request (CR) #: 7671

Related CR Release Date: January 4, 2012

Effective Date: January 1, 2012

Related CR Transmittal #: R2371CP

Implementation Date: January 3, 2012

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MACs instructed to temporarily hold claims for services paid under 2012 MPFS

The negative update under current law for the 2012 Medicare physician fee schedule is scheduled to take effect on January 1, 2012, eight business days from today [December 19, 2011]. Consequently, as it has on previous occasions, the Centers for Medicare & Medicaid Services (CMS) will instruct Medicare claims administration contractors (MAC) to hold claims containing 2012 services paid under the MPFS for the first 10 business days of January (i.e., January 1, 2012, through January 17, 2012). The hold should have minimal impact on provider cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before December 31, 2011, are unaffected by the 2012 claims hold and will be processed and paid under normal procedures and time frames.

The administration is disappointed that Congress has failed to pass a solution to eliminate the sustainable growth rate (SGR) formula-driven cuts and has put payments for health care for Medicare beneficiaries at risk. CMS continues to urge Congress to take action to ensure these cuts do not take effect.

CMS will notify providers on or before January 11, 2012, with more information about the status of congressional action to avert the negative update and next steps regarding the claims hold.

Source: CMS PERL 201112-39

Mental Health

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided for Medicare beneficiaries.

Provider action needed

This article is based on Change Request (CR) 7633, which announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women. Make sure your billing staff is aware of these changes.

Background

Pursuant to Section 1861 (ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare program. CMS reviewed the USPSTF’s “B” recommendation and supporting evidence for “Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse” preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking, which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

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Alcohol ... (continued)

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Note: Two new G codes, G0442 (annual alcohol misuse screening, 15 minutes), and G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE). For claims with dates of service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13x, 71x, 77x, and 85x and release those claims beginning April 2, 2012.

For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic

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Alcohol ... (continued)**Claims processing/payment information**

When claims for G0442 or G0443 are submitted with a place of service (POS) code that is not applicable, line-items on those claims will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code CO (contractual obligation)

Medicare will deny claims for G0442 or G0443 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the service billed." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC N95: "This provider type/provider specialty may not bill this service."
- Group code CO.

Rural health clinics (RHCs) using type of bill (TOB) 71x and federally qualified health centers (FQHCs) using TOB 77x may submit additional revenue lines containing G0442 or G0443. Medicare will pay G0442 and G0443 in TOBs 71x and 77x based on the all-inclusive payment rate. However, Medicare will not pay G0442 or G0443 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply to claims for the initial preventive physical examination (IPPE), claims containing modifier 59, or to 77x claims containing diabetes self-management training or medical nutrition Therapy services. If G0442 or G0443 is billed when an encounter/visit with the same line item date of service, Medicare will assign:

- Group code CO to the G0442/G0443 revenue lines; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0442 or G0443 services billed with revenue codes 096x, 097x, or 098x by

Method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge.

Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 5: "The procedure code/bill type is inconsistent with the place of service." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC M77: "Missing/incomplete/invalid place of service."
- Group code CO.

Medicare will allow payment for both G0442 and G0443 on the same date (except in RHCs and FQHCs), but will not pay for more than one G0443 service on the same date. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x without a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0443 that exceed the limit of one on the same date of service will be denied using:

- CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
- RARC M86: "Service denied because payment already made for same/similar procedure within set time frame."
- Group code CO.

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Alcohol ... (continued)

Medicare will track payments for G0442 screening services and G0443 counseling services so as to not permit payment for G0442 more than once in a 12-month period, and for G0443 no more than four times in a 12-month period, beginning with the date of the G0442 service. Claim lines exceeding these limits will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code: CO.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) along with HICR changes.

Additional information

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

The official instruction, CR 7633, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual* at <http://www.cms.gov/Transmittals/downloads/R138NCD.pdf>. The second transmittal at <http://www.cms.gov/Transmittals/downloads/R2358CP.pdf> modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7633

Related Change Request (CR) #: 7633

Related CR Release Date: November 23, 2011

Effective Date: October 14, 2011

Related CR Transmittal #: November 23, 2011

Implementation Date: December 27, 2011, for local contractor system edits; April 2, 2012, for Medicare's shared system edits; July 2, 2012, for provider inquiry screens & HICR changes

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Screening for depression in adults

Provider types affected

Physicians, nonphysician practitioners, rural health clinics (RHCs) and federally qualified health centers (FQHCs) who bill Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries are affected.

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

This article is based on change request (CR) 7637, which informs Medicare contractors that, effective for claims with dates of service on and after October 14, 2011, Medicare will cover annual depression screening for adults in the primary care setting.

Caution – what you need to know

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, G0444, annual depression screening, 15 minutes, as a covered service.

Note: This code will appear on the January 2012 Medicare physicians fee schedule update. The type of service (TOS) for HCPCS code G0444 is 1. Effective October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For dates of service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this change.

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Depression ... (continued)**Background**

Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.



Older adults have the highest risk of suicide of all age groups. These patients are important in the primary care setting because 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Section 1861 (ddd) of the Social Security Act permits the Centers for Medicare & Medicaid Services

(CMS) to add coverage of “additional preventive services” through the national coverage determination (NCD) process if all of the following criteria are met:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services.

Thus, effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

- A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.
- Effective for claims with dates of service on and after April 2, 2012, contractors shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):
 - 11 – Office
 - 22 – Outpatient hospital
 - 49 – Independent clinic
 - 50 – FQHCs
 - 71 – State or local public health clinic
 - 72 – RHCs
- At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus

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Depression ... (continued)

attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.

Note: Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and Web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.

- Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

Claim processing/payment information

When claim line items for annual depression screening (G0444) are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

RHCs using type of bill (TOB) 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0444 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0444 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0444 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0444 revenue line; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system (OPPS). Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0444 services billed with revenue codes 096x, 097x, or 098x by Method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/billed by this type of provider." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

For claims processed on or after April 2, 2012, Medicare will allow payment for G0444 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service, and, for TOB 13x, and TOB 85x when the revenue code is not 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0444 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

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Depression ... (continued)

- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service and the multi-carrier system desktop tool shall display the HCPCS G0444 depression screening sessions.

A MACs/FIs shall hold institutional claims received before April 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0444.

Additional information

The official instruction, CR 7637, was issued to your carrier, FI, or A/B MAC regarding this change via two transmittals. The first transmittal updates the *National Coverage Determinations Manual* and is available at <http://www.cms.gov/Transmittals/downloads/R139NCD.pdf>. The second transmittal is at <http://www.cms.gov/Transmittals/downloads/R2359CP.pdf> and it updates the *Medicare Claims Processing Manual*.

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

MLN Matters® Number: MM7637

Related Change Request (CR) #: 7637

Related CR Release Date: November 23, 2011

Effective Date: October 14, 2011

Related CR Transmittal #: R139NCD and R2359CP

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.

Preventive Services

Intensive behavioral therapy for cardiovascular disease

Provider types affected

Primary care practitioners in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or nurse practitioner in the doctor's office who bill Medicare contractors (carriers, fiscal intermediaries (FIs) or Medicare administrative contractors [A/B MACs]) for providing intensive behavioral therapy (IBT) for cardiovascular disease (CVD) to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7636 which states that effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers intensive behavioral therapy (IBT) for cardiovascular disease (CVD), inclusive of one face-to-face CVD risk reduction visit annually. The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update.

Background

According to Section 1861 of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

continued on next page

Intensive ... (continued)

CMS reviewed the USPSTF recommendations and supporting evidence for IBT for CVD and determined that the criteria listed above was met, enabling CMS to cover this preventive service.

Coverage of IBT for CVD, referred to as a CVD risk reduction visit, consists of the following three components:

1. Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
2. Screening for high blood pressure in adults age 18 years and older; and,
3. Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Key points

- A new HCPCS code, G0446, Annual, face-to-face IBT for CVD, individual, 15 minutes, will be included in the January 2012 updates of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE), effective for services on or after November 8, 2011.
- Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.
- For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.
- Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
- For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:
 - 01 – General practice
 - 08 – Family practice
 - 11 – Internal medicine
 - 16 – Obstetrics/gynecology
 - 37 – Pediatric medicine
 - 38 – Geriatric medicine
 - 42 – Certified nurse midwife
 - 50 – Nurse practitioner
 - 89 – Certified clinical nurse specialist
 - 97 – Physician assistant
- Medicare contractors will pay claims for G0446 only when services are provided for the following place of service (POS):
 - 11 – Physician's office;
 - 22 – Outpatient hospital;
 - 49 – Independent clinic; or,
 - 71 – State or local public health clinic.

Note: Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered

continued on next page

Intensive ... (continued)

primary care settings under this definition. See below for information relative to these services billed on institutional claims by RHCs, type of bill (TOB) 71x, and FQHCs, TOB 77x.

- The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the five A's approach that has been adopted by the USPSTF to describe such services:
 - **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
 - **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
 - **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
 - **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
 - **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
- Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.

Claim processing/payment information

When IBT for CVD claims are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed (ABN) is not on file.

Medicare will deny claims for G0446 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the service billed." **Note:** Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: "This provider type/provider specialty may not bill this service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

RHCs using TOB 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0446 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0446 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0446 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0446 revenue line; and

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Intensive ... (continued)

- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85X will be paid based on reasonable cost, except those G0446 services billed with revenue codes 096x, 097x, or 098x by method II. CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/billed by this type of provider." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

For claims processed on or after April 2, 2012, Medicare will allow payment for G0446 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x with a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0446 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service.

Additional information

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

The official instruction, CR 7636, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual* at <http://www.cms.gov/Transmittals/downloads/R137NCD.pdf>. The second transmittal at <http://www.cms.gov/Transmittals/downloads/R2357CP.pdf> modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7636

Related Change Request (CR) #: 7636

Related CR Release Date: November 23, 2011

Effective Date: November 8, 2011

Related CR Transmittal #: R137NCD and R2357CP

Implementation Dates: December 27 for local Medicare Contractor system edits; April 2, 2012, for Medicare shared system edits; and July 2, 2012, CWF provider screens and HICR changes

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Medicare covers screening and counseling for obesity

Decision adds a new preventive service for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) announced that Medicare is adding coverage for preventive services to reduce obesity. This adds to Medicare's existing portfolio of preventive services that are now available without cost sharing under the Affordable Care Act. It complements the Million Hearts initiative led jointly by CMS and the Centers for Disease Control and Prevention in partnership with other Health and Human Services (HHS) agencies, communities, health systems, nonprofit organizations, and private sector partners across the country to prevent one million heart attacks and strokes in the next five years.

"Obesity is a challenge faced by Americans of all ages, and prevention is crucial for the management and elimination of obesity in our country," said CMS Administrator Donald M. Berwick, MD. "It's important for Medicare patients to enjoy access to appropriate screening and preventive services."

Over 30 percent of both men and women in the Medicare population are estimated to be obese. Obesity is directly or indirectly associated with many chronic diseases, including those that disproportionately affect racial and ethnic minorities such as cardiovascular disease and diabetes. Addressing the prevention of obesity related disparities has the potential to reduce obesity prevalence while also closing the gap on health disparities among Medicare beneficiaries.

Screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians' offices are covered under this new benefit. For a beneficiary who screens positive for obesity with a body mass index (BMI) ≥ 30 kg/m², the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling.

"This decision is an important step in aligning Medicare's portfolio of preventive services with evidence and addressing risk factors for disease," said Patrick Conway, MD, MSc, CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards and Quality. "We at CMS are carefully and systematically reviewing the best available medical evidence to identify those preventive services that can keep Medicare beneficiaries as healthy as possible for as long as possible."

Through the end of October, 22.6 million people with original Medicare have received one or more of the free covered preventive services this year.

To read the final decision on the new national coverage determination, visit the CMS website at: <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253&>.

For more information about Million Hearts, please visit millionhearts.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 201111-71

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Therapy Services

Therapy cap values for calendar year 2012

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare administrative contractors (MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7529, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year (CY) 2012. Therapy caps for 2012 will be \$1880.00. Be sure your billing staff is aware of the update.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended the exceptions to therapy caps through December 31, 2010; and, the Medicare and Medicaid Extenders Act (MMEA) of 2010 extended the therapy caps exceptions through CY 2011. The exceptions process will continue unchanged for the time frame directed by Congress.

Note that the therapy caps apply to outpatient services and do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, therapy caps do not apply to any therapy services billed under the home health PPS, inpatient hospitals, or the outpatient department of hospitals, including critical access hospitals.

Additional information

The official instruction, CR 7529 issued to your carrier, FI, RHHI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2351CP.pdf>.

If you have any questions, please contact your carrier, FI, RHHI 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: MM7529

Related Change Request (CR) #: 7529

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2351CP

Implementation Date: January 3, 2012

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Now you can find the fee schedule information you need faster than ever before with FCSO's fee schedule lookup, located at http://medicare.fcsso.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.

2012 annual update to the therapy code list

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7648, which updates the therapy code list for calendar year (CY) 2012 with one “always therapy” code 92618, *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)*. Please make sure your billing and coding staff are aware of this change.

Background

The Social Security Act (Section 1834(k)(5); (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology* 2012 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

CR 7648 updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2011 and 2012 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/CPT-4). The list of codes can be found at http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp.

CR 7648 updates the therapy code list by adding one “always therapy” code for CY 2012 shown in the table below.

Therapy code	Descriptor
92618	<i>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)</i>

Additional information

The official instruction, CR 7648, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2350CP.pdf>.

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

MLN Matters® Number: MM7648

Related Change Request (CR) #: 7648

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2350CP

Implementation Date: January 3, 2012

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General Coverage

New Affordable Care Act demonstration to provide care at home for Medicare patients

Health care reform law demonstration to improve care, lower costs for seniors and people with disabilities

Up to 10,000 Medicare patients with chronic conditions will now be able to get most of the care they need at home under a new demonstration announced by the Centers for Medicare & Medicaid Services (CMS).

"This program gives new life to the old practice of house calls, but with 21st Century technology and a team approach," said CMS Acting Administrator Marilyn Tavenner.

Created by the Affordable Care Act, the new Independence at Home Demonstration greatly expands the scope of in-home services Medicare beneficiaries can receive. The Independence at Home Demonstration will provide chronically ill patients with a complete range of primary care services. Participation in the demonstration is voluntary for Medicare beneficiaries.

"In my days as a practicing nurse, I saw many patients whose health improved when they were happier with their living conditions," said Tavenner. "When a critically-ill patient can remain in familiar surroundings, the benefits are many: the person retains greater control over their daily lives, families and caregivers report greater satisfaction with the care, and unnecessary hospitalizations are avoided."

CMS will join with medical practices to test the effectiveness of delivering primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations.

The demonstration will reward health care providers that show a reduction in Medicare expenditures through an incentive payment if they succeed in providing high-quality care while reducing costs. CMS will use quality measures to ensure beneficiaries experience high quality care.

Medical practices eligible to participate in the demonstration must include physicians or nurse practitioners who have experience delivering home-based primary care. Up to 50 practices will be selected and each must serve at least 200 Medicare fee-for-service beneficiaries with multiple chronic conditions and functional limitations. Practices in the demonstration will be responsible for coordinating patient care with other health and social service professionals.

The new demonstration is one of a series of CMS initiatives to build a Medicare program that offers beneficiaries better care and better health at an affordable cost. It will be supported by the CMS Innovation Center, which was created by the Affordable Care Act to develop and test new models of health care delivery and payment, and disperse best practices throughout the health care system.

Applications and letters of intent, if applicable, are due on February 6, 2012. Additional information about this demonstration, including how to apply, can be found at http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf.

Questions on this demonstration may be submitted to CMS at: IndependenceAtHomeDemo@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 201112-44

Preparing for version 5010 – deadline Sunday, January 1, 2012

The compliance deadline for the transition to version 5010 is here. Though the Centers for Medicare & Medicaid Services (CMS) announced an enforcement discretionary period of 90 days for version 5010 compliance, the deadline remains Sunday, January 1, 2012. Enforcement will not be exercised until Sunday, April 1, 2012; however, it is important that organizations continue to complete the transition to version 5010 as soon as possible, if they have not done so already.

Version 5010 resources

CMS is committed to helping organizations make a smooth transition to version 5010 and ICD-10. The CMS ICD-10 website has been updated to include a [new Web page](#) dedicated to version 5010 information and resources. CMS has also posted a new [fact sheet](#), which discusses steps providers should be taking now to ensure a timely transition to version 5010.

Other materials on version 5010 include the following fact sheets:

- [“FAQs: Versions 5010 and D.O Transition Basics”](#)
- [“Versions 5010, D.O, and 3.0 Overview”](#)
- [“Version 5010: Testing Readiness, What You Need to Know”](#)
- [“Talking to Your Vendors About ICD-10 and Version 5010”](#)

Additional resources

Stay on top of deadlines and action items for version 5010 and ICD-10 by referencing the following resources on the CMS ICD-10 website:

Interactive widget: A user-friendly tool that outlines the steps to take to ensure compliance with version 5010 and ICD-10.

Timelines: Printer-friendly checklists that complement the widget, which are available for:

- [Large providers](#)
- [Small providers](#)
- [Payers](#), and
- [Vendors](#)

Implementation handbooks: Detailed step-by-step guides on how to implement ICD-10, which have been customized for different audiences including:

- [Small/medium provider practices](#)
- [Large provider practices](#)
- [Small hospitals](#), and
- [Payers](#)

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

Visit the [CMS ICD-10 website](#) for the latest news/resources and to download and share the implementation [widget](#).

Source: CMS PERL 201112-50



Have You Transitioned to 5010?

Don't wait until it's too late ...

Call FCSO EDI: 888.670.0940 (option-5).

Version 5010 enforcement discretion period

How version 5010 changes modify your transition

90-day period of enforcement discretion for compliance with version 5010 deadline

The Centers for Medicare & Medicaid Services (CMS) recently announced a 90-day enforcement discretion period for all HIPAA-covered entities regarding the version 5010 (ASC X12 version 5010) transition.

The compliance deadline for implementation of version 5010 is still January 1, 2012; however, CMS will not initiate enforcement action until March 31, 2012. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition.

CMS encourages you to continue internal and external testing of version 5010 transactions with trading partners to ensure compliance for version 5010. Although enforcement action will not be taken prior to March 31, 2012, it is important that you continue to move forward to meet version 5010 requirements as soon as possible.

During the 90-day enforcement discretion period, the Office of E-Health Standards and Services (OESS) will continue to accept complaints associated with compliance with version 5010, NCPDP D.0 and NCPDP 3.0 transaction standards beginning January 1, 2012. HIPAA-covered entities that are subject to these complaints must produce evidence of either compliance or an established plan to become compliant within the enforcement discretion period. In addition to testing, if you have not yet created a transition plan for version 5010, you should do so in order to meet these compliance deadlines.

Please visit the CMS ICD-10 website [Latest News](#) page for additional resources and more information on this [enforcement discretion period](#).

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

Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201112-01

Medicare fee-for-service policy – 90-day discretionary enforcement period for non-compliant HIPAA covered entities

The Centers for Medicare and Medicaid Services (CMS) has [announced](#) it would not initiate enforcement action with respect to any HIPAA-covered entity that is non-compliant with version 5010, NCPDP, NCPDP D.0, and 3.0 standards until 90 days after the **January 1, 2012**, compliance date. Although compliance will not be enforced for version 5010 until April 1, 2012, it is important to **continue to take the necessary steps to complete your transition to version 5010 as soon as possible**.

What the 90-day discretionary enforcement period means for Medicare fee-for-service (FFS)

Medicare FFS has experienced significant increases in 5010 production transactions during the last few months. However, there are many submitters that have tested but have not taken the step to move into production for 5010 and D.0. In addition, there are many submitters that have not yet initiated testing with their Medicare administrative contractor (MAC). Therefore, to ensure that submitters and receivers continue to make progress, Medicare FFS is planning to take the following steps for submitters and receivers of Medicare Part B and durable medical equipment (DME) transactions:

- In December, submitters and receivers that have tested and been approved for 5010/D.0 will be notified that they have 30 days to cutover to the 5010/D.0 versions.
- Submitters and receivers that have not yet tested will be notified in December that they must submit their transition plans and timelines to their MAC within 30 days.

MACs will notify the submitters and receivers, **but submitters/receivers have the responsibility to notify the providers they service**.

Note: Submitters and receivers of Medicare Part A transactions will follow the same action plan starting 30 days after Part B and DME.

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

Please visit the [CMS ICD-10 website](#) for the latest news and resources, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201112-48

Important Medicare FFS statement regarding versions 5010 and D.0

On November 17, 2011, the CMS Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement action until Saturday, March 31, 2012, with respect to any HIPAA-covered entity that is not in compliance with the ASC X12 version 5010 (version 5010), NCPDP Telecom D.0 (NCPDP D.0), and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains Sunday, January 1, 2012 (small health plans have until Tuesday, January 1, 2013, to comply with NCPDP 3.0).

Medicare fee-for-service (FFS) will soon issue direction to the Medicare administrative contractors (MACs) on how these transactions are to be processed beginning January 2, 2012. Further guidance related to Medicare FFS will be available via listserv messages and the Centers for Medicare & Medicaid Services website.

Source: CMS PERL 201111-49

Additional 5010 transitional changes and further modifications to the national COBA crossover process

Provider types affected

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

What providers need to know

Supplemental payers are transitioning to HIPAA 5010 or National Council for Prescription Drug Programs (NCPDP) D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national Coordination of Benefits Agreement (COBA) crossover process from their production version 4010A1 HIPAA 837 claims to HIPAA versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all "clean" electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 & 4, 2011. Beginning with claims that CMS' Coordination of Benefits Contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

Note: The same premise will hold for inbound version 5.1 batch National Council for Prescription Drug Programs (NCPDP) claims when a supplemental payer moves into production on the NCPDP D.0, version 5.2 batch format for receipt of crossover claims.

As provided in CMS change requests (CRs) 6658 (<http://www.cms.gov/transmittals/downloads/R1844CP.pdf>) and 6664 (<http://www.cms.gov/transmittals/downloads/R1841CP.pdf>), the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226 – "4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims."
- N22230 – "NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims."

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

- 1) The patient's supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims, and
- 2) For a limited timeframe (likely 30 days after a supplemental payer cuts over to version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients' supplemental payers.

continued on next page

COBA ... (continued)**Key points**

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC error reports with error codes N22226 through N22229, regardless of error percentage.
- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with “production” claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient’s supplemental payer and include a specific “222” error code and accompanying description. *MLN Matters*® article MM3709 details the initial CMS instructions to contractors and may be reviewed at <http://www.cms.gov/MLNProducts/articles/downloads/MM3709.pdf>.
- Complete details of the COBA error notification process are included in the official instruction issued to your Medicare contractor and may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf>.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional information

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

If you have any questions about Electronic Data Interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the *Downloads* section of the Electronic Billing & EDI Transactions Web page at <http://www.cms.gov/ElectronicBillingEDITrans/>.

MLN Matters® Number: SE1137

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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Version 5010 resources are available to help your transition

The version 5010 transition deadline is here

The transition deadline to version 5010 is here and involves important business and systems changes throughout the health care industry. The Centers for Medicare & Medicaid Services (CMS) is committed to helping you by providing resources on the CMS ICD-10 website to understand and manage your transition.

Compliance timelines and widget

CMS has created an interactive [widget](#), and corresponding printer-friendly compliance timelines, to help you remember important action items and meet milestones for the switches to version 5010 and ICD-10. The widget and timelines are tailored to help manage the implementation processes for:

- [Large provider practices](#)
- [Small provider practices](#)
- [Payers](#)
- [Vendors](#)

Implementation handbooks

CMS has developed four implementation handbooks which provide detailed information for planning and executing the version 5010 and ICD-10 transition processes. These guides and their corresponding customizable templates can help you to clarify staff roles, set deadlines, and assess vendor readiness. Choose the handbook most relevant to you based upon your organization:

- [Large provider practices](#)
- [Payers](#)
- [Small hospitals](#)
- [Small/medium provider practices](#)

continued on next page

Resources ... (continued)**Version 5010 testing readiness fact sheet**

CMS has also developed a [version 5010 testing readiness fact sheet](#), which explains the version 5010 transition and necessary phase I internal and phase II external testing. This fact sheet can assist you to determine steps to successfully complete testing phases for version 5010, and help ensure you are compliant by January 1, 2012.

Keep up to date on version 5010 and ICD-10

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201111-61

Trading partners should install the latest version of PC-ACE Pro32™ no later than January 1, 2012

What is PC-ACE Pro32™?

PC-ACE Pro32™ is a “stand alone” software package that creates a patient database and allows your office to electronically submit claims to Medicare Part A and Part B. It is available as a free download from Medicare administrative contractors (MACs) upon request for use by Medicare providers for billing Medicare claims. **Note:** CD-ROM versions are available at cost.

How is PC-ACE Pro32™ becoming compliant with ASC X12 5010 on Sunday, January 1, 2012?

Effective Sunday, January 1, 2012, the only available output format for PC-ACE Pro32™ versions 2.32.0.100 and 2.34.0.100 will be the 5010 version. The Sunday, January 1, 2012, changeover was established as part of the version 2.32 (ASC X12 5010) update, prior to issuance of the Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OEHS) 90-day discretionary enforcement announcement. The PC-ACE Pro32™ (versions 2.32.0.100 and 2.34.0.100) update file includes software changes necessary to ensure your PC-ACE Pro32™ claims are submitted in the ASC X12 837 v5010 format. All trading partners should be on the current version of PC-ACE Pro32™ as the software is set up to automatically expire every eight months; therefore, requiring the new version to be downloaded/installed no later than January 1, 2012.

PC-ACE Pro32™ software versions 2.32.0.100 and 2.34.0.100 for ASC X12 v5010 have several CMS Medicare mandates and enhancements:

- The current Pro32 upgrade is applicable to 1.82.0.100 (January 2007) and later versions for the PC-ACE Pro32™ software
- ASC X12 version 5010 errata production software changes:
 - ASC X12 version 4010A1 no longer an option after January 1, 2012
 - ZIP code requires full 9-position value (**Note:** 9-digit patient ZIP code is optional)
 - Billing provider must include physical address and ZIP code (full nine-position value). Post office and lock boxes are not permitted. **Note:** Pay-to-provider may indicate post office and lock boxes.
 - ZIP code on all facility reference file records must include full nine-position value

5010/D.0 implementation calendar**Past events**

For a complete list of past 5010 national provider calls, please visit the [“5010 National Provider Calls section of our Versions 5010 & D.0”](#) Web page.

Links to more information on version 5010, NCPDP D.0, and NCPDP 3.0 are available at www.CMS.gov/Versions5010andD0.

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

Source: CMS PERL 201112-26

All Medicare provider and supplier payments to be made by electronic funds transfer

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of the Centers for Medicare & Medicaid Services' (CMS) revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified and will be required to submit the CMS-588 EFT form with their provider enrollment revalidation applications.

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

Source: CMS PERL 201112-14

Final rule updates medical loss ratio to account for ICD-10 conversion costs

The version 5010 and ICD-10 transitions require significant changes to software and database systems, and may necessitate training for these updated standards and new coding sets. The Centers for Medicare & Medicaid Services (CMS) understands these system conversions can be costly to implement. To help alleviate this financial concern, CMS has released a final rule that addresses medical loss ratio (MLR), which now includes provisions for ICD-10 conversion cost considerations.

What is MLR?

MLR is the ratio of total losses paid in insurance claims divided by the total earned premiums collected by insurers. Regulations of MLR mandate that insurers may only spend 15 or 20 percent of revenue from premiums on expenses that are non-clinical, such as administrative costs, in order to reduce excessive spending. A minimum level of 85 percent of revenue for large group markets and 80 percent for small group markets has been set to be spent only on clinical costs.

How does this change affect ICD-10?

Under this final rule, insurers may shift some of the costs associated with the ICD-10 conversion to the category of clinical cost, which will be considered as quality improvement activity.

This will allow up to 0.3 percent of earned premiums in the relevant state market to be counted as quality improvement activity. This specification of how the MLR is calculated will help covered entities cover some of the cost of ICD-10 implementation. ICD-10 maintenance costs and claims adjudication system costs are still considered to be administrative, and thus will fall under the MLR restriction on non-clinical spending limits.

This [final rule](#) will be effective on January 1, 2012, and will be open for public comment until January 6, 2012. The final rule addresses comments made in the interim rule published in January 2011.

Keep up to date on version 5010 and ICD-10

Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#).

Source: CMS PERL 201112-24

'Medicare Remit Easy Print Software' brochure revised

The "[Medicare Remit Easy Print Software](#)" brochure (ICN 006903) is designed to provide education about Medicare Remit Easy Print (MREP) software that enables physicians and suppliers to view and print their remittance information. It includes a basic software overview, the benefits of using electronic remittance information, minimum system requirements, and available resources.

Source: CMS PERL 201111-44

Medicare fee-for-service FFS Part B editing of the national drug code

Effective December 9 Medicare fee-for-service (FFS) turned off the current ASC X12 version 5010 common edit and enhancements module (CEM) national drug code (NDC) validation edit for Medicare Part B. The specific NDC edit being turned off is the loop ID 2410 LIN03 and requires that the NDC be validated against the Food and Drug Administration's (FDA) NDC code list. A replacement NDC edit will be implemented in the Part B CEM for the January 2012 shared system quarterly release, which will perform syntactical editing only of the NDC submitted in loop ID 2410 LIN03.

A similar announcement will be disseminated when the Part A NDC edit is deactivated.

Background of the national drug code

The NDC is a unique product identifier used for drugs intended for human use and is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting or adjudication processes. The Drug Listing Act of 1972 requires registered drug establishments to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. Drug products are identified and reported using the NDC.

The NDC is a unique number expressed in three sections. This numeric identifier is assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The sections identify the labeler or vendor, the product (within the scope of the labeler), and the type of package (of this product). The ASC X12 TR3 documents stipulate that the 5-4-2 expression of NDC values must be used. However, the FDA does not have a version of the NDC in this (5-4-2) format. Therefore, the Centers for Medicare & Medicaid Services (CMS) has created a version of the NDC in the 11-byte numeric NDC derivative, which pads the product code (four positions) or package code (two positions) sections of the NDC with a leading zero thus resulting in a fixed length 5-4-2 configuration.

Additional information on version 5010, NCPDP D.0, and NCPDP 3.0 is available at www.CMS.gov/Versions5010andD0.

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

Source: CMS PERL 201112-37



Health care provider taxonomy code set update: Effective January 1, 2012

Effective January 1, 2012, the health care provider taxonomy code (HPTC) set, which allows providers to indicate their specialty, will be updated. The National Uniform Claim Committee (NUCC) updates the code set twice a year with changes effective April 1 and October 1. The latest version of the HPTC set is available from the Washington Publishing Company's website at: www.wpc-edi.com/codes/taxonomy. If an invalid HPTC is reported to Medicare, a batch and/or claim-level deletion (rejection) may occur. To ensure you do not receive a claim or file-level rejection, it is recommended that you verify the HPTC is valid (i.e., included in the most recent HPTC set) before submitting. If you require assistance with updating the taxonomy code set in your practice management system, please contact your software support vendor.

Source: Pub. 100-04, Transmittal 2272, change request 7530

Provider Enrollment

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

Note: This article was revised on November 8, 2011, to reflect a revised change request (CR) 6417. The CR release date, transmittal number and Web address for accessing the CR were changed. All other information is the same. Also remember that 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 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 August 2011 *Medicare B Connection* pages 35-37.

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/MLNMMattersArticles/downloads/MM6421.pdf>.)

Provider action needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty 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

continued on next page

Ordering/Referring ... (continued)

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 claim 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 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/R991OTN.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: November 1, 2011

Effective Dates: Phase 1: October 5, 2009,

Related CR Transmittal #: R991OTN

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

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Get accredited now for advanced diagnostic imaging

As a reminder, beginning Sunday, January 1, 2012, suppliers who furnish the technical component of advanced diagnostic imaging (ADI) must be accredited in order to bill Medicare for these services. ADI procedures include magnetic resonance imaging (MRI), computed tomography (CT), nuclear medicine imaging, and positron emission tomography. X-ray, ultrasound, fluoroscopy, and hospital outpatient procedures are excluded. The technical component of ADI services includes the performance of the imaging procedures, not the physician interpretation.

For dates of service on or after January 1, Medicare administrative contractors (MACs) will begin denying claims for the technical component of ADI that are submitted under the physician fee schedule by suppliers who have not yet been accredited. Once a supplier becomes accredited, they can begin billing Medicare for these services again.

For more information about ADI Accreditation, including a list of accrediting organizations and details of the accreditation process, please visit http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp. An MLN special edition article on this subject – “Important Reminders about Advanced Diagnostic Imaging Accreditation Requirements” (MLN SE1122) – is also available at <http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf>.

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

Source: CMS PERL 201112-08

ADI certification information is not required via enrollment process

In January 2012, all Part B suppliers including physicians, and non-physician practitioners performing the technical component of advanced diagnostic imaging services – also known as ADI – who are paid under the Medicare physician fee schedule will need to be accredited by one of the Centers for Medicare & Medicaid Services (CMS)-approved accrediting organizations. The accreditation organization will transmit all necessary data to CMS on an ongoing basis; your Medicare billing contractor will receive this data from CMS. Due to this file being received at CMS from the accrediting organizations, it is not necessary for the providers to supply the ADI information on their respective CMS-855 form(s) or in the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

Reminder: When submitting your information to the accrediting organization, make sure you provide the national provider identifier (NPI) that you used to register the legal business name of the facility in the National Plan and Provider Enumeration System (NPPES). If you provided the incorrect NPI, please notify your accrediting organization as soon as possible.

See the following *MLN Matters*® articles for more information on the ADI certification requirement:

- [Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component \(TC\) of Advanced Diagnostic Imaging \(ADI\) Services](#)
- [Advanced Diagnostic Imaging Accreditation Enrollment Procedures](#)

Source: CMS PERL 201112-29

Advanced diagnostic imaging accreditation enrollment procedures

Note: This article was revised on November 17, 2011, to refer providers to *MLN Matters*® article SE1122 at <http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf> for important new information about these accreditation requirements. That information is that providers need not submit their ADI data on their 855 enrollment forms or via the PECOS enrollment system. The Centers for Medicare & Medicaid Services (CMS) receives that data from the accrediting organizations. In the near future, CR 7177 and this article will be further modified to reflect this information. This information was previously published in the August 2011 *Medicare B Connection* pages 39-40.

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 technical component (TC) of advanced diagnostic imaging procedures.

continued on next page

Accreditation ... (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

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/MLN MattersArticles/downloads/MM7176.pdf>) and SE1122 available at <http://www.cms.gov/MLN MattersArticles/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

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Complete NPIs will no longer be included in CMS' ordering and referring reports

In response to concerns raised by the provider community, the Centers for Medicare & Medicaid Services (CMS) will include only the last four digits of the national provider identifier (NPI) of physicians and non-physician practitioners listed in its ordering and referring reports. The ordering and referring reports may be found in the "Downloads" section at http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp.

The following reports will be updated shortly to only contain the last four digits of the NPI:

- "Ordering/Referring Report"
- "Initial Physician Applications Pending Contractor Review"
- "Initial Non Physician Applications Pending Contractor Review"

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

Source: CMS PERL 201111-59

Transcript of 'Revalidation of Medicare Provider Enrollment' national provider call now available

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). The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, October 27, 2011, to discuss:

- The revalidation process
- Improvements to the Provider Enrollment, Chain and Ownership System (PECOS)
- Advanced diagnostic imaging and accreditation
- Application fees
- Changes to the 855A form

Don't miss this opportunity to hear from CMS experts on this important topic. Click on [National Provider Call on Revalidation of Medicare Provider Enrollment](#) to view the transcript. This transcript contains a number of post call clarifications – such as where to find the listing of providers which have received a notice to revalidate. The audio file will be posted in the near future.

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

Source: CMS PERL 201111-38

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Incentive Programs

2012 eRx payment adjustment: Assessment and application

Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) electronic prescribing (eRx) incentive program are affected.

What you need to know

This *MLN Matters*® special edition article describes how the 2012 eRx payment adjustment was 1) calculated and 2) applied for individual eligible professionals, and group practices participating in eRx group practice reporting option (GPRO).

Eligible professionals who met the eRx payment adjustment inclusion criteria, but who failed to meet the reporting requirements in 2011, may receive the 2012 eRx payment adjustment starting January 1, 2012. The 2012 eRx payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice participating in eRx GPRO receiving 99 percent (1 percent less) of their Medicare Part B physician fee schedule (PFS) amount that would otherwise apply to such services.

Background

Under Section 1848(a)(5)(A) of the Social Security Act, eligible professionals who are not successful electronic prescribers under the eRx incentive program will be subject to a payment adjustment in 2012.

An eligible professional was included in the 2012 eRx payment adjustment analysis if they meet all of the following criteria:

- Was a physician (M.D., D.O., or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES);
- Had prescribing privileges from January 1-June 30, 2011;
- Had at least 100 cases containing an encounter code in the measure's denominator from January 1-June 30, 2011; and
- Had 10 percent or more of their Medicare Part B allowable charges (per tax identification number [TIN]) from January-June 30, 2011 were for encounter codes in the measure's denominator

Eligible professionals were automatically excluded from the 2012 eRx payment adjustment analysis if they did **not** meet one of the above criteria.

In addition, eligible professionals could have taken the following steps from to avoid the 2012 eRx payment adjustment:

- Submitted 10 or more 2011 eRx quality-data codes (G8553) for Medicare Part B PFS services via claims from January 1-June 30, 2011;
- Indicated that the eligible professional met criteria for a hardship exemption for either living in a rural area without sufficient high speed internet (G8642), or practiced in an area without sufficient pharmacies that can accept eRx (G8643) via claims from January 1-June 30, 2011;
- Indicated that the eligible professional did not have prescribing privileges (G8644) via claims from January 1-June 30, 2011; or
- Requested a hardship exemption via the Quality Reporting Communication Support page on or before November 8, 2011, and received CMS approval.



continued on next page

2012 eRx ... (continued)**Assessing and applying the 2012 eRx payment adjustment****2012 eRx assessment**

An eligible professional who meets the eRx program inclusion criteria will be subject to the 2012 eRx payment adjustment if (s)he did not submit the following:

- 10 valid 2011 eRx G-codes (G8553) via claims during the 6-month reporting period of January 1, 2011 – June 30, 2011; or
- A hardship exemption (G8642, G8643) via claims during the 6-month reporting period; or
- A G-code via claims indicating (s)he did not have prescribing privileges (G8644) during the 6-month reporting period; or
- (S)he requested and was granted a hardship exemption through the Quality Reporting Communication Support Page.

CMS analysis of all valid 2011 eRx QDCs submitted with a date of service during the 6-month reporting period determines whether or not the payment adjustment applies to the eligible professional.

Group practices participating in eRx GPRO who would be subject to the payment adjustment is defined as a TIN who:

- Failed to meet the 2011 eRx criteria for successful reporting during the 6-month reporting period of January 1–June 30, 2011; or
- Failed to indicate a hardship or lack of prescribing privileges to CMS

The analysis of successful reporting for group practices that participate in eRx GPRO will be performed at the TIN level to identify the group's services and quality data. All NPIs under the TIN during the six-month reporting period for 2011 (January 1–June 30, 2011) will receive the payment adjustment if the group practice participating in eRx GPRO is subject to the payment adjustment.

For eligible professionals who submitted claims under multiple TINs, CMS groups claims by unique TIN/ NPIs for analysis and payment adjustment purposes. As a result, an eligible professional who submitted claims under multiple TINs may be subject to an eRx payment adjustment under one of the TINs and not the other(s), or may be subject to a payment adjustment under each TIN.

Application

- The eRx payment adjustment for not being a successful electronic prescriber will result in an individual eligible professional, or group practice participating in eRx GPRO, receiving 99 percent of his or her Medicare Part B PFS amount that would otherwise apply to such services (or 1 percent less reimbursement) for all charges with a date of service from January 1–December 31, 2012.
- Providers who receive the 2012 eRx payment adjustment will see the term “LE” on their remittance advice for all Medicare Part B services rendered January 1 – December 31, 2012. The remittance advice will also contain the following claim adjustment reason code (CARC) and remittance advice remark code (RARC):
 - CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).
 - RARC N545 – Payment reduced based on status as an unsuccessful e-prescriber per the electronic prescribing (eRx) incentive program.
- The TIN/NPI (or group practice participating in eRx GPRO TIN) will receive automatically-adjusted 2012 Medicare Part B reimbursements as (s)he normally would for Medicare Part B PFS-covered professional services furnished to Medicare beneficiaries.
- The 2012 eRx payment adjustments will be applied separately from the 2011 eRx incentive program or any other CMS incentive program payments.

continued on next page

2012 eRx ... (continued)

- If a TIN/NPI or group practice participating in eRx GPRO TIN submits claims to multiple Medicare claims processing contractors (carriers or Medicare administrative contractors [MACs]) and is subject to the eRx payment adjustment, each contractor will pay out 1 percent less for all the Medicare Part B PFS claims the contractor processes with a date of service from January 1 – December 31, 2012.

Frequent concerns

- If the TIN/NPI or group practice that participates in eRx GPRO TIN receives the payment adjustment in error, the claim will be reprocessed to return the 1.0 percent and the remittance advice for the reprocessed claim will include the following codes and messages:
 - CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).
 - RARC N546 – Payment represents a previous reduction based on the electronic prescribing (eRx) incentive program.
- If an individual eligible professional (TIN/NPI) or group practice participating in eRx GPRO submitted an eRx QDC G8553 indicating a valid eRx event in addition to submitting a hardship or lack of prescribing privileges code (or notifies CMS of a hardship or lack of prescribing privileges for group practices participating in eRx GPRO), the hardship/lack of prescribing privileges will take precedence.
- If the eligible professional is enrolled in Medicare, but does not “participate” (non-PAR) by accepting Medicare’s allowed charge for services provided, (s)he should contact his/her Part B carrier or A/B MAC for instruction on how the 2012 eRx payment adjustment will be applied and the amount (s)he can initially charge the beneficiary when the service is provided.

Additional information

For more information about the 2012 eRx payment adjustment, please refer to the ‘How to Get Started’ and ‘Payment Adjustment Information’ sections of the CMS eRx Incentive Program website at <http://www.cms.gov/ERxIncentive> and the “2012 eRx Payment Adjustment Quick Reference Guide.”

MLN Matters® special edition article SE1107, “2011 Electronic Prescribing (eRx) Incentive Program Update – Future Payment Adjustments,” is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1107.pdf>.

“Medicare’s Practical Guide to the Electronic Prescribing (eRx) Incentive Program” is available at <http://www.cms.gov/partnerships/downloads/11399-P.pdf>.

Additional assistance is also available from the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or qnetsupport@sdps.org Monday-Friday from 7:00 a.m. to 7:00 p.m. CST.

MLN Matters® Number: SE1141

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

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Implementation Date: N/A

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Proposed meaningful use timeline changes encourage adoption of EHRs

In response to significant input from multiple stakeholders, expert testimony, and countless hours of review, analysis and deliberation, the Department of Health & Human Services (HHS) [announced](#) its intention to delay the start of stage 2 [meaningful use](#) for the Medicare and Medicaid electronic health record (EHR) incentive programs for a period of one year for those first attesting to meaningful use in 2011. The Centers for Medicare & Medicaid Services (CMS) intends to propose such a delay in the stage 2 meaningful use notice of proposed rulemaking (NPRM), which is scheduled to be published in February 2012.

Why did CMS make this decision?

Input from the vendor community and the provider community makes clear that the current schedule for compliance with stage 2 meaningful use objectives in 2013 poses a challenge for those who are [attesting](#) to meaningful use in 2011.

The current timetable would require EHR vendors to design, develop, and release new functionality, and for providers to upgrade, implement, and begin using the new functionality as early as October 2012.

What are the benefits to the proposed delay?

CMS believes that a proposed delay will be beneficial for several reasons:

- CMS hopes that this will give vendors added time to develop certified EHR technologies for stage 2, as well as give providers additional time to implement new software and meet the new requirements of stage 2.
- CMS also intends to propose maintaining the current expectation for those first attesting to meaningful use in 2012, so that all providers attesting to meaningful use in 2011 or 2012 will begin stage 2 in 2014.
- CMS believes this provides an added incentive for providers to attest to meaningful use in 2011 and rewards early participants.

Under the Medicare and Medicaid EHR incentive programs, providers who attest early receive greater incentives. And now those providers who first attest in 2011 are eligible for three payment years for meeting the stage 1 criteria, while those first attesting in 2012 can only have two payment years under stage 1 criteria.

Are Medicaid program participants affected?

Because Medicaid providers can receive an incentive payment for adopting, implementing, or upgrading to certified EHR technology in their first year of [Medicaid EHR incentive program](#) participation, Medicaid providers will still be able to attest to stage 1 meaningful use for the next two years (first for a 90-day period, then for a 365-day period).

Therefore, most Medicaid providers do not attest to stage 2 requirements until 2014 at the earliest.

Want more information about the EHR incentive programs?

Make sure to visit the [EHR incentive programs](#) website for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201112-21

New Medicare and Medicaid EHR incentive programs FAQs

The Centers for Medicare & Medicaid Services wants to keep you updated with the latest information about the Medicare and Medicaid Electronic Health Record (EHR) incentive programs. These new frequently asked questions (FAQs) include information about clinical quality measures (CQMs), meaningful use, attestation, and other Medicare and Medicaid EHR incentive programs topics.

1. Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete CQM data for the Medicare and Medicaid EHR incentive programs? [Read the answer.](#)
2. Do providers have to contribute a minimum dollar amount toward their certified EHR technology for the Medicare and Medicaid EHR incentive programs? [Read the answer.](#)
3. Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives for the EHR incentive programs? [Read the answer.](#)
4. Can two separate practices with two different tax identification numbers (TINs) purchase a single certified EHR system and share it in order to participate in the Medicare and Medicaid EHR incentive programs? [Read the answer.](#)

continued on next page

FAQs ... (continued)

5. For the Medicare and Medicaid EHR incentive programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures? [Read the answer.](#)
6. For the EHR incentive programs, how should an eligible hospital or CAH with multiple certified EHR systems report their CQMs? [Read the answer.](#)
7. Does the person who completes the registration for the EHR incentive programs need to be the same person who completes the attestation? [Read the answer.](#)
8. For the meaningful use objective “Capability to submit electronic syndromic surveillance data to public health agencies,” what is the definition of “syndromic surveillance”? [Read the answer.](#)

Want more information about the EHR incentive programs?

Make sure to visit the [CMS EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201111-11

Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota launched Medicaid EHR programs

On Monday, November 7, 2011, the Medicaid electronic health record (EHR) incentive program launched in Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota. This means that eligible professionals (EPs) and eligible hospitals in these six states will be able to complete their incentive program registration. More information about the Medicaid EHR incentive program can be found on the [Medicare and Medicaid EHR Incentive Program Basics](#) page of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you are a resident of Arkansas, Delaware, Montana, New Jersey, New York, or North Dakota, and are eligible to participate in the Medicaid EHR incentive program, visit your state Medicaid agency website for more information on your state's participation in the Medicaid EHR incentive program. Click on a state below to access its website.

- [Arkansas](#)
- [Delaware](#)
- [Montana](#)
- [New Jersey](#)
- [New York](#)
- [North Dakota](#)

As of Monday, November 7, 2011, 39 states have launched Medicaid EHR incentive programs; and through October, 23 states have issued incentive payments to Medicaid EPs and eligible hospitals who have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the [Medicaid State Information](#) page on the CMS EHR website.

Want more information about the EHR incentive programs?

Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201111-42

Payment and registration data on Medicare and Medicaid EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has created a [Web page](#) where you can find Medicare and Medicaid Electronic Health Record (EHR) Incentive Program payment and registration data. The page includes up-to-date information about the programs through October 2011. The new page will be your resource for updates regarding the programs' registration, payment, and state Medicaid launches.

The Data and Reports page includes the following information:

- A map that illustrates a state breakdown of payments to Medicare and Medicaid providers
- A map that illustrates a state breakdown of registration by Medicaid and Medicare providers
- A map that illustrates a state breakdown of registration by Medicare providers
- A map that illustrates a state breakdown of registration by Medicaid providers
- Individual state report of registrants and payments
- Updates on state launches of Medicaid EHR program
- List of recipients of Medicare EHR incentive program payments

You can use the maps to see how your state compares to others in [registration](#) and [payment](#) totals for the EHR incentive programs.

October highlights

Below are some highlights about the EHR incentive programs from data through October 2011 that are now featured on the new page:

- Over 135,000 Medicare and Medicaid providers have registered for the programs
- Over \$525 million in Medicare payments have been provided to eligible professionals and eligible hospitals
- Over \$710 million in Medicaid payment have been provided to eligible professionals and eligible hospitals

Want more information about the EHR incentive programs?

Make sure to visit the [EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201112-15

Notification of final primary care incentive program files for payment year 2012

Primary care physicians and non-physicians practitioners may confirm 2012 primary care incentive payment eligibility (PCIP) by checking the "PCIP.Payment.CY2012" file to ensure their national provider identifier (NPI) is listed. Contractors will post the "PCIP.Payment.CY2012" file to their websites no later than January 31, 2012.

Source: CMS PERL 201111-47

Learn about CMS' primary care incentive program with new PCIP FAQs

Per Section 5501(a) of the Affordable Care Act, the primary care incentive payment program (PCIP) authorizes an incentive payment of 10 percent of Medicare's program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015.

The Centers for Medicare & Medicaid Services (CMS) has posted 22 frequently-asked questions (FAQs) items related to the PCIP. These new FAQs can be found [here](#). Alternatively, these FAQ items can be found by visiting <http://questions.CMS.hhs.gov/> and searching for "PCIP" or "primary care incentive payment."

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

Source: CMS PERL 201111-46

Multi-stakeholder group input on quality measures for 2012

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a list of quality and efficiency measures being considered for adoption in calendar year 2012.

Per the statutory requirements of Section 3014 of the Affordable Care Act, a new federal “pre-rulemaking process” has been established. This process includes, but is not limited to, making publicly available by December 1 a list of measures currently under consideration for qualifying programs, including measures suggested by the public and subject to multi-stakeholder group review and input (as convened by the National Quality Forum).

For more information on this process, please visit www.CMS.gov/QualityMeasures/MultiStakeholderGroupInput.

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

Source: CMS PERL 201112-05

Updated information on clinical quality measures

The Centers for Medicare & Medicaid Services (CMS) suggests that eligible professionals participating in the Medicare and Medicaid electronic health records (EHR) incentive programs not select “NQF 0084: Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation” as one of their additional clinical quality measures (CQMs) for meaningful use. As there are other FDA-approved medications available for use as an anticoagulant, CMS suggests this measure not be selected as one of the measures reported for the CQM objective.

CMS does not expect eligible professionals to change their certified EHR systems or purchase another system to replace this measure. Eligible professionals may continue to report NQF 0084 for the 2011-2012 program years if their certified EHR system uses a module that is only certified for nine CQMs with this measure included as one of the nine.

To view all 44 clinical quality measure specifications, please download the [EP Measure Specifications](#).

Additionally, the [Guide to Clinical Quality Measures](#) provides an overview of CQMs, how to choose the appropriate CQMs for meaningful use, and how CQMs are reported during attestation.

Want more information about the EHR incentive programs?

Make sure to visit the [EHR Incentive Program website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201112-16

General Information

CMS announces new demonstrations to help curb improper Medicare and Medicaid payments

Efforts will build on 2011 decreases in Medicare and Medicaid improper payments

In 2010, the President announced three goals for cutting improper payments by 2012: Reducing overall payment errors by \$50 billion, cutting the Medicare fee-for-service error rate in half, and recovering \$2 billion in improper payments.

To help achieve these goals, the Centers for Medicare & Medicaid Services (CMS) has announced it will launch demonstration programs beginning in January 2012 that will target some of the most common factors that lead to improper payments.

Cost saving projects will help protect Medicare and Medicaid

Beginning January 1, 2012, CMS will conduct demonstration projects that will strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sound future of the Medicare trust fund and protect Medicare beneficiaries who depend upon it such as:

- Recovery audit prepayment review
- Prior authorization for certain medical equipment
- Part A to Part B rebilling

continued on next page

Demonstrations ... (continued)

This past May, the Department of Health and Human Services (HHS) announced a pilot project under the Partnership Fund for Program Integrity Innovation to test an automated tool to screen providers for the risk of fraud. Currently, HHS and states lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help states focus their resources where fraud is most likely to occur.

New projects build on 2011 savings

The 2012 projects announced will build on accomplishments in 2011 to reduce Medicare and Medicaid improper payment rates.

CMS is also reporting for the first time a composite improper payment rate for the Medicare Part D prescription drug program. The improper payment rate for the Children's Health Insurance Program (CHIP) will not be published until 2012.

While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid, or CHIP, they do provide HHS, CMS, and states with a more complete assessment of factors leading to error rates and new ways to help prevent them.

CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training, education, and outreach.

The full CMS fact sheet is available at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4176>.

Additional fact sheets issued November 15

- CMS prior authorization fact sheet – <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4168>
- CMS rebilling fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169>
- CMS recovery audit (RAC) demo fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170>
- CMS Medicaid fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4171>
- CMS Medicare D fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4172>
- CMS Medicare C fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4175>
- CMS Medicare improper payments fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4174>

Also, please see the *White House Press Release – We Can't Wait: Agencies Cut Nearly \$18 Billion in Improper Payments, Announce New Steps for Stopping Government Waste* – <http://www.whitehouse.gov/the-press-office/2011/11/15/we-can-t-wait-agencies-cut-nearly-18-billion-improper-payments-announce->

- Agency improper payment data – www.paymentaccuracy.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 201111-34

CY 2012 update to the AIC requirements for ALJ and Federal District Court appeals

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or Federal District Court (fifth level) review. The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2011, is \$130. This amount remains the same for calendar year 2012. The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2011, is \$1,300. This amount increases to \$1,350 for appeals to Federal District Court filed on or after January 1, 2012.

Source: TDL 12113

Release of a national provider comparative billing report on nerve conduction studies

On Tuesday, December 6, 2011, the Centers for Medicare & Medicaid Services (CMS) released a national provider comparative billing report (CBR) addressing nerve conduction studies.

CBRs produced by Safeguard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in their state and across the nation.

These reports are not available to anyone except 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 conform to Medicare billing rules and improve the level of care they furnish to their Medicare patients. 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 and make them available to providers.

For more information and to review a sample of the CBR on Nerve Conduction Studies, please visit the CBR Services website, located at 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 201111-40

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2011, must be paid before the end of business on March 31, 2011.

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

The new rate of 2.625 percent is in effect through June 30, 2012.

Interest is not paid on:

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

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

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

Update to Medicare deductible, coinsurance and premium rates for 2012

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2012. Be sure billing staffs are aware of these updates.

continued on next page

Deductible ... (continued)

Background

2012 Part A – hospital insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Note: An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness. **The 2012 inpatient deductible is \$1,156.00.** The coinsurance amounts are shown below in the following table:

Hospital coinsurance		Skilled nursing facility coinsurance
Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
\$289.00	\$578.00	\$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary enrollees Part A premium schedule for 2012	
Base premium (BP)	\$451.00 per month
Base premium with 10 percent surcharge	\$496.10 per month
Base premium with 45 percent reduction	248.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$272.80 per month

2012 Part B – supplementary medical insurance (SMI)

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- Standard premium: \$99.90 a month
- Deductible: \$140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

Additional information

The official instruction, CR 7567, issued to your carriers, FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R72GI.pdf>.

continued on next page

Deductible ... (continued)

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

MLN Matters® Number: MM7567

Related Change Request (CR) #: CR 7567

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R72GI

Implementation Date: January 3, 2012

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Medicare Shared Savings program application package now available on CMS' website

The Shared Savings program application Web page, located at http://www.CMS.gov/sharedsavingsprogram/37_Application.asp, has been updated to include links to the notice of intent to apply (NOI) and the complete Shared Savings program application package. You will find links to the NOI and application in the *Downloads* section of the Web page. The complete application includes the following documents:

- Medicare Shared Savings Program application 2012
- Appendix A – electronic funds transfer (EFT) authorization agreement (CMS Form 588)
- Appendix B – participant list
- Appendix C – data use agreement (DUA)
- Appendix D – application reference guide

Submitting the NOI is the first step in the application process. The second step is submitting the application and the accompanying required documents.

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

Source: CMS PERL 201111-41

Tools to help people with Medicare and their caregivers compare healthcare options

The Centers for Medicare & Medicaid Services (CMS) has created the [Quality Care Finder](#) as a collection of helpful tools on the [Medicare.gov](#) website to help consumers research their healthcare options. These online research tools can help your Medicare patients and their caregivers compare healthcare providers, facilities, health and drug plans, equipment suppliers and more.

[Quality Care Finder](#) includes the following tools:

- **Hospital Compare:** Compare Medicare-certified hospitals locally and throughout the country based on the quality of their care.
- **Nursing Home Compare:** Find Medicare-certified nursing homes and the special services each nursing home offers, like dementia care, ventilators or rehabilitation. Then compare their star ratings and the quality of care they give.
- **Home Health Compare:** Find Medicare-certified home health agencies based on services like skilled nursing care, physical therapy, speech therapy and home health aides. Then, compare each home health agency based on the quality of their care.
- **Dialysis Facility Compare:** Find Medicare-certified dialysis facilities and their services. Then, compare each facility based on quality of care.

continued on next page

Tools ... (continued)

- **Physician Compare:** Find doctors, and other medical professionals, based on location, specialty, clinical training, foreign languages spoken, and more. Check to see if a doctor accepts the Medicare-approved amount as full payment.
- **Medicare Plan Finder:** Get detailed, personalized information about the cost and benefits of available Medicare health and drug plans, and compare the quality of the services they provide.

CMS has developed several publications about the [Quality Care Finder](#) tools that can be shared with your Medicare patients and their caregivers:

- [Find and Compare High-Quality Healthcare Options \(Pub. # 11580\)](#)
- [Quality Care Finder: Find High-Quality Healthcare Options \(Pub. # 11581\)](#)

These publications may be downloaded or ordered from the [Medicare.gov Publications](#) page.

Source: CMS PERL 201112-30

Health care law will allow patients to compare options and find best value

Consumers and employers will have the health care information they need to make more informed choices about their care, thanks to the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) announced in a final rule.

The rule gives qualified organizations, like employers and consumer groups, access to data that can help them identify high quality health care providers or create online tools to help consumers make educated health care choices. Information that could identify specific patients, however, will not be publicly released and strong penalties will be in place for any misuse of data.

The final rule makes a number of important changes from the original proposed rule. The final rule makes this data less costly for qualified entities, gives qualified organizations more flexibility in their use of Medicare data to create performance reports for consumers, and extends the time period for health care providers to confidentially review and appeal performance reports before they become public. The rule also includes strict privacy and security requirements to protect patients, health care providers, and suppliers as well as stringent penalties for any misuse of Medicare data.

For more information on the final rule, visit <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4205>.

The final rule on "Availability of Medicare Data for Performance Measurement" is on display at the Office of the Federal Register at http://www.ofr.gov/OFRUpload/OFRData/2011-31232_PI.pdf or <http://www.archives.gov/federal-register/public-inspection>.

To read the entire CMS press release, visit http://www.CMS.gov/apps/media/press_releases.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 201112-13

Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

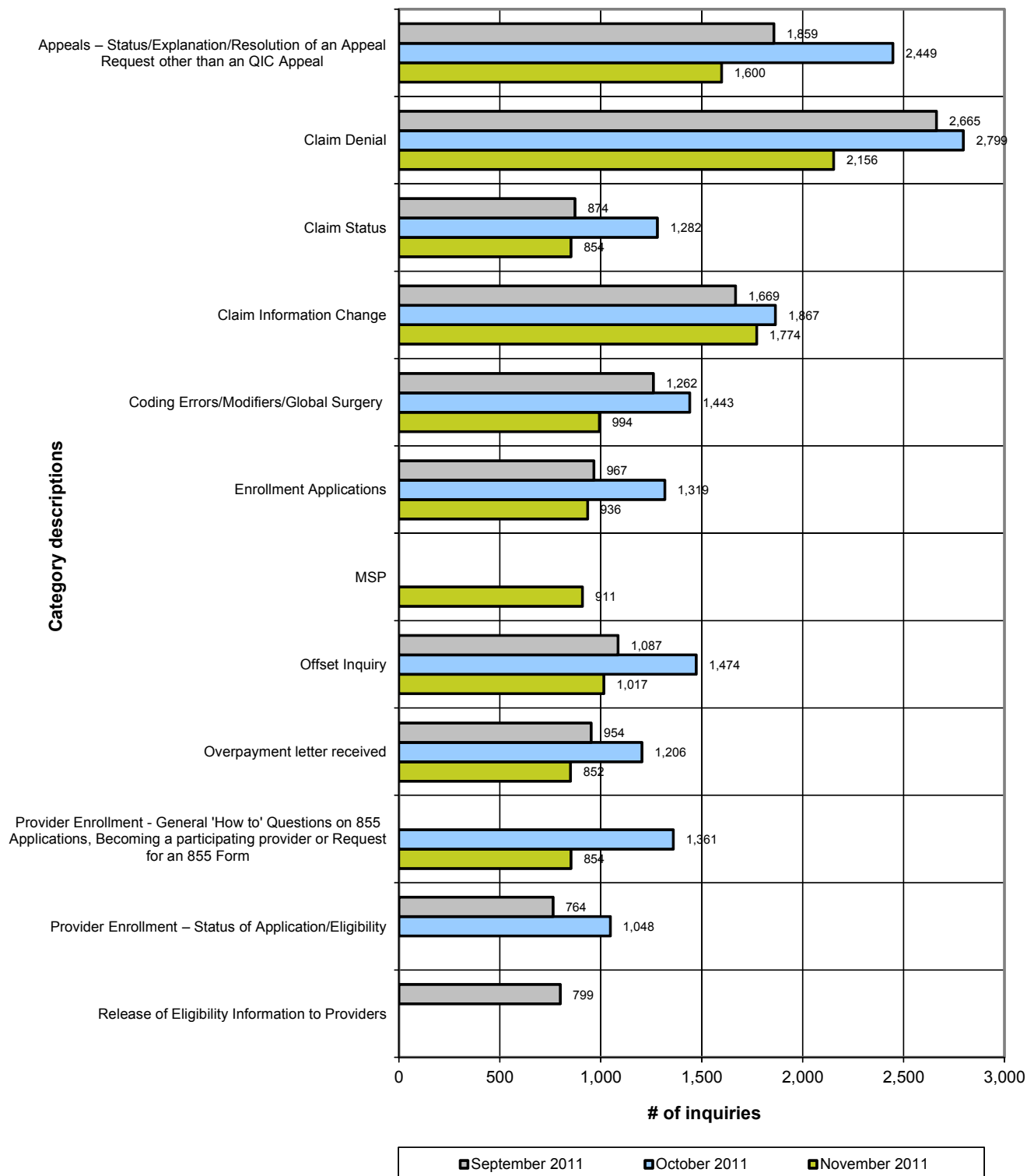
The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

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 September-November 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.

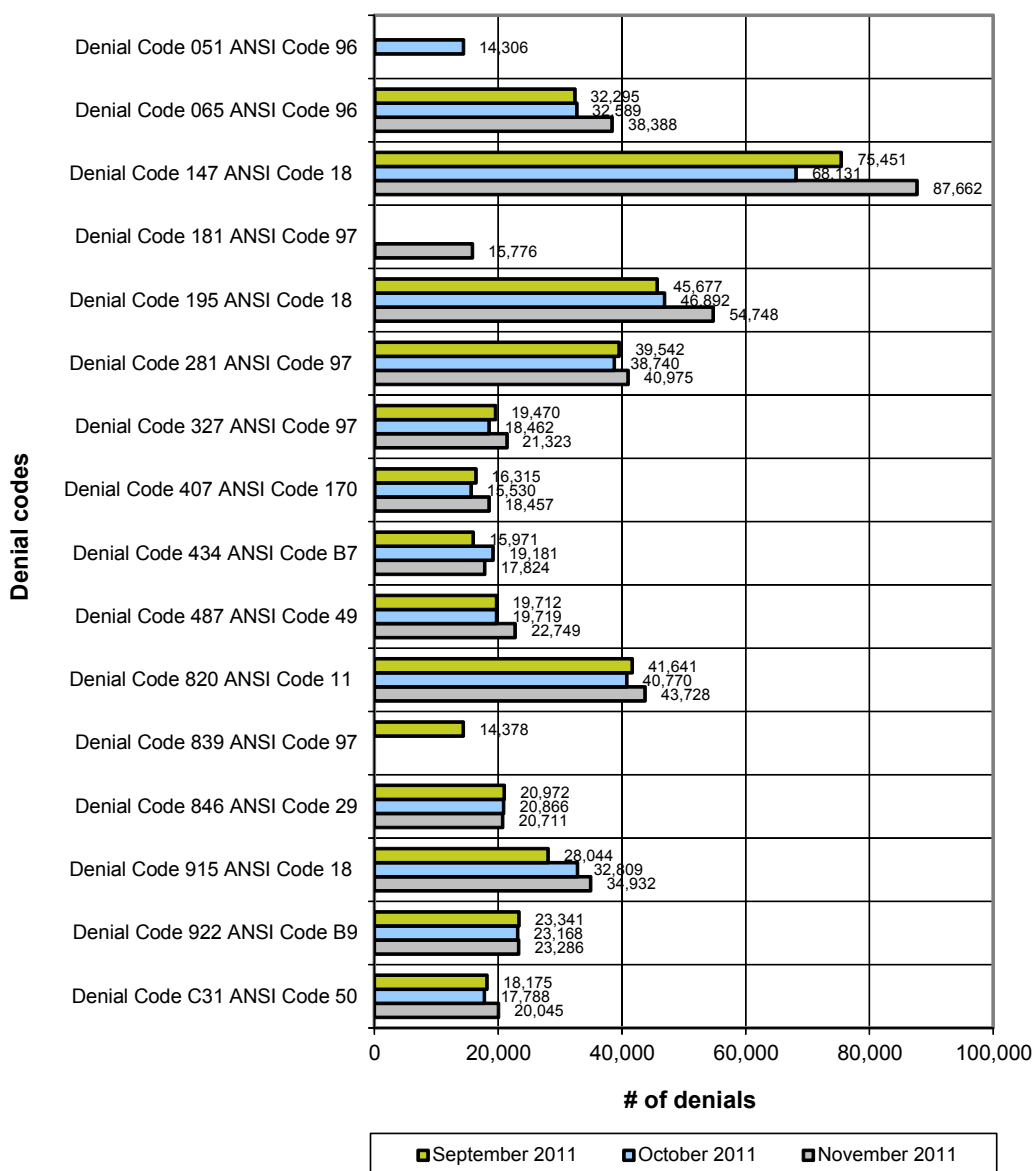
Florida Part B top inquiries for September-November 2011



continued on next page

Top....(continued)

Florida Part B top denials for September-November 2011



What to do when your claim is denied

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

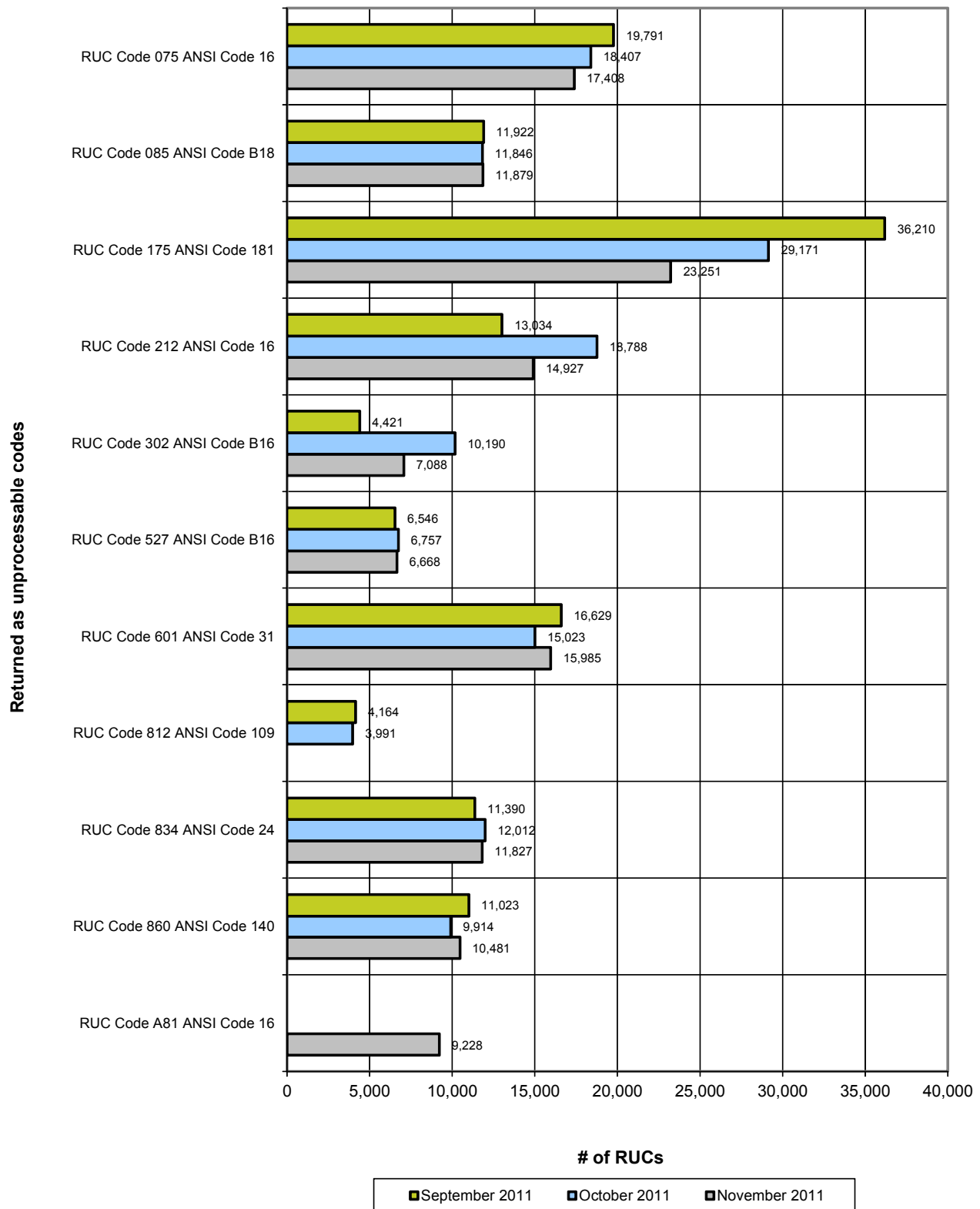
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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)

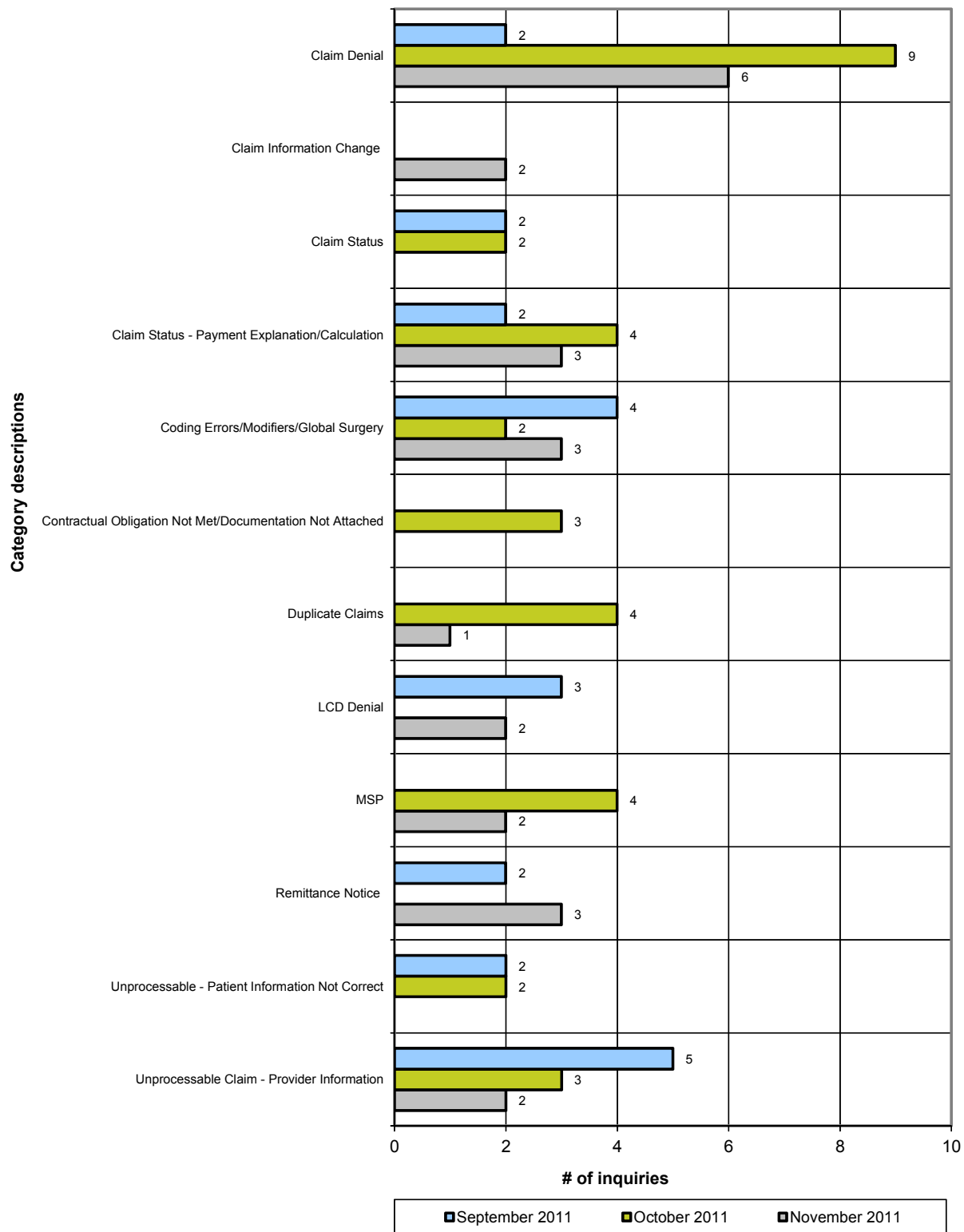
Florida Part B top return as unprocessable claims for September-November 2011



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Top....(continued)

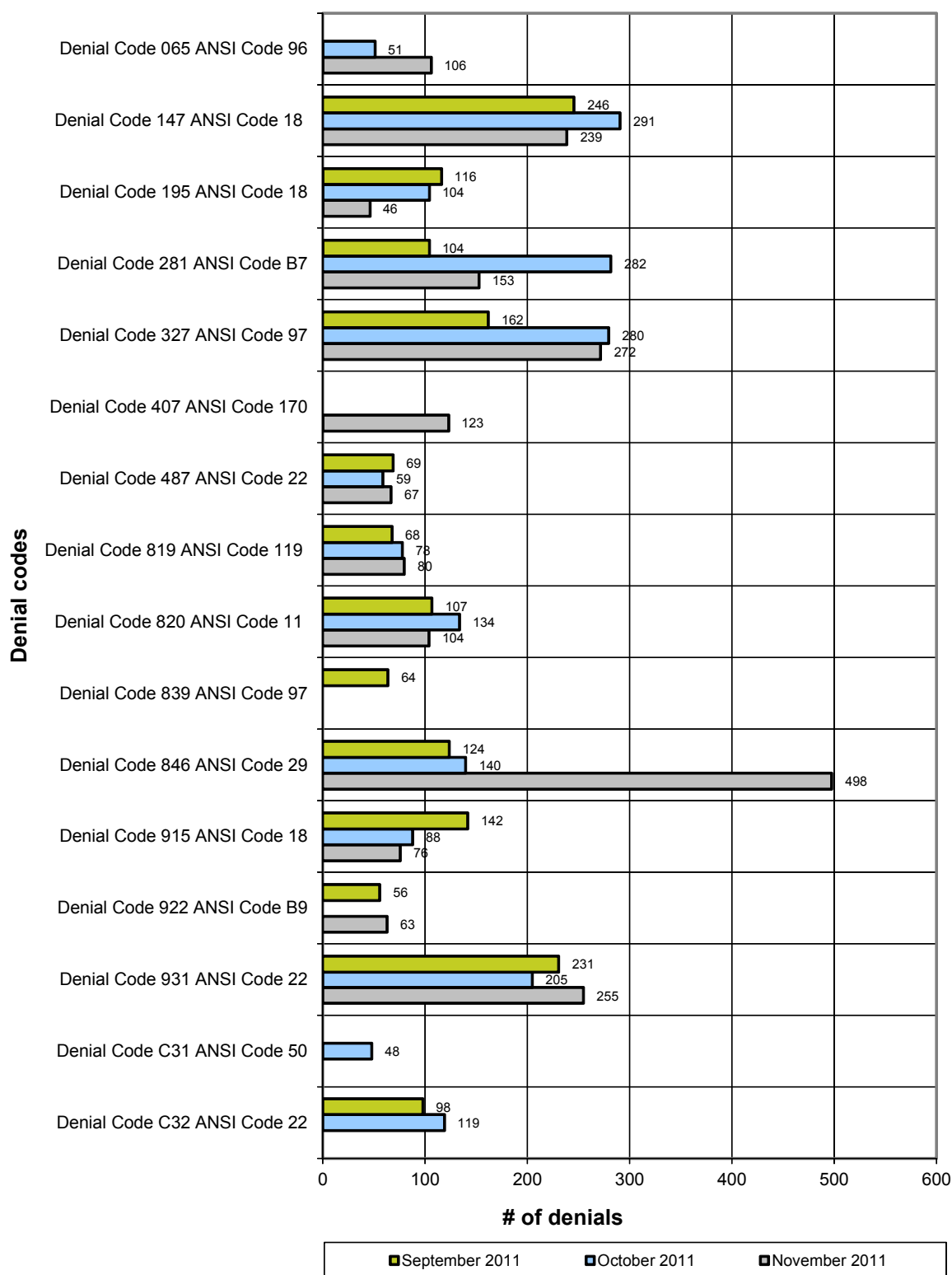
U.S. Virgin Islands Part B top inquiries for September-November 2011



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Top....(continued)

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

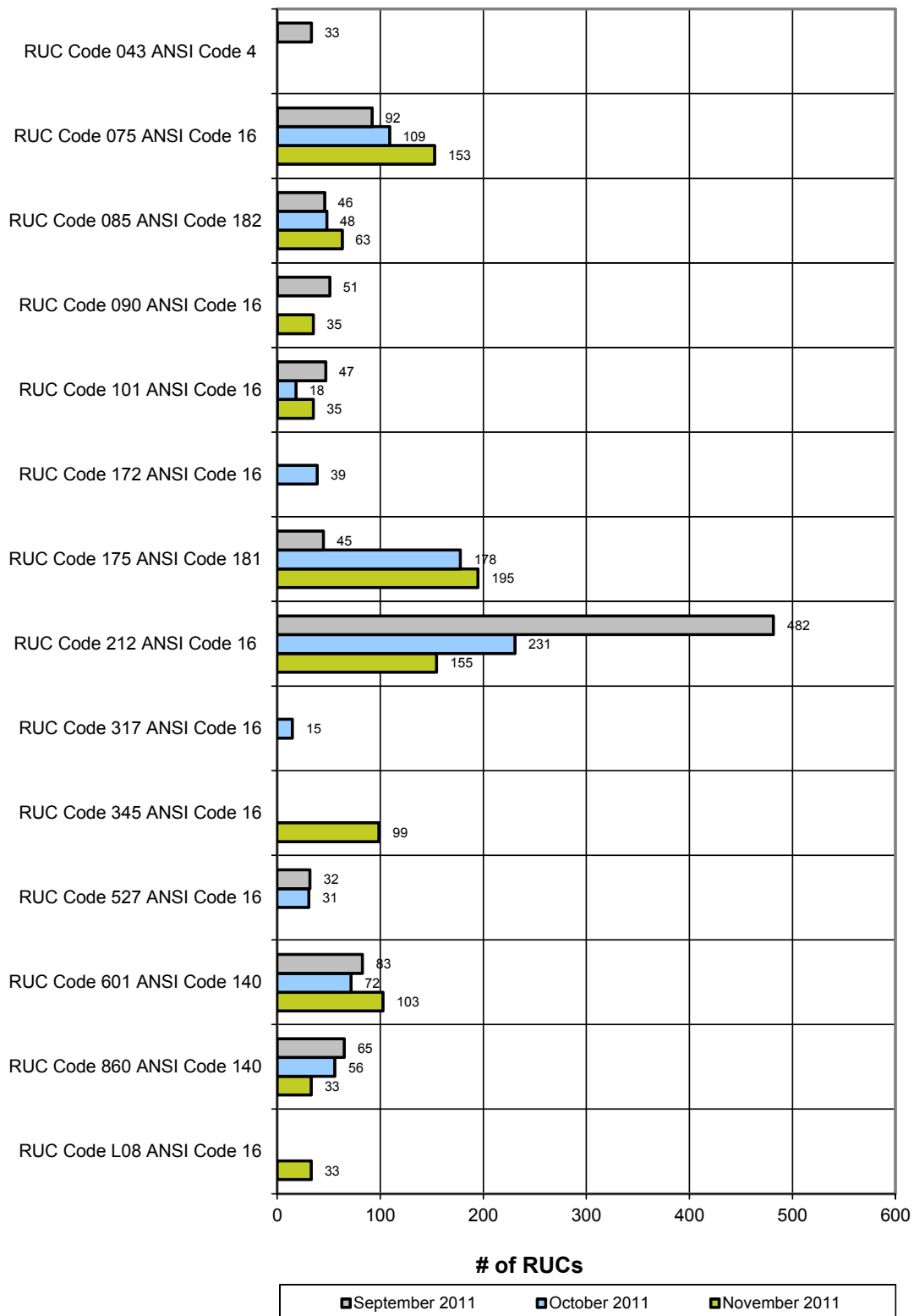


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Top....(continued)

U.S. Virgin Islands Part B top return as unprocessable claims for September-November 2011

Returned as unprocessable codes



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

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Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

New LCDs

64566: Posterior tibial nerve stimulation (PTNS) – new LCD

LCD ID number: L32304 (Florida/Puerto Rico/U.S. Virgin Islands)

Altering the function of the posterior tibial nerve with posterior tibial nerve stimulation (PTNS) is believed to improve voiding function and control. While the posterior tibial nerve is located near the ankle, it is derived from the lumbar-sacral nerves (L4-S3), which control the bladder detrusor and perineal floor. PTNS is a minimally invasive, office-based treatment for patients with overactive bladder that is not intended for first line therapy, but for patients who are refractory to behavioral and /or pharmacologic therapies.

A local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, *CPT* code, ICD-9-CM codes, documentation requirements, utilization guidelines, and coding guidelines for PTNS.

Effective date

This new LCD is effective for services rendered **on or after January 31, 2012**. 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.

76376: 3D interpretation and reporting of imaging studies – new LCD

LCD ID number: L32312 (Florida/Puerto Rico/U.S. Virgin Islands)

The technological approach of multi-slice imaging along with the enhanced imaging techniques has allowed for the generation of three-dimensional (3D) images known as 3D reconstruction or 3D rendering. Three-dimensional imaging has been applied to ultrasound, echocardiography, computed tomography (CT), magnetic resonance imaging (MRI), and other tomographic modalities. Applications of this technology include, for example, coronary artery imaging, visualization of central nervous system vasculature, and enhanced imaging of the thorax which includes, for example, aortic aneurysms, embolic disease, and inflammatory and neoplastic lesions.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, *CPT* codes, secondary ICD-9-CM diagnosis codes that support medical necessity, documentation requirements, and utilization guidelines.

Effective date

This new LCD is effective for services rendered **on or after January 31, 2012**. 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.

Revisions to LCDs

NCSVCS: Noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)

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

The local coverage determination (LCD) for noncovered services was most recently revised on January 1, 2012. Since that time, a revision was made to the LCD. The following codes were evaluated and determined not to be medically reasonable and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): HCPCS code C1749 (Endoscope, retrograde imaging/illumination colonoscopic device (implantable); e.g. Third Eye Retroscope®) (Ambulatory Surgical Centers [ASCs] only) and CPT code 44799 (*Endoscope, retrograde imaging/illumination colonoscopic device (implantable) [e.g. Third Eye Retroscope®]*) (physician services only) based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 7147, and HCPCS code C1840 (Lens, intraocular [telescopic] (ASCs only) and CPT code 66999 (*Lens, intraocular (telescopic)/implantable miniature telescope [IMT]*) (physician services only) based on CMS CR 7547. Category III CPT codes 0276T (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe*) and 0277T (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes*) were also evaluated and determined to be not medically reasonable and necessary at this time. The following codes were added to the “CPT/HCPCS Codes, Local Noncoverage Decisions – Devices” section of the LCD: C1749, C1840, 44799, and 66999. The following codes were added to the “CPT/HCPCS Codes, Local Noncoverage Decisions – Procedures” section of the LCD: 0276T and 0277T.

Effective date

This LCD revision is effective for services rendered **on or after January 31, 2012**. 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.

17311: Mohs micrographic surgery (MMS) – draft revision to the LCD

LCD ID number: L29230 (Florida)

LCD ID number: L29366 (Puerto Rico/U.S. Virgin Islands)

A draft revision of the local coverage determination (LCD) was published on October 7, 2011, to clarify coverage criteria regarding the appropriate use of Mohs micrographic surgery (MMS). The current LCD that is in play has been effective since 1998 before the jurisdiction 9 (J9) transition in 2009, and has had minor revisions (not considered more restrictive to the community). The current draft is a **major revision** (new requirements). The majority of the comments received addressed the “Limitations” section of the LCD, specifically the training requirements, and the issue of limiting the procedure to physicians with certain training, given that Medicare’s reasonable and necessary definition includes language requiring the service be ordered and furnished by qualified personnel. Additionally, there were comments on the language requiring digital photos of the defects to be available upon request (noted in the “Documentation Requirements” section of the LCD). The comment summary is available on the First Coast Service Options Inc. (FCSO) website.

Medicare administrative contractor (MAC) J9’s major revision will remain under consideration until further notice. It is anticipated that additional information in the public domain will be available in early 2012 for consideration in the draft.

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.

93922: Non-invasive physiologic studies of upper or lower extremity arteries – revision to the LCD

LCD ID number: L29237 (Florida)

LCD ID number: L29324 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-invasive physiologic studies of upper or lower extremity arteries was most recently revised on October 1, 2011. Since that time, the LCD has been revised to add indications relative to follow-up studies for postoperative conditions and to update language within the sections listed below.

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision

The “Methods not acceptable for Reimbursement” and the “Training Requirements” sections of the LCD have been relocated within the LCD. The LCD “Coding Guidelines” attachment has also been revised.

Effective date

This LCD revision is effective for services rendered **on or after January 31, 2012**. 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.

93925: Duplex scan of lower extremity arteries – revision to the LCD

LCD ID number: L29158 (Florida)

LCD ID number: L29336 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scan of lower extremity arteries was most recently revised on October 1, 2011. Since that time, the LCD has been revised to add indications relative to follow-up studies for postoperative conditions and to update language within the sections listed below.

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision

The “Methods not acceptable for Reimbursement” and the “Training Requirements” sections of the LCD have been relocated within the LCD. The LCD “Coding Guidelines” attachment has also been revised.

Effective date

This LCD revision is effective for services rendered **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.



Additional Information

G0250: Physician review, interpretation, and patient management of home prothrombin time (PT) and international normalized ratio (INR) monitoring

First Coast Service Options Inc. (FCSO) has identified an increase in utilization of HCPCS code G0250 (Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include four tests). Additionally, a pattern of billing that exceeds the utilization parameters noted in the code descriptor is evident. Providers appear to be billing for review, interpretation and management of each PT/INR test. FCSO would not expect HCPCS code G0250 to be billed more than once in a 30-day period as each unit billed equals a total of four tests not occurring more frequently than weekly.

For additional information on PT/INR home monitoring please refer to the Centers for Medicare & Medicaid Services (CMS) Publication 100-03, *Medicare National Coverage Determination (NCD) Manual*, Chapter 1, Section 190.11 (Home Prothrombin Time/International Normalized Ratio [PT/INR]) Monitoring.

J9033: Treanda® (bendamustine hydrochloride) for injection, for intravenous infusion-clarification on billing

Treanda® for injection is an alkylating drug which was approved by the food and drug administration (FDA) on March 20, 2008, for the following indications:

- Chronic lymphocytic leukemia (CLL)
- Indolent B-cell non-Hodgkin's lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab containing regimen.

The Medicare administrative contractor (MAC) for jurisdiction 9 (J9) has a local coverage determination (LCD) on label and off-label coverage of outpatient drugs and biologicals. This LCD outlines general coverage criteria for drugs approved for marketing by the FDA-labeled use as well as the off-labeled use in the absence of a national coverage determination (NCD) or a MAC J9 LCD addressing a specific drug. Currently there is not a MAC J9 LCD for Treanda®.

MAC J9 considers ICD-9-CM diagnosis codes 200.00-200.88; 202.00-202.98, 204.10, 204.11, and 204.12 to be in support of the above indications of CLL and NHL. The MAC J9 plans to develop an LCD in the near future that will address both the label and off-label indications for Treanda®.

YERVOY™ (ipilimumab)

Melanomas are malignant neoplasms of melanocytes developing predominantly in the skin, but occasionally arising from eyes, mucous membranes, and the central nervous system (CNS). Melanocytes are responsible for providing pigment to the skin (eyes, mucous membranes and CNS). Among the three types of skin cancer, melanoma is the most aggressive and also the most serious. Metastatic melanoma refers to a disease that has spread from its original lesion site to deeper parts of the skin, and eventually to other parts of the body distant to the primary lesion site.

YERVOY™ (ipilimumab) is indicated by the Food and Drug Administration (FDA) for the treatment of unresectable or metastatic melanoma.

The recommended dose of YERVOY (ipilimumab) is 3 mg/kg administered intravenously over 90 minutes every three weeks for a total of four doses.

The Medicare administrative contractor (MAC) for jurisdiction 9 (J9) has a local coverage determination (LCD) for "label and off-label coverage of outpatient drugs and biologicals." This LCD outlines general coverage criteria for drugs approved for marketing by the FDA labeled use, as well as the off-labeled use in the absence of a national coverage determination (NCD) or a MAC J9 LCD addressing a specific drug. Currently there is not a MAC J9 LCD for YERVOY™ (ipilimumab).

continued on next page

YERVOY™....(continued)

Effective for claims with dates of service March 25, 2011, through October 15, 2011, YERVOY can be considered for coverage, assuming documentation supports the reasonable and necessary indications when requested for the following ICD-9-CM codes:

ICD-9-CM codes	Descriptors for ICD-9-CM codes
154.2	Malignant neoplasm of anal canal
154.3	Malignant neoplasm of anus, unspecified
172.0-172.9	Malignant melanoma of skin
184.0	Malignant neoplasm of vagina
184.1	Malignant neoplasm of labia majora
184.2	Malignant neoplasm of labia minora
187.1	Malignant neoplasm of prepuce
187.4	Malignant neoplasm of penis, part unspecified
187.7	Malignant neoplasm of scrotum
187.9	Malignant neoplasm of male genital organ, site unspecified
190.0	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
190.1	Malignant neoplasm of orbit
190.2	Malignant neoplasm of lacrimal gland
190.3	Malignant neoplasm of conjunctiva
190.5	Malignant neoplasm of retina
190.6	Malignant neoplasm of choroid
190.9	Malignant neoplasm of eye, part unspecified

Effective for claims with dates of service on or after October 16, 2011, in addition to consideration for coverage for the above indications and above ICD-9-CM codes, the following compendia indications and additional ICD-9-CM codes will also be considered for coverage for YERVOY (ipilimumab) as a single agent:

- Unresectable stage III intransit metastases
- Local/satellite and/or intransit unresectable recurrence
- Incompletely resected nodal recurrence
- Limited recurrence or metastatic disease
- Disseminated recurrence or metastatic disease in patients with good performance status
- Reinduction in select patients who experience no significant systemic toxicity during prior ipilimumab therapy and who relapse after initial clinical response or progress after stable disease greater than three months.



ICD-9-CM codes	Descriptors for ICD-9-CM codes
198.3	Secondary malignant neoplasm of brain and spinal cord
199.0	Malignant neoplasm without specification of site, disseminated
199.1	Other malignant neoplasm without specification of site
V10.82	Personal history of malignant neoplasm of malignant melanoma of skin

For dates of service prior to January 1, 2012, the unlisted HCPCS codes J3490, J3590, J9999, or HCPCS code C9284 should be billed for YERVOY™ (ipilimumab). On or after date of service January 1, 2012, HCPCS code J9228 should be billed for YERVOY™ (ipilimumab).

2012 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2012 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
BOTULINUM TOXINS Botulinum Toxins	Deleted HCPCS code Q2040 Added HCPCS code J0588
IDTF Independent Diagnostic Testing Facility (IDTF) (Coding Guidelines only)	Deleted CPT codes 73542, 75722, 75724, 77079, 77083, 78220, 78223, 78584, 78585, 78586, 78587, 78588, 78591, 78593, 78594, 78596, 92120, 92130, 93720, 93721, 93875, 94240, 94260, 94350, 94360, 94370, 94720, and 94725 from the "Coding Guidelines" attachment Added CPT codes 74174, 78226, 78227, 78579, 78582, 78597, 78598, 94726, 94727, 94728, 94729, 95885, 95886, 95887, 95938, and 95939 to the "Coding Guidelines" attachment
J0129 Abatacept	Descriptor change for HCPCS code J0129
J1459 Intravenous Immune Globulin	Deleted HCPCS code C9270 Added HCPCS code J1557
J1740 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications	Deleted HCPCS code C9272 Removed HCPCS code J3590 Added HCPCS code J0897 Changed "Contractor's Determination Number" to J0897
J7187 Hemophilia Clotting Factors	Deleted HCPCS code Q2041 Added HCPCS code J7183 Changed "Contractor's Determination Number" to J7183
NCSVCS Noncovered Services	Descriptor change for CPT codes 90581, 90644, 90867, and 90868 Deleted CPT codes 0155T, 0156T, 0157T, and 0158T (replaced with CPT code 43659) and CPT code 0168T (replaced with CPT code 30999) Removed CPT code 46999 and replaced with CPT code 0288T Added CPT code 90869
PULMDIAGSVCS Pulmonary Diagnostic Services	Deleted CPT codes 93720, 93721, 93722, 94240, 94260, 94350, 94360, 94370, 94720, and 94725 Added CPT codes 94726, 94727, 94728, and 94729
SKINSUB Skin Substitutes	Deleted HCPCS code C9365 Added HCPCS code Q4124 Added HCPCS codes C9366, Q4122, Q4123, Q4125, Q4126, Q4127, Q4128, Q4129, and Q4130 to "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products" section of the LCD Deleted application CPT code range 15100-15431, CPT codes 15170, 15171, 15175, 15176, 15340, 15341, 15360, 15361, 15365, 15366, 15430, and 15431 and HCPCS codes G0440 and G0441 from the "Coding Guidelines" attachment Added CPT codes 15271-15278 to the "Coding Guidelines" attachment
THERSVCS Therapy and Rehabilitation Services	Descriptor change for CPT code 96111 Added information related to therapy cap (Change request 7529)

continued on next page

HCPCS....(continued)

LCD Title	Changes
Xiaflex® Collagenase clostridium histolyticum (Xiaflex®)	Removed CPT code 26989 Added CPT codes 20527 and 26341
01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services (Coding Guidelines only)	Descriptor change for CPT codes 27096, 62310 and 62311
22520 Percutaneous Vertebroplasty	Descriptor change for CPT codes 22520, 22521, and 22522
22533 Lumbar Spinal Fusion for Instability and Degenerative Disc Disease	Descriptor change for CPT code 22612 Added CPT codes 22633 and 22634
27096 Sacroiliac Joint Injection	Descriptor change for CPT code 27096 Deleted CPT code 73542 Removed CPT code 77003 based on descriptor change for CPT code 27096
32491 Lung Volume Reduction Surgery	Descriptor change for CPT code 32491
61885 Vagal Nerve Stimulation (VNS) for Intractable Depression	Descriptor change for CPT codes 64585, 95970, 95974, and 95975
62310 Epidural	Descriptor change for CPT codes 62310 and 62311
64561 Sacral Neuromodulation	Descriptor change for CPT codes 64561 and 64581 Descriptor change for CPT code 64585 in the "Coding Guidelines" attachment
64622 Destruction of Paravertebral Facet Joint Nerve(s)	Deleted CPT codes 64622, 64623, 64626, and 64627 Added CPT codes 64633, 64634, 64635, and 64636 Changed "Contractor's Determination Number" to 64633
75722 Renal Angiography	Deleted CPT codes 75722 and 75724 Added CPT codes 36251, 36252, 36253, and 36254 Changed "Contractor's Determination Number" to 36251
77078 Bone Mineral Density Studies	Deleted CPT codes 77079 and 77083
86849 Circulating Tumor Cell Testing	Removed CPT code 86849 Added CPT codes 0279T and 0280T Changed "Contractor's Determination Number" to 0279T
93875 Non-invasive Extracranial Arterial Studies	Deleted CPT code 93875 Changed "Contractor's Determination Number" to 93880
95860 Electromyography and Nerve Conduction Studies	Added CPT codes 95885, 95886, and 95887
95925 Somatosensory Testing	Added CPT code 95938
95990 Implantable Infusion Pump for the Treatment of Chronic Intractable Pain	Descriptor change for CPT codes 62367, 95990, and 95991 Added CPT codes 62369 and 62370

Source: Pub 100-04, transmittal, change request 7540

Educational Events

Upcoming provider outreach and educational events January 2012

Medicare Signature Requirements: Avoiding claim denials

When: Wednesday, January 17

Time: 11:30 a.m.-1:00 p.m.

Physical therapy services and using the KX modifier

When: Tuesday, January 24

Time: 11:30 a.m.-1:00 p.m.

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

Two easy ways to register

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

First-time User? Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive login 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: _____

Email 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

Preventive services educational resources for health care professionals

Provider types affected

This *MLN Matters*® special edition articles is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide Medicare-covered preventive services to Medicare beneficiaries.

What you need to know

- Use this article as a reference to available educational resources related to Medicare-covered preventive services.
- Make each office visit an opportunity to encourage your patients to receive preventive services for which they are eligible.

Introduction

Medicare covers a wide variety of preventive services and screenings for eligible beneficiaries.

Educational products for health care professionals

The *Medicare Learning Network*® (MLN) offers a variety of educational products to help you understand coverage, coding, reimbursement, and billing information related to these services.

1. MLN preventive services products for health care professionals

- The *Guide to Medicare Preventive Services, Fourth Edition* – this guide is designed to provide education on Medicare's preventive benefits. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.
- *Quick Reference Information: Preventive Services* – this educational tool is designed to provide education on the Medicare-covered preventive services. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- *Quick Reference Information: Medicare Part B Immunization Billing* – this educational tool is designed to provide education on Medicare-covered preventive immunizations. It is available in print and as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf. This product is also available in hardcopy as part of the *Quick Reference Information Resources* hardcopy booklet.
- *Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination* – this educational tool is designed to provide education on the initial preventive physical examination, also known as the IPPE. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf.
- *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit* – this educational tool is designed to provide education on the annual wellness visit (AWV). It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.
- Preventive brochures and fact sheets – in addition, the *MLN* offers the following brochures and fact sheets:
 - *Annual Wellness Visit*
 - *Bone Mass-Measurements*
 - *Cancer Screenings*
 - *Diabetes-Related Services*
 - *Expanded Benefits*
 - *Human Immunodeficiency Virus Screening*

continued on next page

Preventive ... (continued)

- *Mass Immunizers and Roster Billing*
- *Preventive Immunizations*
- *Tobacco-Use Cessation Counseling Services*

To view the downloadable PDFs for these products, visit the *Preventive Services Educational Products* Web page at http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf.

Note: To order hardcopy products, please visit the *Preventive Services MLN Educational Products* Web page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp and go to the “Related Links Inside CMS” section and select “MLN Product Ordering Page.”

- *MLN Preventive Services Educational Products* Web page – this MLN Web page provides descriptions of all MLN preventive service-related educational products and resources designed specifically for Medicare FFS health care professionals. This Web page is available at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.

2. Other CMS resources

- *Prevention General Information Overview* Web page is available at <http://www.cms.gov/PrevntionGenInfo>.
- CMS frequently asked questions are available at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi.

3. Additional preventive services

Under the Affordable Care Act, CMS has the authority to cover additional preventive services that meet certain criteria through the national coverage determination process. In addition to the websites above, please visit the CMS press release Web page at http://www.cms.gov/apps/media/press_releases.asp.

Beneficiary information

Please visit the Medicare.gov Web page at <http://www.medicare.gov> for beneficiary-related information and resources you may share with your Medicare patients.

MLN Matters® Number: SE1142
 Related Change Request (CR) #: NA
 Related CR Release Date: NA
 Effective Date: NA
 Related CR Transmittal #: NA
 Implementation Date: NA

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.

‘Mass Immunizers and Roster Billing’ fact sheet available

The new “*Mass Immunizers and Roster Billing*” fact sheet (ICN 907275) is designed to provide education on mass immunizers and roster billing. It includes information on simplified billing procedures for the influenza and pneumococcal vaccinations.

Source: CMS PERL 201112-07

Join CMS in observing the Great American Smokeout

The Centers for Medicare & Medicaid Services (CMS) would like Medicare providers to join in communicating the message of this year's Great American Smokeout, Thursday, November 17, 2011. The Great American Smokeout spotlights the dangers of tobacco use and the challenges of quitting, and has set the stage for change in social norms related to smoking – the leading cause of preventable disease and death in the United States – since 1977. Quitting smoking is the single most important action smokers can take to protect their own health and their families' health, as it can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Quitting tobacco use can be difficult, but Medicare can help through its coverage under Medicare Part B of tobacco-use cessation counseling for beneficiaries:

- Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease
- Who are competent and alert at the time that counseling is provided
- Whose counseling is furnished by a qualified physician or other Medicare recognized practitioner

Medicare Part B covers two tobacco cessation counseling attempts (four intermediate or intensive sessions per attempt) per 12-month period. Both the coinsurance and deductible are waived. Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a physician.

What can you do?

Talk with your Medicare patients about the smoking and tobacco-use cessation benefits Medicare makes available to them. Encourage your patients to participate in national health observances such as the Great American Smokeout that for many can be a first step toward quitting tobacco use. It's never too late to quit smoking, and with the cessation benefits provided under Medicare, and your recommendation, you can help your patients become tobacco free and reduce their risk of suffering from smoking-related diseases. Encourage those eligible to take advantage of Medicare-covered smoking and tobacco-use cessation and counseling services.



For more information

- [The Guide to Medicare Preventive Services for Healthcare Professionals \(see Chapter 15\)](#)
- [Medicare Preventive Services Quick Reference Information Chart](#)
- [Counseling to Prevent Tobacco Use" MLN Matters article \(MM7133\)"](#)
- [Tobacco-Use Cessation Counseling Services brochure](#)
- [The MLN Preventive Services Educational Products Web page](#)
- [The Great American Smokeout official Web page](#)

Thank you for joining with CMS to help increase awareness and educate about smoking, smoking and tobacco-use cessation, counseling, the Great American Smokeout, and related preventive health services now covered by Medicare.

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

Source: CMS PERL 201111-43

December 4-10 is National Influenza Vaccination Week

Get the flu vaccine, not the flu

National Influenza Vaccination Week (NIVW) is a national observance that was established by the Centers for Disease Control and Prevention (CDC) in 2005 to highlight the importance of continuing influenza vaccination – as well as fostering greater use of flu vaccine – after the holiday season into January and beyond. For the 2011-2012 season, NIVW was scheduled for December 4-10. This year's events encouraged everyone six months and older to "get the flu vaccine, not the flu."

Influenza is among the most common respiratory illnesses in the United States, infecting millions of people every flu season. An annual flu vaccination is the best way to prevent the flu and the flu-related complications that could lead to hospitalization and even death. Also, since flu viruses are constantly changing and immunity can decline over time, annual vaccination is needed for optimal protection.

Influenza can cause severe illness and even death for anyone, regardless whether or not they have high risk conditions. However, people with certain long-term health conditions are at much greater risk of suffering from serious flu complications, as demonstrated last season when 80 percent of adults hospitalized from flu complications had a long-term health condition (asthma, diabetes, and chronic heart disease were the most common).

What can you do?

National Influenza Vaccination Week presents a great opportunity for healthcare providers to educate seniors and others with Medicare that a flu vaccine is the first and best way to prevent influenza, and that it's particularly important in people who are at higher risk of serious flu complications. It is also a great time to inform those with Medicare about other preventive services covered by Medicare that may be appropriate for them.

Additional information

- [The CMS Guide to Medicare Preventive Services](#)
- [Medicare Immunizations Billing Quick Reference Chart](#)
- [CMS Adult Immunizations Brochure](#)
- [Medicare Preventive Services Quick Reference Information Chart](#)
- [The CDC Vaccines and Immunizations Web Page](#)

Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is **not** a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.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 201111-66

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Other Educational Resources

CMS has expanded and enhanced its online presence

The Centers for Medicare & Medicaid Services (CMS) is always looking for ways to make your experience with the Medicare, Medicaid, Children's Health Insurance, and other healthcare programs better. On Monday, December 5, CMS expanded and enhanced their online presence at CMS. They're debuting a new look and feel for [CMS.gov](#) and launching a brand-new site for the Medicaid program, [Medicaid.gov](#).

These changes reflect what CMS has heard from you – the users – and they are a response to what you've said you want to be able to do on the CMS website.

- A significantly-improved search engine that gets you to the information you're looking for – fast
- More in-depth information about what CMS is doing to implement the Affordable Care Act and other new initiatives and details about how you can apply for new programs
- Up-to-date, real-time updates that reflect important developments and initiatives happening with CMS programs
- Medicaid program information that's readily available, easy-to-find, and easy-to-use – and CMS will be continually looking for ways to enhance your experience on its site
- Easy-to-access links to Healthcare.gov, which will continue to be the primary site for consumer information

While CMS moved content around to make it easier to find, don't worry that you'll lose access to any of the current Medicare and Medicaid information you rely on now. CMS is launching an archive version of each of its websites too, so that historic information can remain online without adding clutter to its primary sites.

CMS thinks these changes are a good first step to improving its online presence and making information more accessible for all the patients, partners, providers, states, advocates, and others who interact with its programs. However, this is just the first step – CMS has plans for continuous, ongoing improvements.

Take a look around at the [www.CMS.gov](#) and [www.Medicaid.gov](#), and *let CMS know what you think*. CMS would like to use your feedback to help drive the direction of future website improvements.

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

Source: CMS PERL 201112-18

Updates from the *Medicare Learning Network*®

"Contractor Entities At A Glance" educational tool available in hard copy

The *"Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities"* educational tool (ICN 906983) is designed to provide education on the definitions and responsibilities of entities involved in claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially fee-for-service providers. To place an order for a hard-copy version, go to <http://www.CMS.gov/MLNProducts> and click on "MLN® Product Ordering Page" under "Related Links Inside CMS" at the bottom of the page.

New fast fact on MLN® provider compliance Web page

A new fast fact on [MLN provider compliance](#) is now available. This Web page provides the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new "fast fact" is added each month.

Medicare billing certificate programs coming soon to the Medicare Learning Network® (MLN)

The *Medicare Billing Certificate Program for Part A Providers* and *The Medicare Billing Certificate Program for Part B Providers* are coming soon to the MLN®. Learn about the Medicare program with a special focus on Medicare billing specific to your billing or provider type, and you'll receive a certificate in Medicare billing from the Centers for Medicare & Medicaid Services (CMS). Look for these programs to become available in early 2012.

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

Source: CMS PERL 201111-57

Revised resources available from the *Medicare Learning Network*

‘Medicare Physician Guide’ revised and available on CD-ROM

The *Medicare Physician Guide* (ICN 005938) has been revised and is available in CD-ROM format. This guide includes the following information:

- 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
- Provider outreach and education

To place your order, visit the [MLN Products page](#), scroll to the “Related Links Inside CMS,” and select the [MLN Product Ordering Page](#).

‘Power Mobility Devices’ fact sheet revised

The *Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements* is designed to provide education on common comprehensive error rate testing program errors related to power mobility devices. It includes a checklist of the documentation needed to support a claim submitted to Medicare for PMDs.

‘Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants’ booklet available

The revised *Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet* (ICN 901623) provides education on services furnished by advanced practice registered nurses, anesthesiologist assistants, and physician assistants. This booklet includes the following information about Medicare requirements for these provider types:

- Required qualifications
- Coverage criteria
- Billing
- Payment

To place your order, visit the [MLN Products page](#), scroll to the “Related Links Inside CMS,” and select the [MLN Product Ordering Page](#).

Source: CMS PERL 201111-57

‘CMS Electronic Mailing Lists’ fact sheet

The “*CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed*” Fact Sheet (ICN 006785) is designed to provide education on the various Centers for Medicare & Medicaid Services (CMS) fee-for-service (FFS) electronic mailing lists. It includes information about how to register for the service and receive the latest news regarding important FFS initiatives.

Source: CMS PERL 201111-44

2012 ICD-10-CM code updates now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2012 ICD-10-CM code updates to the CMS website, including the 2012 ICD-10-CM index and tabular, code titles, addendum, general equivalence mappings (GEMs), and reimbursement mappings files. The 2012 ICD-10-CM files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, volumes 1 and 2. These files are available on the 2012 ICD-10-CM and GEMs Web page at http://www.cms.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp. To access the files, scroll to the bottom of the page to the “Downloads” section.

The 2012 ICD-10-PCS (procedure) files were posted in June on the 2012 ICD-10-PCS and GEMs Web page at http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.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 201112-11

‘How to Use the Searchable Medicare Physician Fee Schedule’ booklet available

The new *“How to Use the Searchable Medicare Physician Fee Schedule”* booklet (ICN 901344) is designed to provide education on how to use the Medicare physician fee schedule (MPFS). It includes steps to search for payment information, pricing, relative value units (RVUs), and payment policies.

If you like the MPFS booklet, check out *“How to Use the Medicare Coverage Database”* and *“How to Use the National Correct Coding Initiative (NCCI) Tools”* from the *Medicare Learning Network*®.

Source: CMS PERL 201112-07

‘Ambulance Fee Schedule’ fact sheet revised

The revised *“Ambulance Fee Schedule” fact sheet* (ICN 006835) includes the following information:

- Background
- Ambulance providers and suppliers
- Ambulance services payments
- How payment rates are set

Source: CMS PERL 201111-65

‘Misinformation on Chiropractic Services’ fact sheet revised

The *“Misinformation on Chiropractic Services” fact sheet* (ICN 006953) is designed to provide education on Medicare regulations and policies on chiropractic services to Medicare fee-for-service providers. It includes information on the documentation needed to support a claim submitted to Medicare for chiropractic services.

Source: CMS PERL 201111-44

‘Medicare Secondary Payer’ fact sheet

The *“Medicare Secondary Payer” fact sheet* (ICN 006903) is designed to provide education on the Medicare secondary payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the coordination of benefits contractor.

Source: CMS PERL 201111-44

‘Medicare Fraud & Abuse: Prevention, Detection, and Reporting’ fact sheet revised

The *“Medicare Fraud & Abuse: Prevention, Detection, and Reporting” fact sheet* (ICN 0006827) is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes definitions of as well as information on laws, partnerships with other organizations, and resources for additional information.

Source: CMS PERL 201111-57

‘Outpatient Rehabilitation Services: Complying with Documentation Requirements’ fact sheet revised

The *“Outpatient Rehabilitation Services: Complying With Documentation Requirements” fact sheet* (ICN 905365) is designed to provide education on comprehensive error rate testing program errors related to outpatient rehabilitation therapy services. It includes information on the documentation needed to support a claim submitted to Medicare for outpatient rehabilitation therapy services.

Source: CMS PERL 201111-44

‘Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets’ booklet discontinued

The “Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets” booklet (ICN 907663) has been discontinued. To alleviate confusion, the *Medicare Learning Network*® (MLN) has decided to discontinue its recently-published booklet, which contained fact sheets that were issued at the time that the “Medicare Shared Savings Program (MSSP) notice of proposed rulemaking” was released.

However, the MLN has released several fact sheets on the final rule:

- [“Accountable Care Organizations: What Providers Need to Know”](#)
- [“Improving Quality of Care for Medicare Patients: Accountable Care Organizations”](#)
- [“Advance Payment Accountable Care Organization \(ACO\) Mode”](#)
- [“Medicare Shared Savings Program and Rural Providers”](#)
- [“Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program”](#)
- [“Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program”](#)

Source: CMS PERL 201112-34

New podcast on the ‘Medicare Overpayment Collection Process’ released

The *Medicare Learning Network*® (MLN) has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and comply with requirements of the Medicare program. The new [“Medicare Overpayment Collection Process”](#) podcast (ICN 907563), posted Thursday, December 8, 2011, is designed to provide education on the Medicare overpayment collection process. It includes information from the MLN® fact sheet titled *The Medicare Overpayment Collection Process*, which describes the collection of Medicare physician and supplier overpayments.

Visit the [MLN® Multimedia Web page](#) to download this and other podcasts from the MLN®. CMS also encourages providers to visit the [MLN® Provider Compliance Web page](#) for the latest educational products. This page is designed to help Medicare fee-for-service providers understand and avoid common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the MLN®.

Source: CMS PERL 201112-34

Try our E/M interactive worksheet

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

Mail directory

Claims submissions

Routine paper claims

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

Participating providers

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

Chiropractic claims

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

Ambulance claims

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

Medicare secondary payer

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

ESRD claims

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

Communication

Redetermination requests

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

Fair hearing requests

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

Freedom of Information Act

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

Administrative law judge hearing

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

Status/general inquiries

Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments

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

Durable medical equipment (DME)

DME, orthotic or prosthetic claims

Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries

Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

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

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:

Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

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

Provider change of address:

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

Provider education

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

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

Education event registration:

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

Limiting charge issues:

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

Refund verification:

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

Medicare claims for Railroad retirees:

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

Fraud and abuse

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

Phone numbers

Providers

Toll-Free

Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):

1-877-847-4992

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/prevaling charges or fee schedule:

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

Education event registration:

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email 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_B/index.asp (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 2011 through September 2012.	40300260	\$33		
2011 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2011, are available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	\$12		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (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