Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers January 2012

In this issue

Health care professionals selected for the new innovation advisors program to improve care for patients

The Centers for Medicare & Medicaid Services (CMS) announced that it has selected 73 individuals from 27 states and the District of Columbia for its innovation advisors program.

A list of innovation advisors can be found at *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4240*.

The initiative, launched by the CMS Innovation Center in October 2011, will help health professionals deepen skills that will drive improvements to patient care and reduce costs. After an initial orientation phase, innovation advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Funding for this initiative was made possible by the Affordable Care Act.

"There has been an incredible groundswell of interest in becoming an innovation advisor. It's clear that doctors, hospitals and health care providers are enthusiastic about implementing the Affordable Care Act and strengthening our health care system," said CMS Acting Administrator Marilyn Tavenner.

The 73 individuals were selected from 920 applications through a competitive process, and include clinicians, allied health professionals, health administrators and others. By attending in-person meetings as well as remote sessions to expand their skills and applying what they learn, the advisors will be able to deepen their knowledge in health care economics and finance, population health, systems analysis, and operations research.

"We're looking to these innovation advisors to be our partners – we want them to discover and generate new ideas that will work and help us bring them to every corner of the United States," said CMS Innovation Center Director Rick Gilfillan, M.D.

Among other duties, the advisors will be expected to support the Innovation Center in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost.

Each innovation advisor's home organization will receive a stipend of up to $20,000. The stipend will support an individual's activities while serving as an innovation advisor.

More information about the innovation advisors program, including a fact sheet and list of participants and their home organization, may be found at *http://innovations.cms.gov/initiatives/innovation-advisors/index.html*.

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

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Contents

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

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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.

About the *Medicare B Connection*

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

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

Who receives the Connection

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

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

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

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

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

Publication format

The Connection is arranged into distinct sections.

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

In addition to the above, other sections include:

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

The Medicare B Connection represents formal notice of coverage policies

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

HPSA bonus payment policy reminders

Provider types affected

This *Medicare Learning Network* (*MLN*) *Matters*® special edition article is intended for physicians and providers submitting claims to Medicare carriers, Medicare administrative contractors (A/B MACs), and/or fiscal intermediaries (FIs) for services furnished to Medicare beneficiaries in areas designated as geographic health professional shortage areas (HPSAs).

Provider action needed

Stop – impact to you

Physicians who furnish services to Medicare beneficiaries in areas designated as primary care geographic HPSAs by the Health Resources and Services Administration (HRSA) as of December 31, 2011, are eligible for a 10 percent bonus payment for services furnished from January 1, 2012, to December 31, 2012. If an area does not have a geographic primary care HPSA designation, but does have a geographic mental health HPSA designation, then only psychiatrists furnishing services to Medicare beneficiaries in the designated area are eligible for the ten percent bonus.

Caution – what you need to know

The physician must determine whether a service is furnished in a geographic primary care (or mental health) HPSA. Eligibility is determined annually based on the status of the designation, as of December 31 of the prior year. That is, a physician who was eligible for the 10 percent bonus in 2011 may not be eligible for the bonus in 2012. A physician or provider that was not eligible for the 10 percent bonus in 2011 may be eligible for the bonus in 2012. Information about designated areas is available from HRSA. The following Web pages may help you determine whether an area is a geographic primary care or mental health HPSA:

- The Shortage Designation Advisor page identifies areas located in an HPSA by entering a valid address. It is available at *http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx*.
- The HPSA State & County Search page identifies HPSA designation with a state and is available at *http://hpsafind.hrsa.gov/HPSASearch.aspx*.
- The Geocoding System page identifies census tracts by entering a valid address and is available at *http://www.ffiec.gov/Geocode/default.aspx*.

Go – what you need to do

The Centers for Medicare & Medicaid Services (CMS) publishes an annual list of ZIP codes that automatically receive the HPSA bonus. Only areas where the entire ZIP code falls within the designated area at the time the list is developed are listed. Services provided in eligible areas that are not listed for automatic bonus payment must use the AQ modifier to receive the bonus.

Only physicians who furnish services in areas designated as a geographic primary care HPSA, as of December 31, 2011, and whose ZIP code is not on the list should use the modifier. Only psychiatrists, who furnish services in areas that are not designated as primary care HPSAs, as of December 31, 2011, but are designated as a geographic mental health HPSA, should use the modifier if the ZIP code is not on the list for automatic payment.

Information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic payment of the bonus, is available at *http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp*. An *MLN Matters*® article, MM7517, on this issue can be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf*.

Additional information

For more information about the Medicare Physician Bonus Program, including the list of ZIP codes eligible for automatic bonus payment, visit the HPSA/PSA Physician Bonuses Web page at *http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp*. *MLN Matters*® article MM7517, titled, "2012 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf*. The *MLN* fact sheet titled, "Health Professional Shortage Area," which is designed to provide education on the HPSA payment system, is available at *http://www.cms.gov/MLNProducts/downloads/HPSAfctsht.pdf*.

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

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April 2012 update of correct coding initiative edits

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7726 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in January, 2012.

Background

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

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

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

The latest package of CCI edits, version 18.1, is effective April 1, 2012, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in two tables:

- Column I/Column 2 Correct Coding Edits, and
- Mutually exclusive code (MEC) edits.

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

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, (Chapter 23, Section 20.9) which is available at *http://www.cms.gov/manuals/downloads/clm104c23.pdf*.

The official instruction, CR 7726, issued to your carrier or and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2384CP.pdf*.

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

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Ambulatory Surgery Center

January 2012 update of the ambulatory surgery center payment system

Provider types affected

This article is for ambulatory surgery centers (ASCs), which submit claims to Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

What you need to know

This article is based on change request (CR) 7682 which describes changes to and billing instructions for payment policies implemented in the January 2012 ASC payment system update. CR 7682 also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in CR 7682 are calendar year (CY) 2012 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2012 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with CR 7682 reflect the most recent changes to CY 2012 MPFS payment.

Key points of CR 7682

New device pass-through category and device offset from payment

CMS is establishing one new device pass-through category as of January 1, 2012, for the outpatient prospective payment system (OPPS) and the ASC payment system. HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality [insertable]), which is assigned ASC payment indicator (PI) of J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

- CMS has determined that it is able to identify a portion of the OPPS payment associated with the cost of HCPCS code C1840 for the insertion procedure described by new HCPCS code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens). Therefore, ASC payment for the nondevice facility resources for the insertion procedure will be based upon the nondevice portion of the related OPPS payment weight for HCPCS code C9732. The ASC code pair file will be used to establish the reduced ASC payment amount for HCPCS code C9732 only when billed with HCPCS code C1840.

Billing instructions for C9732 and C1840

Pass-through category C1840 (Lens, intraocular [telescopic]), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012.

New procedure code

CMS is establishing two new procedure codes effective January 1, 2012. The following table provides a listing of the descriptor and payment information for these new codes.

HCPCS	Effective date	Short descriptor	Long descriptor	CY2012 PI
C9732	01-01-12	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens	G2
G0448	01-01-12	Place perm pacing cardiovert	Insertion or replacement of a permanent cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing	J8

Cardiac resynchronization therapy payment for calendar year 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures (described by *Current Procedural Terminology*® (*CPT*®) code

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33249 (*Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator)*) and pacing electrode insertion procedures (described by *CPT* code *33225* (*Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator [including upgrade to dual chamber system]*) when performed on the same date of service in an ASC.

- The payment rate for CRT-D services in ASCs will be based on the OPPS payment rate applicable to APC 0108 and ASCs will use the HCPCS Level II G-code G0448 (Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing) for proper reporting when the procedures described by *CPT* codes *33225* and *33249* are performed on the same date of service. When these procedures are not performed on the same date of service, the ASC payment rate will be based on the standard APC assignment for each service and ASCs should report the appropriate *CPT* codes for the individual procedures.

Reporting HCPCS codes for all drugs, biologicals, and radiopharmaceuticals

- CMS strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct Healthcare Common Procedure Coding System (HCPCS) codes for the items used. ASCs billing for these products must make certain that the reported units of service for the reported HCPCS codes are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

- CMS reminds ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.
- Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed. HCPCS payment updates are posted to the CMS website quarterly at *http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp*.

Drugs and biologicals with payment based on average sales price effective January 1, 2012

- Payments for separately payable drugs and biologicals based on the average sales prices (ASPs) are updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2012, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2012 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2011. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2012 release of the ASC DRUG file. CMS is not publishing the updated payment rates in CR 7682 implementing the January 2012 update of the ASC payment system. However, the updated payment rates effective January 1, 2012, for covered ancillary drugs and biologicals can be found in the January 2012 update of the ASC, Addendum BB. That addendum is available at: *http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp*.

New CY 2012 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

- For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are listed in the following table.

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CY 2012 HCPCS code	CY 2012 long descriptor	CY 2012 PI
A9585	Injection gadobutrol, 0.1 ml	N1
C9287	Injection, brentuximab vedotin, 1 mg	K2
C9366	EpiFix, per square centimeter	K2
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K2
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	K2
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K2
J8561	Everolimus, oral, 0.25 mg	K2
Q4122	Dermacell, per square centimeter	K2

Other changes to CY 2012 HCPCS for certain drugs, biologicals, and radiopharmaceuticals

- Many HCPCS and *CPT* codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and *CPT* code descriptors that will be effective in CY 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011, and replaced with permanent HCPCS codes in CY 2012. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and *CPT* codes. These changes are reflected in the following table:

CY 2011 HCPCS code	CY 2011 long descriptor	CY 2012 HCPCS code	CY 2012 long descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043*	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified

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CY 2011 HCPCS code	CY 2011 long descriptor	CY 2012 HCPCS code	CY 2012 long descriptor
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/ Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q1079	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

*HCPCS code Q2043 was effective July 1, 2011 ** HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.

Updated payment rates for certain HCPCS codes effective October 1, 2011, through December 31, 2011

- The payment rates for HCPCS codes J9600 and Q4121 were incorrect in the October 2011 ASC drug file. The corrected payment rates are $19,143.46 for J9600 and $20.77 for Q4121. They have been included in the revised October 2011 ASC drug file, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. Suppliers who think they may have received an incorrect payment between October 1, 2011, and December 31, 2011, may request contractor adjustment of the previously processed claims.

Correct reporting of biologicals when used as implantable devices

- ASCs are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the *CPT* codes describing application of a skin substitute (*15271-15278*). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

ASC quality measures

In Transmittal 934, issued August 1, 2011, CMS announced that the G codes tied to the M5 PI indicator would be effective January 1, 2012. CMS intends to include these HCPCS and further clarification in the April 2012 ASC quarterly update.

Billing for thermal anal lesions by radiofrequency energy

- For CY 2012, the *CPT* Editorial Panel created new *CPT* code *0288T* (*Anoscopy, with delivery of thermal energy to the muscle of the anal canal [e.g., for fecal incontinence]*) to describe the procedure associated with radiofrequency energy of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and *CPT* code *0288T* was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by *CPT* code *0288T*, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with *CPT* code *0288T* effective January 1, 2012. In addition, CMS is reassigning *CPT* code *0288T* from APC 0148 to APC 0150 effective January 1, 2012. The table below lists the final ASC payment indicator for HCPCS codes C9716 and *0288T*. The ASCPI file will reflect this deletion with PI=D5 for C9716 effective 1/1/2012.

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HCPCS code	Short descriptor	CY 2012 PI
C9716	Radiofrequency energy to anu	D5
0288T	Anoscopy w/rf delivery	G2

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

- For CY 2012, CMS updated the list of ASC covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. Contractors will reduce the payment for the device implantation procedures listed in Attachment A of CR 7682, by the full device offset amount for no cost/full credit cases. ASCs must append the modifier "FB" to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment B of CR 7682, and the associated implantation procedure code is listed in Attachment A of CR 7682. In addition, contractors will reduce the payment for implantation procedures listed in Attachment A of CR 7682 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Attachment B of CR 7682, the ASC must append the modifier "FC" to the associated implantation procedure code if the procedure is listed in Attachment A of CR 7682. A single procedure code should not be submitted with both modifiers "FB" and "FC."
- More information regarding billing for procedures involving no cost/full credit and partial credit devices is available in the *Medicare Claims Processing Manual*, Chapter 14, Section 40.8. This manual section is at *http://www.cms.gov/manuals/downloads/clm104c14.pdf*.

Additional information

Three attachments are included in CR 7682. They are:

- Attachment A: CY2012 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs;
- Attachment B: CY 2012 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES;
- Attachment C: CY 2012 DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE ASC.

CR 7682 may be viewed at *http://www.cms.gov/Transmittals/downloads/R2378CP.pdf*. If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7682
Related Change Request (CR) #: 7682
Related CR Release Date: December 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2378CP
Implementation Date: January 3, 2012

Revised 'Ambulatory Surgical Center Fee Schedule' fact sheet

The *"Ambulatory Surgical Center Fee Schedule" fact sheet (ICN 006819)* has been revised and is now available in downloadable format. It includes information on the definition of an ambulatory surgical center fee schedule (ASC), ASC payment, how payment rates are determined, and health care quality.

Source: CMS PERL 201201-42

Consolidated Billing

ESRD PPS and consolidated billing for limited Part B services

Note: This article was revised on December 21, 2011, to clarify the cost report language for "low volume facility adjustments." All other information remains the same. This information was previously published in the February 2011 *Medicare B Update!* Pages 9-12.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7064 which announces the implementation of an end-stage renal disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

Caution – what you need to know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Go – what you need to do

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

Background

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

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

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

Patient-level adjustments

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

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ESRD ... (continued)

Outlier adjustment

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

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

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

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

Facility-level adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from core-based statistical areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training add-on

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

Adjustments specific to pediatric patients

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

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS four-year phase-in (transition) period

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

The ESRD PPS four-year transition period blended rate determination

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

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

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ESRD ... (continued)

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

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

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

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

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

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

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

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

Three new adjustments applicable to the adult rate

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

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

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

- Bacterial pneumonia
- Gastrointestinal bleeding, and
- Pericarditis.

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

Change in processing home dialysis claims

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

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ESRD ... (continued)

Therefore, all home dialysis claims:

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

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

Consolidated billing

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

Other billing reminders

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

Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2134CP.pdf*. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits
- Attachment 5, which contains a list of DME ESRD supply HCPCS codes that are **not** payable to DME suppliers

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ESRD ... (continued)

- Attachment 6, which is a list of laboratory *CPT*/HCPCS codes subject to ESRD consolidated billing
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing, and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

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

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Related Change Request (CR) #: 7064
Related CR Release Date: January 14, 2011
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Related CR Transmittal #: R2134CP
Implementation Date: January 3, 2011

Drugs and Biologicals

Autologous cellular immunotherapy treatment of metastatic prostate cancer

Note: This article was revised on January 10, 2012, to reflect a revised change request (CR) 7431 issued on January 6, 2012. The article has been revised to show that a separate payment for the cost of administration is allowed. In addition, the transmittal numbers, release date, and the Web address for accessing CR 7431 have been revised. All other information is the same. This information was previously published in the November 2011 *Medicare B Connection*, Pages 14-17.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors [A/B MACs]) for metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7431 regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. It is therefore reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)) effective for services performed on or after June 30, 2011.

Go – what you need to do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure

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Autologous ... (continued)

"trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

CR 7431 instructs that, effective for services performed on or after June 30, 2011, CMS concludes that the evidence is adequate to support the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

Medicare contractors will continue to process claims for PROVENGE® with dates of service on June 30, 2011, as they do currently when providers submit not otherwise classified Healthcare Common Procedure Coding System (HCPCS) code(s) J3590, J3490 or C9273. HCPCS code C9273 will be deleted on June 30, 2011.

The new HCPCS code Q2043 will:

- Replace C9273 (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion)
- Be implemented in the July 2011 Update of Quarterly HCPCS Drug/Biological Code Changes (CR 7303 (Transmittal R2227CP); see *http://www.cms.gov/transmittals/downloads/R2227CP.pdf*), and
- Have an effective date of July 1, 2011.

The ambulatory surgical center (ASC) payment system will be updated to reflect these coding changes, and these changes will be announced in the ASC quarterly update CR for July 2011.

Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one (1) treatment regimen in a patient's lifetime, consisting of three (3) doses with each dose administered approximately two (2) weeks apart for a total treatment period not to exceed 30 weeks from the first administration.

The language given in the long descriptor of Provenge® that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs with the exception of its administration - the cost of PROVENGE® administration can be billed separately.

Note: For a local coverage determination by an individual MAC to cover PROVENGE® "off-label" for the treatment of prostate cancer, the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code must be either 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate). ICD-9 diagnosis code 233.4 may not be used for "on-label" coverage claims.

Coding and billing information

ICD-9 diagnosis coding

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9 code	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - The spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung – Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.

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ICD-9 code	Description
197.7	Malignant neoplasm of liver secondary - Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney - The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow – Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland
198.82	Secondary malignant neoplasm of genital organs

Coding for off-label PROVENGE® services

At the discretion of the local Medicare administrative contractors, claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE® services must be billed with either ICD-10 code D075 (carcinoma in situ of prostate) or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 Diagnosis Coding

The appropriate ICD-10 code(s) that are listed below are for future implementation.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

Types of bill (TOB) and revenue codes

The applicable TOBs for PROVENGE® are: 12x, 13x, 22x, 23x, 71x, 77x, and 85x.

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Autologous ... (continued)

On institutional claims, TOBs 12x, 13x, 22x, 23x, and 85x, use revenue code 0636 - drugs requiring detailed coding.

Payment methods

Payment for PROVENGE® is as follows:

- TOBs 12x, 13x, 22x, and 23x - based on the average sales price (ASP) + 6 percent
- TOB 85x – based on reasonable cost
- TOBs 71x and 77x – based on all-inclusive rate (drugs/supplies are not reimbursed separately).
- For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6 percent.

Note: Medicare contractors will not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.

Remittance advice remark codes (RARCs), claim adjustment reason codes (CARCs), and group dodes

Medicare will use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table shown above:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code - contractual obligation (CO)

Medicare will use the following messages when denying line items on claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4 or 185:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group code – CO.

When denying claims for PROVENGE®, HCPCS Q2043® that exceed three (3) payments in a patient's lifetime, contractors shall use the following messages:

- RARC N362 - The number of Days or Units of Service exceeds our acceptable maximum.
- CARC 149 - Lifetime benefit maximum has been reached for this service/benefit category.
- Group code - CO.

When denying claims for PROVENGE®, HCPCS Q2043® that are provided more than 30 weeks from the date of the 1st PROVENGE® administration, contractors shall use the following messages:

- CARC B5 – Coverage/program guidelines were not met or were exceeded.
- Group code – CO.

Additional information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the *National Coverage Determinations Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R140NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2380CP.pdf*.

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

MLN Matters® Number: MM7431 *Revised*
Related Change Request (CR) #: CR 7431
Related CR Release Date: January 6, 2012
Effective Date: June 30, 2011
Related CR Transmittal #: R2380CP and R140NCD
Implementation Date: August 8, 2011

Durable Medical Equipment

Time is running out to register for DMEPOS competitive bidding

If you are a supplier 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 and have registered an authorized official (AO) but not a backup authorized official (BAO), the Centers for Medicare & Medicaid Services (CMS) strongly recommended that a BAO register no later than Thursday, January 12. It is important to do it now so that the BAO will be able to assist the AO with approving end user (EU) registration. The establishment of a BAO is encouraged, if your company has someone that can occupy the BAO role, to avoid any disruption in the bidding process once the 60-day bid window opens. The individual in the BAO role can also assume the AO role if for some reason the AO can no longer fulfill his or her bidding responsibilities; if there is no BAO and the AO leaves the company, all end users associated with the company will lose access to the bidding system.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "Individuals Authorized Access to CMS Computer Services (IACS) Reference Guide" posted on the competitive bidding implementation contractor (CBIC) website (*www.DMECompetitiveBid.com*). To register, visit the *CBIC website* and click on "Registration is Open" above the registration clock on the homepage. You will also find a registration checklist and quick step guides on the *CBIC website*. Please note that suppliers with multiple locations typically must register only one provider transaction access number (PTAN) that will submit the bid for all locations. If you have any questions about the registration process, please contact the CBIC customer service center at 877-577-5331.

The deadline has now passed for AO registration. If the AO for your company has not already registered and obtained a user ID and password, CMS cannot guarantee that he or she will be able to complete the registration process before the registration window closes on Thursday, February 9, 2012, at 9 p.m. ET. This should be of particular concern if the national supplier clearinghouse (NSC) record for your company is not current and accurate. AOs should register now to allow BAOs and EUs time to register. In addition, suppliers whose AOs do not register now run the risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the covered document review date (CDRD). As a result, CMS encourages you to register now.

Remember, the AO and BAO must be listed on the CMS-855S enrollment form as an AO. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as BAOs; the AO and BAOs can then designate other supplier employees as EUs. 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 of the AO and BAOs must match exactly with what is on file with the NSC to register successfully.

Registration will close on Thursday, February 9, 2012, at 9 p.m. ET – no AOs, BAOs, or EUs will be able to register after registration closes.

Remember that 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 *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*. For information about round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under the "Bidding Suppliers: Round 2 & National Mail-Order" menu on the CBIC website.

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

Source: CMS PERL 201201-13

DMEPOS competitive bidding announcements

The Centers for Medicare & Medicaid Services (CMS) has the following announcements for suppliers that are interested in participating in the round 2 and national mail-order competitions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

- The bid limits in the round 2 rebid preparation worksheets have been revised for 14 Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs (K0813 through K0829). The previous bid limits listed in the worksheet were erroneously based on 150 percent of the actual bid limits.
- CMS has made three clarifying updates to the list of glucose monitors on the 50 percent compliance form, a required bid document for the national mail-order competition:
    1. ASCENSIA AUTO DISC has been consolidated with ASCENSIA BREEZE 2. (ASCENSIA AUTO DISC is no longer manufactured but uses the same test strips as the ASCENSIA BREEZE 2.)
    2. FREESTYLE FLASH has been consolidated with FREESTYLE and FREESTYLE FREEDOM. (FREESTYLE FLASH is no longer manufactured but uses the same test strips as FREESTYLE and FREESTYLE FREEDOM.)
    3. PROTÉGÉ has been consolidated with SMARTEST. (PROTÉGÉ is no longer manufactured but uses the same test strips as SMARTEST.)
- CMS would like to remind potential bidders that four adjustable seat cushion codes (E2622 through E2625) have been removed from the round 2 standard wheelchairs product category. The competitive bidding implementation contractor (CBIC) has deleted these codes from the bidder education materials.
- The competitive bidding implementation contractor (CBIC) has issued a new fact sheet providing anti-trust guidance for bidders. To view the fact sheet, please go to the CBIC website at *www.dmecompetitivebid.com* and select “Bidding Suppliers: Round 2 & National Mail-Order” and then choose “Fact Sheets.”
- Four adjustable seat cushion codes have been removed from the round 2 standard wheelchair product category. CMS is in the process of deleting these codes from the educational materials on the CBIC website. A follow-up listserv notice will be sent when the updates to the educational materials are complete.

All of these updates are now available on the CBIC website, *www.dmecompetitivebid.com/*.

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

Source: CMS PERL 201112-53, 201201-12

Credit report/score requirements for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) has issued the following clarification to assist suppliers bidding in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. This information will also be posted on the competitive bidding implementation contractor (CBIC) website. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. ET during the registration and bidding periods.

Q. The request for bids instructions say that suppliers must submit a copy of a credit report with numerical score that was prepared within 90 days prior to the opening of the bid window. Does this mean I can’t submit a credit report and score that is dated after bidding opens but before bidding closes?

A. No. Credit reports and scores must not be prepared earlier than 90 days prior to the opening of the bid window, but they can be prepared after bidding opens as long as they are received by the competitive bidding implementation contractor (CBIC) by the close of the bid window. When bidding opens, CMS will post the specific date that is 90 days prior to the opening of the bid window on the CBIC website. Credit reports and scores that are older than this date will not be accepted.

Source: CMS PERL 201201-43

Learn about the DMEPOS competitive bidding program with CMS' new on-demand webcasts

Several new educational webcasts for the round 2 and national mail-order competition of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program are now available on the competitive bidding implementation contractor (CBIC) website (at *www.DMECompetitiveBid.com*).

- "National Mail-Order Competition for Diabetic Supplies," covers rules that apply specifically to this competition and provides resources to assist you with bidding.
- "Program Rules," explains important rules detailed in the request for bids (RFB) instructions that you should understand before you prepare your bids. The webcast also provides resources to assist you with bidding.
- "How a Bid is Evaluated," goes over each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The webcast also provides resources to assist you with bidding.
- "Financial Documentation Requirements," goes over the rules and requirements for the financial documents that you must submit in addition to your online bid.

These webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and transcripts are also posted on the website. To view the webcasts, please go to the *CBIC website*, select "Bidding Suppliers: Round 2 & National Mail-Order," and choose "Education Events."

The Centers for Medicare & Medicaid Services (CMS) will be issuing one more webcast that will address how to submit a bid in the online bidding system, DBidS. CMS will announce its availability with an email update. If you have not already done so, please register on the *CBIC website* to receive this announcement 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. Eastern Time, 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 201201-44, 201201-38, 201201-25, 201201-14

Find out first: Subscribe to FCSO eNews

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

Laboratory/Pathology

Extension of moratorium for independent laboratories billing the technical component for hospital patients

On Friday, December 23, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service policies. Included in these provisions is an extension of a moratorium that allows certain practitioners and suppliers (such as pathologists and independent laboratories) to bill for the technical component (TC) of physician pathology services furnished to hospital patients through Wednesday, February 29.

Under previous law, including, most recently, Section 105 of the Medicare & Medicaid Extenders Act of 2010, a statutory moratorium allowed certain pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B Medicare administrative contractor for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire on Saturday, December 31. However, Section 305 of the TPTCCA extends that moratorium beginning Sunday, January 1 through Wednesday, February 29. Therefore, qualified pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with dates of service Sunday, January 1 through Wednesday, February 29.

For background and policy information regarding payment to independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to change request (CR) 5347, *Transmittal 1221*, issued on Wednesday, April 18, 2007, and CR 5943, *Transmittal 1440*, issued on Thursday, February 7, 2008.

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

Source: CMS PERL 201201-17

Medicare Physician Fee Schedule Database

Emergency update to the 2012 Medicare physician fee schedule database

Provider types affected

Physicians, non-physician practitioners, and providers who bill Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7737, which informs you that new Medicare physician fee schedule (MPFS) payment files have been created and are available to Medicare contractors.

- Payment files were issued to Medicare contractors based upon the CY 2012 MPFS final rule, issued on November 1, 2011, and published in the "Federal Register" on November 28, 2011.
- CR 7737 amends those payment files to include corrections described in the CY 2012 MPFS final rule correction notice, as well as relevant statutory changes applicable January 1, 2012.

Background

Medicare physician fee schedule revisions and updates

Some physician work, practice expense, and malpractice relative value units (RVUs) published in the CY 2012 MPFS final rule have been revised to align their values with the CY 2012 MPFS final rule policies. These changes are discussed in the CY 2012 MPFS final rule correction notice and revised RVU values are found in Addendum B and Addendum C of the CY 2012 MPFS final rule correction notice.

In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2012 MPFS final rule correction notice.

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Emergency ... (continued)

Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2012 MPFS final rule correction notice public use data files, which are located at: *http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp*.

Changes to the physician work RVUs and payment indicators can be found in the attachment associated with CR 7737, which is cited in the Additional information section. Changes to practice expense RVUs are reflected in Addendum B and Addendum C of the CY 2012 MPFS final rule correction notice.

Legislative changes subsequent to issuance of the CY 2012 MPFS final rule, specifically, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA), have led to the further revision of the values published in the CY 2012 MPFS Final Rule Correction Notice, including a change to the conversion factor. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 MPFS is now scheduled to take effect on March 1, 2012, the Administration remains strongly opposed to letting this cut take effect. The Centers for Medicare & Medicaid Services (CMS) will work quickly to update MPFS payment rates in the event Congress passes legislation to prevent the negative update from going into effect. Please be on the alert for more information about the 2012 physician update as it becomes available.

Temporary Payroll Tax Cut Continuation Act of 2011

On December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This law contains a number of Medicare provisions, which extend current Medicare fee-for-service program policies, and, as previously mentioned, prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. A summary of the TPTCCA provisions relevant to the MPFS payment files are provided below.

Medicare physician payment update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect on January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. Therefore, the conversion factor will not be unchanged in CY 2012 from CY 2011. The revised conversion factor to be used for physician payment as of January 1, 2012, is $34.0376. The calculation of the CY 2012 conversion factor is illustrated in the following table.

December 2011 conversion factor	TPTCCA of 2011 "Zero Percent Update"	CY 2012 RVU Budget Neutrality Adjustment	CY 2012 Conversion Factor thru 2/29/12
$33.9764	0.0 percent (1.000)	0.2 percent (1.0018)	$34.0376

The revised CY 2012 MPFS payment files will reflect this conversion factor through February 29, 2012.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense (PE), and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index through February 29, 2012. This change is included in the revised CY 2012 MPFS payment files. Updated CY 2012 geographic practice cost indices (GPCI) are included in the attachment to CR 7737. See the *Additional information* section for information on accessing CR 7737.

Extension of MPFS mental health add-on

For calendar year 2011, certain mental health services' payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services through February 29, 2012. This five percent increase is reflected in the revised CY 2012 MPFS payment files. The lists of Psychiatry *Current Procedural Terminology*® (*CPT*) codes that represent the specified services subject to this payment policy are included in the attachment to CR 7737.

Extension of exceptions process for Medicare therapy caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier (Specific required documentation on file), when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,880. For occupational therapy services, the limit is $1,880. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached and also apply for services above the cap where the KX modifier is used.

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Emergency ... (continued)

Extension of payment for the technical component (TC) of certain physician pathology services
In the CY 2000 PFS final rule, published in the *Federal Register* on November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the TC of a pathology service provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the TC of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the most recent extension of the moratorium expired at the end of 2011, Section 305 of the TPTCCA restores the moratorium through February 29, 2012. Therefore, those independent laboratories that are eligible may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was furnished. This policy is effective for claims with dates of service on or after January 1, 2012, through February 29, 2012.

Extension of the minimum payment for bone mass measurement
Section 3111(a) of the Affordable Care Act changed the payment calculation for dual-energy x-ray absorptiometry (DXA) services described *CPT* codes *77080* (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)*) and *77082* (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment*) for CYs 2010 and 2011. This provision required payment for these services at 70 percent of the product of the CY 2006 RVUs for these DXA codes, the CY 2006 conversion factor (CF), and the geographic adjustment for the relevant payment year. CMS provided for payment in CYs 2010 and 2011 under the physician fee schedule (PFS) for *CPT* codes *77080* and *77082* at the specified rates. Because this provision did not include CY 2012, the CY 2012 PFS final rule with comment period listed resource-based, rather than imputed, RVUs for *CPT* codes *77080* and *77082*. However, Section 309 of the TPTCCA extended the Affordable Care Act minimum payment for bone mass measurement for the first two months of CY 2012. For claims with dates of service on or after January 1, 2012, through February 29, 2012, *CPT* codes *77080* and *77082* will be paid at 70 percent of the product of the CY 2006 RVUs, the CY 2006 CF, and the geographic adjustment for the CY 2012. The revised CY 2012 work, PE, and malpractice RVUs for *CPT* codes *77080* and *77082* are shown below.

RVUs for DXA *CPT* codes *77080* and *77082*, January 1, 2012, through February 29, 2012

CPT code	Modifier	Work RVU	Fully Implemented Non-Facility PE RVU	Transitional Non-facility PE RVU	Fully Implemented Facility PE RVU	Transitional Facility PE RVU	Malpractice RVU
77080		0.23	2.50	2.50	N/A	N/A	0.14
77080	TC	0.00	2.42	2.42	N/A	N/A	0.13
77080	26	0.23	0.08	0.08	0.08	0.08	0.01
77082		0.13	0.63	0.63	N/A	N/A	0.05
77082	TC	0.00	0.58	0.58	N/A	N/A	0.04
77082	26	0.13	0.05	0.05	0.05	0.05	0.01

Additional information

The official instruction, CR 7737, issued to your FI, RHHI, carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1015OTN.pdf*.

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

MLN Matters® Number: MM7737
Related Change Request (CR) #: 7737
Related CR Release Date: January 20, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1015OTN
Implementation Date: No later than January 26, 2012

Revised 'Medicare Physician Fee Schedule' fact sheet

The *"Medicare Physician Fee Schedule" fact sheet (ICN 006814)* has been revised and is now available in downloadable format. It includes information on physician services, therapy services, Medicare physician fee schedule (PFS) payment rates, and the Medicare PFS rates formula.

Source: CMS PERL 201201-42

Radiology

Multiple procedure payment reduction on certain diagnostic imaging procedures

Provider types affected

This article is for physicians, clinical diagnostic laboratories, and other providers who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MACs]) for providing diagnostic imaging services to Medicare beneficiaries.

Provider action needed

Change request (CR) 7442, from which this article is taken, announces that Medicare is expanding the multiple procedure payment reduction (MPPR) to the professional component (PC) in addition to the technical component (TC) of certain diagnostic imaging procedures. You should make sure that your billing staffs are aware of these changes.

Background

Section 3134 of the Affordable Care Act (ACA) added Section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of the Department of Health and Human Services must identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare is making a change to the MPPR on the certain diagnostic imaging procedures. Specifically, the Centers for Medicare & Medicaid Services (CMS) is applying the MPPR to the PC services as well as to TC services. The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Currently, the MPPR on diagnostic imaging services applies only the TC services. It applies to both TC-only services and to the TC portion of global services. Full payment is made for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day. CMS is expanding the MPPR by applying it to PC services. Full payment is made for each PC and TC service with the highest payment under the Medicare physician fee schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. Due to operational considerations, CMS is not applying the imaging MPPR to group practices at this time.

The complete list of codes subject to the MPPR on diagnostic imaging is in Attachment 1 of CR 7442, which is at *http://www.cms.gov/Transmittals/downloads/R937OTN.pdf*. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction. The current and proposed payments are summarized in the following table:

	Procedure 1	Procedure 2	Current Total payment	Current payment calculation	Proposed total payment	Proposed payment calculation
PC	$68	$102	$170	No Reduction	$153	$102 + (.75 x $68)
TC	$476	$340	$646	$476 + (.50 x $340)	$646	$476 + (.50 x $340)
Global	$544	$442	$816	$170 + $476 + (.50 x $340)	$799	$102 + (.75 x $68) + $476 + (.50 x $340)

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MPPR ... (continued)

When applying the reduction, Medicare contractors will use modifier 51 to identify reduced PC services and reduced global services as they do today for TC services. In addition, they will append claim adjustment reason code 59 (Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia) **Note**: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.) They will also assign group code CO (contractual obligation).

Additional information

You will find the complete list of codes subject to the MPPR on diagnostic imaging and an example of how payments are calculated in CR 7442, which is the official instruction issued to your carrier or A/B MAC on this issue. CR 7442 is available at *http://www.cms.gov/Transmittals/downloads/R995OTN.pdf*.

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

MLN Matters® Number: MM7442
Related Change Request (CR) #: 7442
Related CR Release Date: November 4, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R995OTN
Implementation Date: January 3, 2012

General Coverage

President Obama signs the Temporary Payroll Tax Cut Continuation Act of 2011

New law includes physician update fix through February 2012

On Friday, December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 Medicare Physician Fee Schedule is now scheduled to take effect on March 1, 2012, the administration remains strongly opposed to letting this cut take effect. As he has repeatedly made clear, President Obama is committed to a permanent solution to eliminating the sustainable growth rate's cut. We will continue to work with Congress to achieve this goal.

The Centers for Medicare & Medicaid Services (CMS) has also recently implemented several important changes for Medicare providers and beneficiaries, and we would like to remind physicians and practitioners of some of these key changes for 2012. For many of your patients, Medicare costs will go down. Medicare cost-sharing for Part B services will decline in some cases and, for the first time, the Part B deductible will decrease, by $22, to $140.

Additionally, health care professionals will be paid more to provide certain important services for people with Medicare. CMS has increased the payment amount for the initial and annual wellness visit -- which has no cost sharing for patients – to account for the introduction of health risk assessment (HRA). CMS believes it is important to balance the comprehensiveness of the HRA with the potential burden on patients and health professional time constraints. As such, in 2012, CMS will allow for variation in the content of the HRA.

The Medicare Part D prescription drug program has also been enhanced for 2012, with the coverage gap being further reduced as it is phased-out over the next several years. These improvements to the drug benefit from the Affordable Care Act have already saved millions of seniors nearly $2 billion.

CMS wishes to remind physicians and practitioners about the Primary Care Incentive Program. Again in 2012, primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants may be eligible to receive an incentive payment equal to 10 percent of their allowed charges for primary care services under Medicare Part B. This incentive is paid in addition to any physician incentive payments for services furnished in health professional shortage areas. Please remember that if a practitioner has reassigned his or her benefits to another entity, such as a group practice, Medicare will pay that entity and not the individual practitioner.

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Obama ... (continued)

The Affordable Care Act created the Center for Medicare and Medicaid Innovation that offers physicians, practitioners and other health care leaders the opportunity to propose innovative payment and service delivery models to lower costs, improve quality, and improve health. More information can be found at *www.innovations.cms.gov*.

Below please find summaries of key provisions of the TPTCCA along with some information about how these changes may affect providers and provider billing.

Physician payment update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect on January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. CMS is currently developing the 2012 Medicare physician fee schedule (MPFS) to implement the zero percent update. As previously advised, Medicare claims administration contractors will be holding new, January 2012 claims for up to 10 business days in order to effectively test and implement the new 2012 MPFS. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected. Finally, Medicare contractors will be posting the new rates on their websites no later than January 11, 2012.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense, and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index, through February 29, 2012. As with the physician payment update, this change will be accomplished through a revised 2012 MPFS.

Extension of physician fee schedule mental health add-on payments

For calendar year 2011, certain mental health services' payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services, through February 29, 2012. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2012 MPFS.

Extension of Medicare Modernization Act section 508 reclassifications

Section 302 of the TPTCCA extends section 508 reclassifications and certain special exception wage indexes for 2 months, from October 1, 2011, through November 30, 2011. For the period beginning on October 1, 2011, and ending on November 30, 2011, Section 302 also requires removing section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by section 302 of the TPTCCA shall be assigned a special wage index effective for only October and November 2011. We will apply the provision to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception wage index will be applicable from January 1, 2012, through February 29, 2012.

Extension of exceptions process for Medicare therapy caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,880. For occupational therapy services, the limit is $1,880. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Extension of moratorium on independent laboratory billing for the technical component (TC) of physician pathology services furnished to hospital patients

In the final physician fee schedule regulation published in the *Federal Register* November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the technical component of a pathology service

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Obama ... (continued)

provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the technical component of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the most recent extension of the moratorium expired at the end of 2011, section 305 of the TPTCCA restores the moratorium through February 29, 2012. Therefore, those independent laboratories that are eligible may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was furnished. This policy is effective for claims with dates of service on or after January 1, 2012, through February 29, 2012.

Extension of ambulance add-on payments

The provisions that were extended by section 306 of the TPTCCA are:

1. The three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas;
2. The provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and
3. The provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through February 29, 2012. As previously advised, Medicare claims administration contractors will be holding new, January 2012 ambulance claims for up to 10 business days in order to effectively implement the new 2012 ambulance fee schedule. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected.

Extension of outpatient hold harmless provision

Section 308 of the TPTCCA extends the outpatient hold harmless provision, effective for dates of service on and after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Extension of minimum payment for bone mass measurement

Section 309 of the TPTCCA extends through February 29, 2012, the 2011 payment rate for bone mass measurement. Similar to the zero percent update and other provisions, this extension will be reflected in the revised 2012 MPFS.

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

Source: CMS PERL 201201-01

HCPCS code set update

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

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

Source: CMS PERL 201201-18

Bundling of payments for services provided to outpatients who later are admitted as inpatients: 3-day payment window policy and the impact on wholly-owned or wholly-operated physician offices

Provider types affected

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

Provider action needed

Physicians, suppliers, and providers must insure that their billing staffs are aware of these new changes to the rules for services provided to outpatients who are later admitted as inpatient. The Centers for Medicare & Medicaid services (CMS) includes these changes in CR 7502.

Background

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) (Pub. L. 111-192) was enacted. Section 102 of this Act entitled, "Clarification of 3-Day Payment Window," clarified when certain nondiagnostic services furnished to Medicare beneficiaries in the 3-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 1 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."

Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the inpatient claim for a Medicare beneficiary's inpatient stay, the technical portion of all outpatient diagnostic services and admission-related nondiagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

Prior to June 25, 2010, and the enactment of Public Law 111–192, the payment window policy for preadmission nondiagnostic services was rarely applied as the policy required an exact match between the principal ICD–9 CM diagnosis codes for the outpatient services and the inpatient admission. The requirement of the exact match resulted in very few services furnished in an entity that is wholly owned or operated by the hospital being subject to the policy. The statutory change to the payment window policy made by Public Law 111–192 significantly broadens the definition of nondiagnostic services that are subject to the payment window to include any nondiagnostic service that is clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

In accordance with Section 102(a)(1) of the PACMBPRA, for outpatient services furnished on or after June 25, 2010, the technical portion of all nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be included on the bill for the inpatient stay. Also, the technical portion of outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay.

PACMBPRA did not change the requirement that the technical portion of all diagnostic services provided by the hospital (or entity wholly owned or wholly operated by the hospital) occurring on the date of an inpatient admission, or during the 3 calendar days (or 1 calendar day) immediately preceding the date of an inpatient admission must be billed with the inpatient admission.

Note: If the nondiagnostic services are unrelated to the inpatient hospital claims, that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission, the unrelated outpatient hospital nondiagnostic services are covered by Medicare Part B, and the wholly owned or wholly operated entity shall include the technical portion of the services in their billing.

Implementation of the 3-day payment window policy in wholly-owned or wholly-operated entities
Wholly-owned or wholly-operated entities are subject to the 3-day (or 1-day) payment window policy when they furnish preadmission diagnostic services to a patient who is later admitted as an inpatient on the same day or within the preceding three calendar days (preceding one calendar day), or when they furnish preadmission nondiagnostic services to a patient, who is later admitted as an inpatient on the same day or within the preceding three calendar days (preceding one calendar day) for related medical care.

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Bundling ... (continued)

When an entity that is wholly-owned or wholly-operated by a hospital furnishes a service subject to the 3-day 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 the entity has received confirmation of a beneficiary's inpatient admission from the admitting hospital, they shall, for services furnished during the 3-day window, append a CMS payment modifier to all claim lines for diagnostic services and for those nondiagnostic services that have been identified as related to the inpatient stay. Physician nondiagnostic services that are unrelated to the hospital admission are not subject to the payment window and shall be billed without the payment modifier.

Defining wholly-owned and wholly-operated entities

Wholly-owned or wholly-operated entities are defined in 42 CFR §412.2: "An entity is wholly-owned by the hospital if the hospital is the sole owner of the entity." And, "an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity."

Payment methodology

CMS has established new payment modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days), and require that the modifier be appended to the entity's preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/CPT codes, which are subject to the 3-day payment window policy. The wholly owned or wholly operated entity will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay.

The modifier is available for claims with dates of service on or after January 1, 2012, and entities may begin to coordinate their billing practices and claims processing procedures with their hospitals to ensure compliance with the 3-day payment window policy no later than for claims received on or after July 1, 2012.

When the modifier is present on claims for service CMS shall pay:

- Only the professional component (PC) for CPT/HCPCS codes with a technical component (TC)/PC split that are provided in the 3- calendar day (or, 1- calendar day) payment window; and
- The facility rate for codes without a TC/PC split.

Global surgical services and the 3-day payment window policy

We note that the time frames associated with 10 and 90 day global surgical packages could overlap with the 3-day (or 1-day) payment window policy. The 3-day payment window makes no change in billing surgical services according to global surgical rules, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the 3-day window policy, as would occur if the surgery were performed within the 3-day window. For example, a patient could have a minor surgery in a wholly owned or wholly operated entity and then, due to a complication, be admitted as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.

Additional information

The official instruction, CR 7502 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2373CP.pdf*. Revised portions of the *Medicare Claims Processing Manual*, containing further details on this change, are attached to CR 7502.

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

MLN Matters® Number: MM7502
Related Change Request (CR) #: 7502
Related CR Release Date: December 21, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2373CP
Implementation Date: January 3, 2012

Recovery audit program: Medicare administrative contractor-issued demand letters

Note: This article was revised on January 9, 2012, to reflect the revised change request (CR) 7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR 7436 were revised. All other information is the same. This information was previously published in the August 2011 *Medicare B Connection*, Page 23.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

Background

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

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

Additional information

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

To see the official instruction (CR 7436) issued to your Medicare contractor, see *http://www.cms.gov/Transmittals/downloads/R202FM.pdf*.

MLN Matters® Number: MM7436 *Revised*
Related Change Request (CR) #: 7436
Related CR Release Date: January 6, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R202FM
Implementation Date: January 3, 2012

Use of revised RARC N103 when denying services furnished to federally incarcerated beneficiaries

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, A/B Medicare administrative contractors [MACs], and durable medical equipment MACs or DME MACs) for Medicare beneficiaries who are incarcerated in a federal facility.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7678 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending remittance advice remark code (RARC) N103 to include language that further explains the newly modified RARC N103 – denying claims for services to federally incarcerated beneficiaries.

Caution – what you need to know

CR 7678 is limited to providers billing for services for beneficiaries while they are in federal, state, or local custody and the goal of this CR 7678 is to be more specific in explaining the accompanying adjustment.

Go – what you need to do

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

Background

The following exclusions presumptively apply to individuals who are incarcerated in a federal facility under federal authority:

- According to federal regulations at 42 *Code of Federal Regulations* (CFR) Section 411.4 Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service and no other person or organization has a legal obligation to provide or pay for the service;
- Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency; and
- Under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

Key points

When denying claims for services furnished to federally incarcerated Medicare beneficiaries, the newly modified RARC N103 will be used (in addition to remittance advice language already in use) and it reads as follows:

"Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a federal facility, or while he or she is in state or local custody under a penal authority, unless under state or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt."

Additional information

The official instruction, CR 7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R1012OTN.pdf*. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7678
Related Change Request (CR) #: 7678
Related CR Release Date: January 6, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R1012OTN
Implementation Date: July 2, 2012

Claim adjustment reason code, remittance advice remark code, and Medicare Remit Easy Print and PC Print update

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7683 which updates claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

Caution – what you need to know

CR 7683 instructs Medicare contractors and the shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software. Be sure your billing staff is aware of these changes.

Go – what you need to do

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate group code must be reported as well. Additionally, for transaction 837 COB, CARC must be used. The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and SSMs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual “stop date” posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 7683, Medicare contractors must implement on the date specified on the WPC website. The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times

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CARC ... (continued)

a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

The WPC website (at *http://www.wpc-edi.com/Reference*) has four listings available for both CARC and RARC:

1. **All**: All codes including deactivated and to be deactivated codes are included in this listing.
2. **To be deactivated**: Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated**: Only codes with prior deactivation effective date are included in this listing.
4. **Current**: Only currently valid codes are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

Claim adjustment reason code (CARC)

A national code maintenance committee maintains the health care CARCs. The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see *http://www.wpc-edi.com/Reference*.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than a future date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on coordination of benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule. The following new CARCs were approved by the code committee in October, and must be implemented, if appropriate, by April 2, 2012.

New codes – CARC

Code	Current narrative	Effective date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).	3/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA).	3/1/2012

Modified codes – CARC

Code	Modified narrative	Effective date
18	Exact duplicate claim/service (Use with Group Code OA).	1/1/2013

Deactivated codes – CARC

Code	Current narrative	Effective date
141	Claim spans eligible and ineligible periods of coverage.	7/1/2012

Remittance advice remark codes (RARC)

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change.

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CARC ... (continued)

CR 7683 contains no new, modified, or deactivated RARC codes.

Additional information

The official instruction, CR 7683, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2372CP.pdf*.

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

MLN Matters® Number: MM7683
Related Change Request (CR) #: CR 7683
Related CR Release Date: December 22. 2011
Effective Date: April 1, 2012
Related CR Transmittal #: R3372CP
Implementation Date: April 2, 2012

Non-specific procedure code description requirement for HIPAA version 5010 claims

Provider types affected

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

What you need to know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012, will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required.

Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when non-specific procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all non-specific procedure codes.

Background

The HIPAA version 5010 implementation guide describes non-specific procedure codes as codes that may include, in their descriptor, terms such as: “not otherwise classified (NOC); unlisted; unspecified; unclassified; other; miscellaneous; prescription drug generic; or prescription drug, brand name.” If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional information

A complete listing of not otherwise classified (NOC) code set is available at *http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp*.

For 5010/D.O implementation information and deadlines, refer to *MLN Matters*® special edition article SE1131, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf*.

If you are not ready, consider contacting your Medicare contractor to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

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Non-specific ... (continued)

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, change request (CR) 7392, "Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates," dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR 7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

MLN Matters® Number: SE1138
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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Stay on track and complete your version 5010 upgrade

As 2012 begins, it is important to keep your focus on compliance with version 5010 and beginning to plan for the transition to ICD-10.

The version 5010 deadline was on January 1, 2012; however, because of the *90-day enforcement discretion period* for all HIPAA covered entities upgrading to version 5010 (ASC X12 version 5010), the Centers for Medicare & Medicaid Services (CMS) will not initiate enforcement action until April 1, 2012. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades to be compliant.

CMS encourages you to continue internal testing as well as external testing of version 5010 transactions with trading partners to ensure compliance for version 5010. Although enforcement action will not be taken prior to April 1, 2012, it is important that you continue to move forward to meet version 5010 requirements as soon as possible. In addition to testing, if you have not yet created a plan for version 5010, you should do so in order to meet these compliance deadlines.

To find out about steps to take toward a successful upgrade, consult the new CMS fact sheet: *Version 5010: How Health Care Providers Can Ensure a Smooth Transition*.

Remember: Upgrading to version 5010 is a critical first step for the nationwide transition to ICD-10 that will take place on October 1, 2013. It is important that you finish this process, so that you can continue to prepare your organization for the ICD-10 transition.

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 *http://www.browserspring.com/widgets/cms2/iframe.html* today.

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

Source: CMS PERL 201201-15

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

Note: This article was revised on January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims to the coordination of benefits agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS-1500 or UB-04 hardcopy formats. All other information remains unchanged. This information was previously published in the December 2011 *Medicare B Connection*, Pages 38-39.

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 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 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 and 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 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* and 6664*, 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."

*To review the entire CR 6658, visit *http://www.cms.gov/transmittals/downloads/R1844CP.pdf*.

*To review the entire CR 6664, visit *http://www.cms.gov/transmittals/downloads/R1841CP.pdf*.

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.

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/MLNMattersArticles/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.gov/transmittals/downloads/R474CP.pdf*.

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Crossover ... (continued)

- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional clarification of the crossover claims process

There is some confusion in the provider community concerning whether billing of hardcopy CMS-1500 or UB-04 claims or HIPAA version 4010A1 or NCPDP version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or version 4010A1 or NCPDP 5.1 batch formats. This assumption is incorrect, as explained below.

During the 90 day non-enforcement period (January 1-March 31, 2012), Medicare will have the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of version 5010 COB claims in production; and
- Take incoming claims submitted by the provider community in the version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare's common working file (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90 day non-enforcement period.

Note: For physicians/practitioners, providers, and suppliers that have the authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims to Medicare using a hardcopy format, Medicare has the systematic capability to convert keyed claims into outbound compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90 day non-enforcement period.

Summary

During the 90 day non-enforcement period, Medicare has the ability to take incoming claims formats (hardcopy, version 4010A1, version 5010A1 or 5010A2, NCPDP 5.1 batch, or NCPDP D.0 batch) and transform them into alternative version HIPAA claim or NCPDP claim formats for COB purposes to address the "production" specifications of various supplemental payers. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of 90 day non-enforcement period.

Additional information

If you have any questions, please contact your Medicare contractor at their toll-free number found at *http://www.cms.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 *Revised*
Related Change Request (CR) #: N/A
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Implementation Date: N/A

Feeling confused about 5010?
We can help remove the mystery …
Try our 5010 reject code lookup at *http://medicare.fcso.com/EDI_resources/errorcode.asp*.

CMS requires adoption of HIPAA standards for electronic payments and remittance advice

Action

The Centers for Medicare & Medicaid Services (CMS) has announced an interim final rule (IFC) – with comment period (CMS-0024-IFC) – under which the Department of Health and Human Services (HHS) must adopt health care electronic funds transfers (EFT) and remittance advice transaction (RA) standards specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Section 1104 of the Patient Protection and Affordable Care Act of 2010 requires CMS to issue a series of regulations over the next five years that are designed to streamline health care administrative transactions, encourage greater use of standards by providers, and make existing standards work more efficiently. On July 8, 2011, CMS published the first regulation, an IFC that puts in place operating rules for two electronic health care transactions that make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer.

This regulation is the second in the series and establishes EFT standards that, when implemented by health plans, will save physician practices and hospitals between of $3 billion to $4.5 billion over the next ten years. Further environmental benefits from the use of an electronic payment in contrast to payments made by paper checks will result in an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over 10 years.

Future administrative simplification rules will address adoption of:

- A standard unique identifier for health plans;
- A standard for claims attachments; and
- Requirements that health plans certify compliance with all HIPAA standards and operating rules.

Background

Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996. HIPAA amended the Social Security Act (the Act) by adding Part C – Administrative Simplification – to Title XI of the Act, requiring the Secretary of the Department of Health and Human Services (DHHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Section 1104(b)(2)(A) of the Patient Protection and Affordable Care Act (Pub. L. 111 148) amended Section 1173(a)(2) of the Act by adding the electronic funds transfers (EFT) transaction to the list of electronic health care transactions for which the Secretary must adopt a standard under HIPAA.

In general, the savings and benefits related to use of EFT for business and consumer payments are well established. The most common savings are in paper, printing, and postage costs, as well as savings in staff time to manually process and deposit paper checks. Yet adoption and use of EFT by the health care industry has been low, resulting in administrative savings that go unrealized. The obstacles to greater use of EFT by the health care industry can be lessened by standardization of the EFT transaction. Beyond the material and administrative time savings for health care providers and health plans, the time and resources that physician practices and hospitals spend on billing and related tasks will be better spent on delivering health care to patients.

On December 3, 2010, the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards held a hearing and from it gathered a comprehensive review of the health care payment and remittance advice transaction for purposes of making a recommendation to the Secretary. Participants represented a cross section of the health care industry. On February 17, 2011, the NCVHS sent a letter to the Secretary that contained recommendations for adoption of a “health care EFT” standard.

continued on next page

Payments ... (continued)

Based on that recommendation, HHS is adopting two standards for the health care EFT that a health plan must comply with in order to transmit health care claim payments to providers via EFT. The first is a standard format for when a health plan orders, authorizes, or initiates an EFT with its financial institution. The second standard specifies the data content to be contained within the EFT.

The goal for adopting these standards is to ensure that a trace number that connects the payment to the electronic remittance advice is inputted into a standard EFT format and that is received without error by the health care provider. This can be best achieved by requiring that a single electronic file format (CCD+Addenda) be used by all health plans that transmit health care EFT to their financial institutions and by requiring that data elements are consistent and ordered according to clear implementation specifications.

Provisions of the IFC

HHS is adopting two standards for the health care EFT: The "CCD+Addenda" implementation specifications in the *2011 National Automated Clearing House Association (NACHA) Operating Rules & Guidelines* and the "TRN Segment" implementation specifications in the X12 835 TR3 for the data content of the addenda record of the "CCD+Addenda."

Costs/benefits

Although all covered entities are required to comply with the adopted standards of HIPAA transactions, the health care EFT standards are expected to have the most substantial cost and benefit impacts on physician practices, hospitals, and commercial and government health plans.

CMS estimates that many health plans will have direct costs associated with implementing and using the health care EFT standards. However, those costs are expected to be comparably small software investments: Approximately $18 million to $28 million overall for all commercial health plans and $400,000 to $600,000 for Medicaid, the Children's' Health Insurance Program (CHIP), and the Indian Health Service (IHS). Over ten years, the savings could be as much as $40 million for commercial health plans and $31 million for Medicaid, CHIP, and IHS.

For physician practices and hospitals, there is little to no cost to implement the health care EFT standards, as providers are the receivers of the standardized transaction and not the senders. Overall, physician practices and hospitals should see savings of $3 billion to $4.5 billion over the next ten years as health plans implement the health care EFT standards.

CMS can also expect a modest environmental benefit from the use of an electronic payment in contrast to payments made by paper checks, including an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

Regulation effective date/ standards compliance date

The effective date of this regulation is January 1, 2012. Under the Affordable Care Act, HIPAA-covered entities must be in compliance with the standards (i.e., use the health care EFT standards) by January 1, 2014.

The rule (CMS-0024-IFC) is on display and may be viewed at *www.ofr.gov/inspection.aspx*. A news release on the rule may be viewed at *http://www.hhs.gov/news*.

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

Source: CMS PERL 201201-10

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 application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.

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 201201-36

Version 5010 and NCPDP D.0 cut over and impacts on crossover claims

On Monday, December 5 the Centers for Medicare & Medicaid Services (CMS) issued a special edition *MLN Matters* article (SE1137) titled "Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process." CMS issued this guidance for the benefit of physicians/practitioners, providers, and suppliers to help them understand why they were seeing greater instances of Medicare correspondence letters that made reference to error N22226 as the basis for why their patients' claims could not be crossed over.

CMS has since learned that concern exists in the provider community on whether billing of hardcopy CMS-1500 or UB-04 claims or HIPAA version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. This is not true.

During the 90-day version 5010 non-enforcement period (Sunday, January 1, 2012, through Saturday, March 31, 2012), Medicare will have the systematic capability to perform up- or down-version conversion of incoming claim formats (ie. convert incoming hardcopy formats to HIPAA equivalent claim formats and convert incoming version 4010A1 claim formats to 5010 formats and vice versa), in accordance with external supplemental payer specifications concerning production claims format. This practice will discontinue, however, at the conclusion of the 90-day non-enforcement period, with the exception below. (This action is controlled by information that the common working file receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode.)

Note that physicians/practitioners, providers, and suppliers that have authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims using a hardcopy format should know that Medicare has the systematic capability to convert keyed claims into outbound-compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90-day non-enforcement period.

Source: CMS PERL 201201-28

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

Effective December 21 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 A. The specific NDC edit that was turned off requires that the NDC in loop ID 2410 LIN03 to be validated against the Food and Drug Administration's (FDA) NDC code list. A replacement NDC edit will be implemented in the Part A 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 was disseminated for the deactivation of the Part B NDC edit on Monday, December 19. The Medicare Part B NDC edit was deactivated on Friday, December 9.

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.

Source: CMS PERL 201112-55

Version 5010 benefits and resources

Version 5010 offers great improvement over version 4010/4010A; for example, version 5010:

- Greatly improves standardization of administrative data and supports both ICD-9 and ICD-10 codes sets
- Supports electronic submission of claims
- Provides greater specificity of clinical data and patient information, and
- Has a more logical structure, which will assist in faster code selection and improved ease of use.

Version 5010 resources

Please visit the *Version 5010* and *Latest News* pages on the CMS ICD-10 website for resources to assist with the version 5010 transition. Resources include:

- The following fact sheets can assist with making a smooth version:
  - *Version 5010: How Health Care Providers Can*
  - *Version 5010: Testing Readiness, What You Need to Know*
  - *FAQs: Versions 5010 and D.0 Transition Basics*
- Implementation handbooks tailored for:
  - *Large provider practices*
  - *Payers*
  - *Small hospitals*, and
  - *Small/medium provider practices*
- An interactive *widget* as well as printer friendly timelines for:
  - *Large provider practices*
  - *Small provider practices*
  - *Payers*, and
  - *Vendors*

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.

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

Source: CMS PERL 201201-05

New ASC X12 version 5010 FAQs posted available – link corrected

Medicare fee-for-service (FFS) issued an announcement Wednesday, December 14 regarding its plan for the 90-day discretionary enforcement period for non-compliant Health Insurance Portability and Accountability Act (HIPAA) covered entities. The Centers for Medicare & Medicaid Services published six frequently-asked questions (FAQs) related to this plan. These new FAQs can be found at *http://www.cms.gov/Versions5010andD0/Downloads/QandA_for_90_day_announcement.pdf*.

For more information on ASC X12 version 5010, National Council for Prescription Drug Program (NCPDP) D.0, and NCPDP 3.0; please visit *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 201201-02

New resources available to assist providers with ICD-10 transition

On January 16, 2009, the U.S. Department of Health and Human Services published final rules that mandated all organizations covered by Health Insurance Portability and Accountability Act (HIPAA) must upgrade to version 5010 by January 1, 2012, and transition to ICD-10 coding sets by October 1, 2013. As a result of the enforcement discretion period for version 5010, all organizations must complete their version 5010 upgrade by no later than March 31, 2012. Upgrading to version 5010 is an essential step that must be taken before the transition to ICD-10, and the deadline for the ICD-10 transition is quickly approaching.

To help with this transition, the Centers for Medicare & Medicaid Services (CMS) has developed a number of resources available on the CMS ICD-10 website.

Fact sheets

- *Ensuring a Smooth Transition to Version 5010*
- *ICD-10 Transition: An Introduction*
- *ICD-10 Basics for Medical Practices*
- *ICD-10 FAQs*
- *Talking to Your Vendors about the Transition to ICD-10*

Implementation widget

CMS' interactive *widget* outlines the steps to take to ensure compliance with version 5010 and ICD-10. CMS encourages you to download or share the widget and take advantage of printer-friendly versions of the timelines available for small provider practices, large provider practices, payers, and vendors.

Implementation timelines

Timelines are printer-friendly checklists that complement the widget. Timelines are available for:

- *Small providers*
- *Large providers*
- *Payers*, and
- *Vendors*.

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.

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

Source: CMS PERL 201201-40

Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at *http://www.cms.gov/cmsforms/downloads/CMS588.pdf*.

Provider Enrollment

2012 annual participation enrollment program extension

Attention health professionals

The Centers for Medicare & Medicaid Services (CMS) is anticipating congressional action to avert the negative update for the 2012 Medicare physician fee schedule. Therefore, CMS is extending the 2012 annual participation enrollment period through February 14, 2012. The enrollment period now runs November 14, 2011, through February 14, 2012.

However, the effective date for any participation status change during the extension remains January 1, 2012, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are post-marked on or before February 14, 2012.

Source: CMS PERL 201112-47

Important reminder for providers and suppliers who provide services and items ordered or referred by other providers and suppliers

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs [DVA] or the Public Health Service [PHS]) who order or refer items or services for Medicare beneficiaries.

Provider action needed

Stop – impact to you

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual national provider identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Caution – what you need to know

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

Go – what you need to do

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Portable X-ray services may only be ordered by an M.D. or D.O. Portable X-ray services ordered by any other practitioners will be denied.

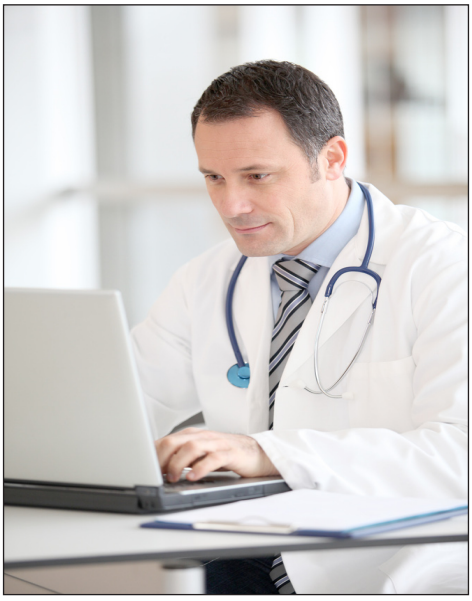
continued on next page

Ordering/Referring ... (continued)

MLN Matters® special edition article SE1011 provides further details about edits on the ordering/referring provider information on claims. The article is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf*.

Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/MedicareProviderSupEnroll* or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Contact_list.pdf*.



The *Medicare Learning Network*® (*MLN*) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *https://www.cms.gov/MLNMattersArticles/downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6417.pdf*.

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf*.

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6129.pdf*.

MLN Matters® Number: SE1201
Related Change Request (CR) #: N/A
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Related CR Transmittal #: N/A
Implementation Date: N/A

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Reminder: Technical component of advanced diagnostic imaging accreditation requirements effective January 1

Suppliers of the technical component of advanced diagnostic imaging, billing with a service date on or after January 1, must have evidence of an active accreditation date for diagnostic imaging of *Current Procedural Terminology*® (*CPT*) codes attached to a magnetic resonance imaging, computed tomography, and nuclear medicine claim. The professional component claims are not affected by the accreditation requirements and must be processed as usual.

Refer to Transmittal 380, *http://www.cms.gov/transmittals/downloads/R380PI.pdf* or *MLN Matters*® MM7177, *http://www.cms.gov/MLNMattersArticles/downloads/MM7177.pdf* for further information on claim processing.

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

Source: CMS PERL 201112-60

Advanced diagnostic imaging accreditation enrollment procedures – fully rescinds and replaces CR 7177

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for advanced diagnostic imaging (ADI) services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7681 which fully rescinds and replaces CR 7177.

Caution – what you need to know

CR 7177 established that ADI providers/suppliers would need to provide their ADI accreditation information by completing an Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) application or a CMS-855 application. CR 7681 changes this requirement and allows for the accrediting organizations to provide the listing of who is accredited through a weekly file. Since this change, providers/suppliers no longer need to complete the ADI information in Internet-based PECOS or on a CMS-855 form(s).

Go – what you need to do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA - Section 135(a); see *http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf*) amended the Social Security Act (Section 1834(e); see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) and required the Secretary of the U.S. Department of Health and Human Services (HHS) to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners, and independent diagnostic testing facilities, that furnish the technical component (TC) of ADI services.

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

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

The Centers for Medicare & Medicaid Services (CMS) implemented (effective January 1, 2012) the requirement that ADI providers and/or suppliers must be accredited for ADI services specific to each modality for which they will submit claims. Originally, CMS required the providers/suppliers to provide their accreditation information on their respective CMS-855 form, or through the Internet-based PECOS.

CR 7681 establishes a new process that allows for ADI providers and/or suppliers to bypass ADI information collection on the appropriate CMS-855 form or in the Internet-based PECOS Web application. CR 7681 instructs that Medicare contractors will:

- Not require documentation from the ADI provider/supplier for proof of their accreditation; and
- Not require providers/suppliers to complete the ADI section in the Internet-based PECOS application nor in the appropriate CMS-855 form.

Instead, Medicare and its contractors will receive this information directly from the accrediting organizations.

Additional information

The official instruction, CR 7681, issued to your carriers and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R402PI.pdf*.

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

MLN Matters® Number: MM7681
Related Change Request (CR) #: CR 7681
Related CR Release Date: January 13, 2012
Effective Date: January 27, 2012
Related CR Transmittal #: R402PI
Implementation Date: January 27, 2012

Advanced diagnostic imaging accreditation enrollment procedures

Note: This article was rescinded on January 17, 2012, as change request (CR) 7177 was rescinded and replaced by CR 7681 on January 13, 2012. See the new article at *http://www.cms.gov/MLNMattersArticles/downloads/MM7681.pdf*. This information was previously published in the December 2011 *Medicare B Connection*, Pages 45-46.

MLN Matters® Number: MM7177 *Rescinded*
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

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.

Incentive Programs

Upcoming dates for the Medicare EHR incentive program and information on the payment threshold for eligible professionals

As 2012 begins, the Centers for Medicare & Medicaid Services (CMS) wants to remind eligible professionals (EPs) participating in the Medicare electronic health record (EHR) incentive program of important approaching deadlines and what can still be completed in 2012 in order to receive an incentive payment for calendar year (CY) 2011.

Important Medicare EHR incentive program dates:

On Saturday, December 31, 2011, the reporting year ended for EPs who participated in the Medicare EHR incentive program in 2011. What does this mean? For participating EPs, they must have completed their 90-day reporting period by the end of 2011.

However, EPs have until Wednesday, February 29, 2012, to actually register and attest to meeting meaningful use to receive an incentive payment for CY 2011 through the *Medicare & Medicaid EHR incentive program registration and attestation system*.

Payment threshold information:

Wednesday, February 29, 2012, is also the deadline for EPs to submit any pending Medicare Part B claims from CY 2011, as CMS allows 60 days after Saturday, December 31, 2011, for all pending claims to be processed. This means that EPs have 60 days in 2012 to submit claims for allowed charges incurred in 2011.

Medicare EHR incentive payments to EPs are based on 75 percent of the Part B allowed charges for covered professional services furnished by the EP during the entire payment year. If the EP did not meet the $24,000 threshold in Part B allowed charges by the end of CY 2011, CMS expects to issue an incentive payment for the EP in April 2012 for 75 percent of the EP's Part B charges from 2011.

Note for Medicaid participants: Medicaid incentives will be paid by the states, but the timing will vary according to state. Please contact your state's Medicaid agency for more details about payment.

Want more information about the EHR incentive programs? Visit the *EHR Incentive Programs* website for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201201-31

2012 eRx incentive program payment adjustment feedback report discontinued

The Centers for Medicare & Medicaid Services (CMS) would like to advise providers that due to the high volume of significant hardship exemption requests received, it is no longer technically feasible for CMS to provide a 2012 electronic prescribing (eRx) incentive program payment adjustment feedback report as originally intended.

As CMS continues to explore alternative means to notify eligible professionals that they are subject to the 2012 eRx payment adjustment, CMS urges providers to review their remittance advices for claims submitted for dates of services on or after January 1, 2012.

Eligible professionals and group practices (GPRO) participating in the eRx GPRO that 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.*

If an eligible professional or group practice that participated in the eRx GPRO receives the payment adjustment in error (e.g., the eligible professional or group practice submitted a hardship exemption request that is ultimately approved by CMS), the claim will be reprocessed to return the 1.0 percent. 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.*

For more information on how the 2012 eRx payment adjustment will be assessed and applied, please refer to *MLN Matters* article *SE1141* for additional information. Or feel free to visit the eRx Incentive Program Web page at *http://www.cms.gov/erxincentive*.

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

Source: CMS PERL 201112-46

Available 2012 Physician Quality Reporting System educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2012 Physician Quality Reporting System educational products at *http://www.cms.gov/PQRS*.

To access the 2012 Physician Quality Reporting System educational products, visit the Spotlight page at *http://www.cms.gov/PQRI/02_Spotlight.asp* for the listing of educational products and the corresponding section page where they can be found.

- 2012 Physician Quality Reporting System Measures List – this document identifies and explains the measures used in Physician Quality Reporting, including information on the reporting options/methods, measure developers and their contact. **Please note that this document was updated and re-posted on January 5, 2012.
- 2012 Physician Quality Reporting System Quality-Data Code (QDC) Categories – a table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual eligible professional as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require two or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the 2012 Physician Quality Reporting System Measure Specifications Manual) will result in invalid reporting.
- 2012 Physician Quality Reporting System Single Source Code Master – this file includes a numerical listing of all codes included in 2012 Physician Quality Reporting for incorporation into billing software.

continued on next page

2012 eRx ... (continued)

- 2012 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry Reporting of Individual Measures – the 2012 measure specifications include codes and reporting instructions for the 210 Physician Quality Reporting System measures for claims and/or registry-based reporting. **Please note that this document was revised and re-posted on January 5, 2012.
- 2012 Physician Quality Reporting System Measure Specification Release Notes – outlines changes from the 2011 Physician Quality Reporting System Measure Specifications Manual in the form of Release Notes. **Please note that this document was revised and re-posted on January 5, 2012.
- 2012 Physician Quality Reporting System Implementation Guide – provides guidance about how to select measures for reporting, how to read and understand a measure, and outlines the reporting options available for 2012 Physician Quality Reporting System. The Implementation Guide also details how to implement claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals.
- 2012 Physician Quality Reporting System Measures Groups Specifications Manual – measures group specifications are different from those of the individual measures that form the group. Therefore, the specifications and instructions for measures group reporting are provided in a separate manual. The 2012 measures groups specifications include codes and reporting instructions for the 22 Physician quality Reporting System measures groups for claims or registry-based reporting.

- 2012 Physician Quality Reporting Measures Groups Release Notes – this document outlines changes from the 2011 Physician Quality Reporting System Measures Groups Specifications Manual in the form of release notes.
- Getting Started with 2012 Physician Quality Reporting System of Measures Groups – provides guidance on implementing the 2012 Physician Quality Reporting System measures groups.
- 2012 Physician Quality Reporting Measures Groups Single Source Code Master – this file includes a numerical listing of all codes included in 2012 Physician Quality Reporting System Measures Groups for incorporation into billing software.
- 2012 Physician Quality Reporting System Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures – provides guidance for those eligible professionals who satisfactorily submit quality-data codes for fewer than three Physician Quality Reporting measures, and how the measure-applicability validation process will determine whether they should have submitted QDCs for additional measures.
- 2012 Physician Quality Reporting Measure-Applicability Validation Process Release Notes – the release notes for the changes occurring for the 2015 Physician Quality Reporting Measure-Applicability Validation Process (MAV).
- 2012 Physician Quality Reporting System Measure-Applicability Validation Process Flow – a chart that depicts the Measure-Applicability Validation Process (MAV).
- Group Practice Reporting Option (GPRO) Requirements for Submission of 2012 Physician Quality Reporting System Data – provides guidance on how a group practice of over 25 eligible professionals can self-nominate to participate in GPRO for 2012 data submission.
- 2012 Physician Quality Reporting System Group Practice Reporting Option (GPRO) Measures List – a document containing a list of the 2012 Physician Quality Reporting GPRO measures.
- 2012 Physician Quality Reporting GPRO Narrative Measure Specifications and Release Notes – this document contains descriptions of the 2012 Physician Quality Reporting GPRO measures and changes in the program since the 2011 reporting year.
- 2012 EHR Direct Vendor Qualification Requirements – provides guidance on how EHR Direct Vendors can self-nominate and qualify to submit Physician Quality Reporting System measures data for 2012.
- 2012 EHR Data Submission Vendor Qualification Requirements – provides guidance on how EHR data submission vendors can self-nominate and qualify to submit Physician Quality Reporting System measures data for 2012.

continued on next page

2012 eRx ... (continued)

- 2012 EHR Documents for Eligible Professionals – this zipped file contains the following:
  - 2012 Physician Quality Reporting System EHR Measure Specifications – the detailed description of data element names and codes related to each of 51 2012 Physician Quality Reporting System quality measures available for electronic submission.
  - 2012 Physician Quality Reporting System Physician Quality Reporting System EHR Measure Specifications – Release Notes – the corresponding release notes for the 2012 EHR measure specifications.
  - 2012 EHR Downloadable Resource Table
  - 2012 EHR Downloadable Resource Table – Release Notes
- 2012 EHR Documents for Vendors – this zipped file contains the following:
  - Data Submission Specifications Utilizing HL7 QRDA Implementation Guide Based on HL7 CDA Release 2.0
  - Updated EHR Data Submission Specifications Utilizing QRDA – Release Notes – release notes for Data Submission Specifications Utilizing HL7 Quality Reporting Document Architecture Based on HL7 CDA Release 2.0
  - 2012 EHR Downloadable Resource Table
  - 2012 EHR Downloadable Resource Table – Release Notes
  - Updated EHR Data Submission Specifications Utilizing QRDA Header Errors and Edits
  - Updated EHR Data Submission Specifications Utilizing QRDA Body Errors and Edits
  - 2012 CMS EHR QRDA Data Submission Specifications and Errors Edits Release Notes

To access the 2012 Physician Quality Reporting System educational products, visit the Spotlight page at *http://www.cms.gov/PQRI/02_Spotlight.asp* for the listing of educational products and the corresponding section page where they can be found.

Further information on the 2012 Physician Quality Reporting System may be found in the final 2012 Medicare physician fee schedule rule with comment period that was published in the *Federal Register* on November 28, 2011.

The final rule can be found at *http://www.cms.gov/PQRS/05_StatuteRegulationsProgramInstructions.asp* on the CMS Physician Quality Reporting System Web page.

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

Source: CMS PERL 201201-09

Video slideshow presentation of the November 8 national call available

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation from the November 8 national provider call “Overview of the Medicare Physician Fee Schedule to Address the 2012 Physician Quality Reporting System & Electronic Prescribing Incentive Program.”

YouTube video slideshow presentation

Did you miss the November 8 Physician Quality Reporting System and e-prescribing incentive program call? The call presentation is now available on the *CMS YouTube channel* as a video slideshow that includes the call audio with captions.

Available 24/7, YouTube video presentations make learning about the Physician Quality Reporting System and e-prescribing incentive program easy and convenient. Check them out today.

For additional program information and educational products available on both programs visit *Physician Quality Reporting System* and *e-prescribing incentive program*.

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

Source: CMS PERL 201201-19

Available 2012 eRx incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2012 Electronic Prescribing (eRx) Incentive Program educational products to the eRx Web page at *http://www.cms.gov/ERxIncentive*.

To access the 2012 eRx Incentive Program educational products, visit the Spotlight section on the eRx incentive program Web page at *http://www.cms.gov/ERxIncentive/02_Spotlight.asp* for the listing of educational products and their corresponding section pages where they can be found.

- 2012 Electronic Prescribing (eRx) Incentive Program Measure Specifications and Release Notes – provides guidance on the 2012 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the 2011 eRx measure specifications.
- Claims-Based Reporting Principles for the 2012 Electronic Prescribing (eRx) Incentive Program – provides guidance on the principles for reporting the eRx measure on claims for the 2011 eRx incentive program.
- 2012 Electronic Prescribing (eRx) Incentive Program CMS-1500 Claim Example – a detailed sample of an individual NPI reporting the eRx measure on a CMS-1500 form
- 2012 Electronic Health Record (EHR) Measure Specifications for Electronic Prescribing (eRx) Incentive Program and Release Notes – provides guidance on the 2012 EHR measure specifications for eRx and release notes. In addition, the specifications contain a detailed description of data element names and codes.
- 2012 Electronic Health Record (EHR) Downloadable Resource Table and Release Notes – an Excel spreadsheet and release notes listing 2012 EHR information.
- 2012 Electronic Prescribing (eRx) Incentive Program GPRO Measure Specifications and Release Notes – provides guidance on the specifications for the eRx measure for use in 2012 eRx GPRO and release notes.

Further information on the 2012 Physician Quality Reporting System may be found in the final 2012 Medicare physician fee schedule rule with comment period that was published in the *Federal Register* on November 28, 2011.

Further information on the 2012 eRx Incentive Program may be found in the final 2012 Medicare physician fee schedule rule that was published in the *Federal Register* on November 28, 2011. The final rule can be found on the *Statute/Regulations/Program Instructions* section page at *http://www.cms.gov/ERxIncentive/04_Statute_Regulations_Program_Instructions.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 201201-11

Now available: Medicare Shared Savings Program '2012 ACO Narrative Quality Measures Specifications Manual' and application crosswalks

The Centers for Medicare & Medicaid Services (CMS) has added new information to the Medicare Shared Savings Program (Shared Savings Program) website at *www.cms.gov/sharedsavingsprogram*.

A new Web page on quality measures and performance standards at *http://www.cms.gov/sharedsavingsprogram/37e_Quality_Measures_Standards.asp* has the latest information on Medicare accountable care organization (ACO) quality measures. The *2012 ACO Narrative Quality Measures Specifications Manual* provides guidance about the 33 required quality measures that are part of the quality performance standard.

Two crosswalks have been added to the Shared Savings Program Application Web page at *http://www.cms.gov/sharedsavingsprogram/37_Application.asp*. Organizations who submitted an application under the pioneer ACO model or have been participating in the physician group practice (PGP) transition demonstration, who would like to submit a Shared Savings Program application, scroll down the page for links to these two application crosswalks.

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

Source: CMS PERL 201201-06

General Information

CMS announces delays in the implementation of two demonstration projects due to provider feedback

On November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) announced the prepayment review and prior authorization for power mobility devices (PMD) demonstration and the recovery audit prepayment review demonstration. These demonstrations were scheduled to begin on January 1, 2012. However, CMS received many comments/suggestions regarding these demonstrations and is carefully considering these comments. Therefore, CMS will delay implementation of these demonstrations. CMS will provide at least 30-day's notice before the demonstrations begin.

However, the Part A to Part B rebilling demonstration began on January 1, 2012, as scheduled.

Please continue to check *http://go.cms.gov/cert-demos* for updated information.

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

Source: CMS PERL 201112-59

Do not forward initiative reminder

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

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

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

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

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

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

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

Update to Medicare deductible, coinsurance and premium rates for 2012

Note: This article was revised on December 19, 2011, to reflect a revised change request (CR) 7567 issued on December 16. In the article, the CR release date, transmittal number, and the Web address for accessing change request (CR) 7567 were revised. All other information is the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 56-58.

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.

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.

continued on next page

Deductible... (continued)

- 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 RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R74GI.pdf*.

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 *Revised*
Related Change Request (CR) #: CR 7567
Related CR Release Date: December 16, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R74GI
Implementation Date: January 3, 2012

January is National Glaucoma Awareness Month

With January designated as National Glaucoma Awareness Month, the Centers for Medicare & Medicaid Services (CMS) asks you to join it in promoting increased awareness of glaucoma and the glaucoma screening service covered by Medicare. Today, more than 2.2 million Americans age 40 and older have open angle glaucoma, the most common form of glaucoma, and at least half don't even know they have it. Through early detection and treatment, you can help prevent blindness.

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

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

Medicare's coverage of glaucoma screening includes a dilated eye examination with an intraocular pressure (IOP) measurement and a direct ophthalmoscopy examination or a slit-lamp bio-microscopic examination.

What can you do?

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

For more information

- *The CMS Glaucoma Screening Brochure*
- *The CMS Guide to Medicare Preventive Services* (see Chapter 7)
- *The MLN Preventive Services Educational Products Web page*
- *The National Eye Institute*

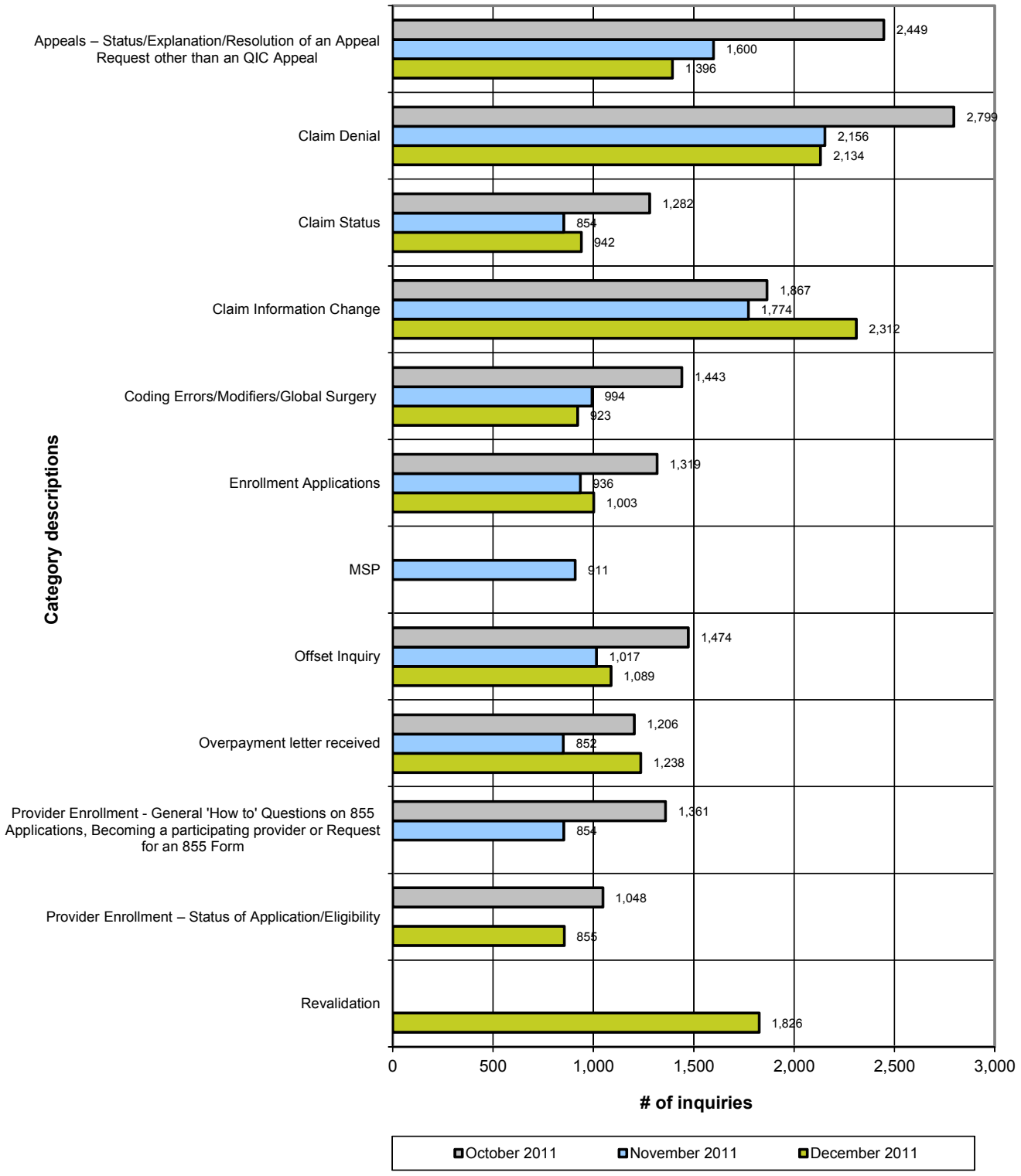
Thank you for joining CMS in promoting increased awareness of glaucoma and the glaucoma screening benefit covered by Medicare.

Source: CMS PERL 201201-34

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 October-December 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 October-December 2011



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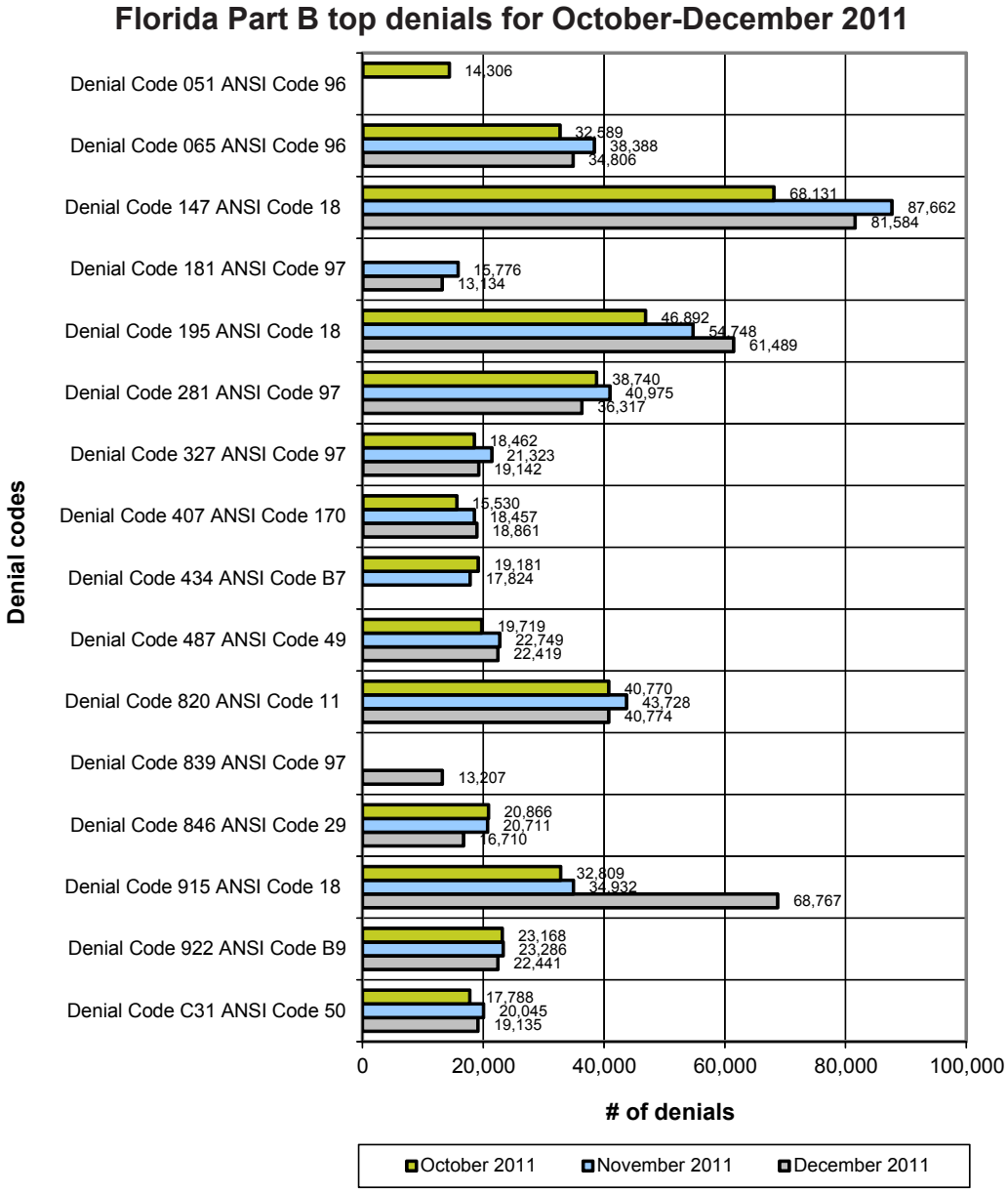


What to do when your claim is denied

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

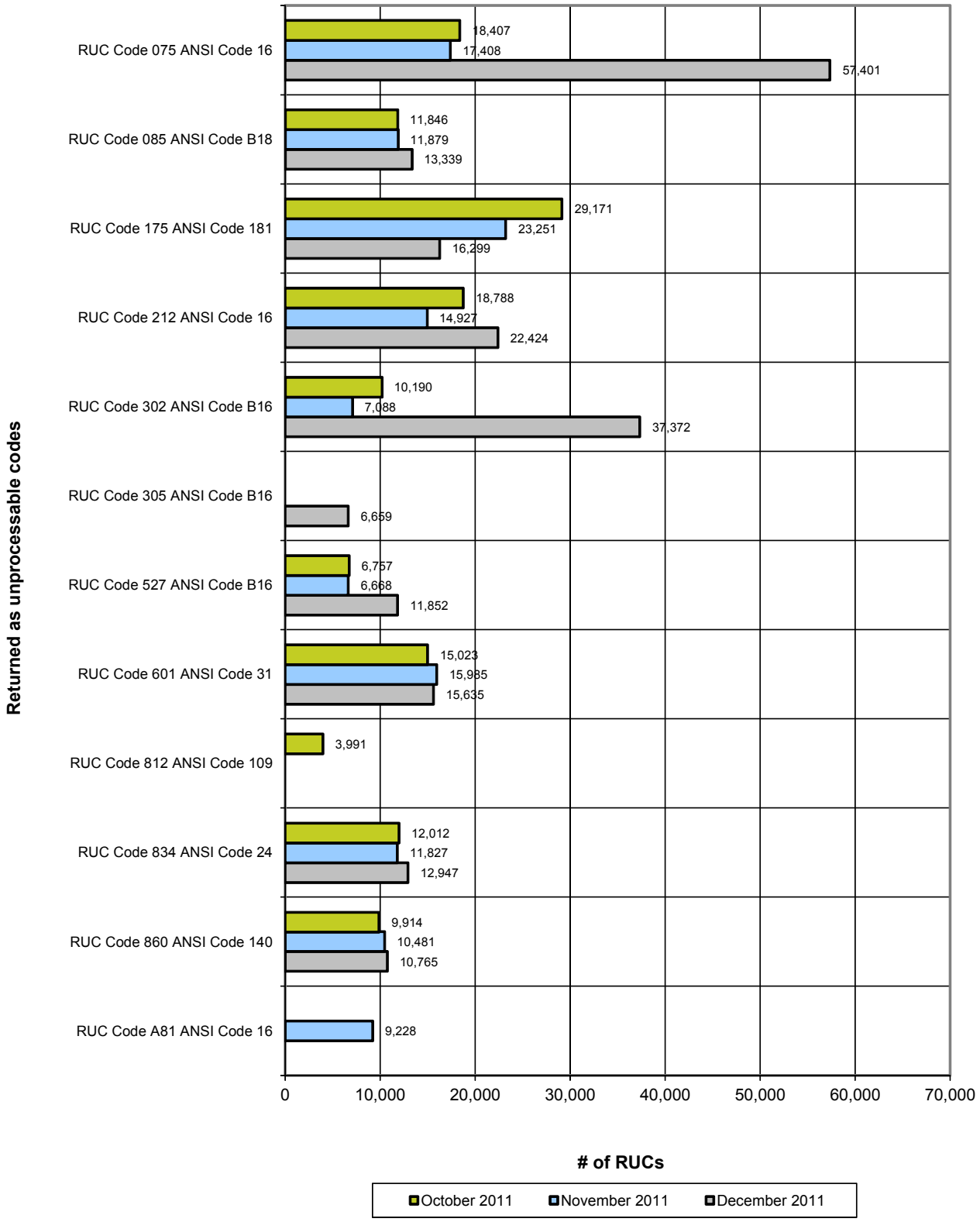
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top....(continued)

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



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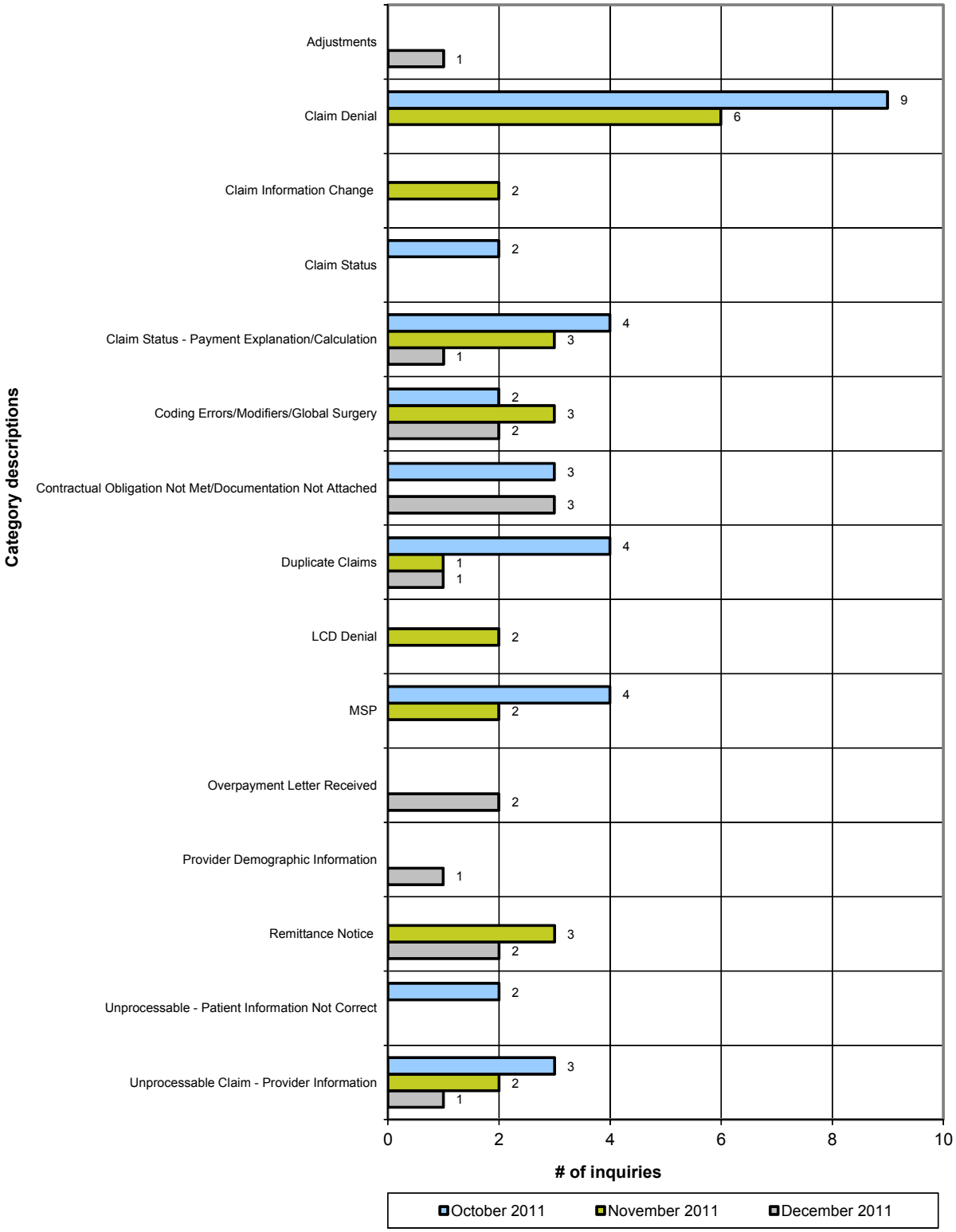
U.S. Virgin Islands Part B top inquiries for October-December 2011



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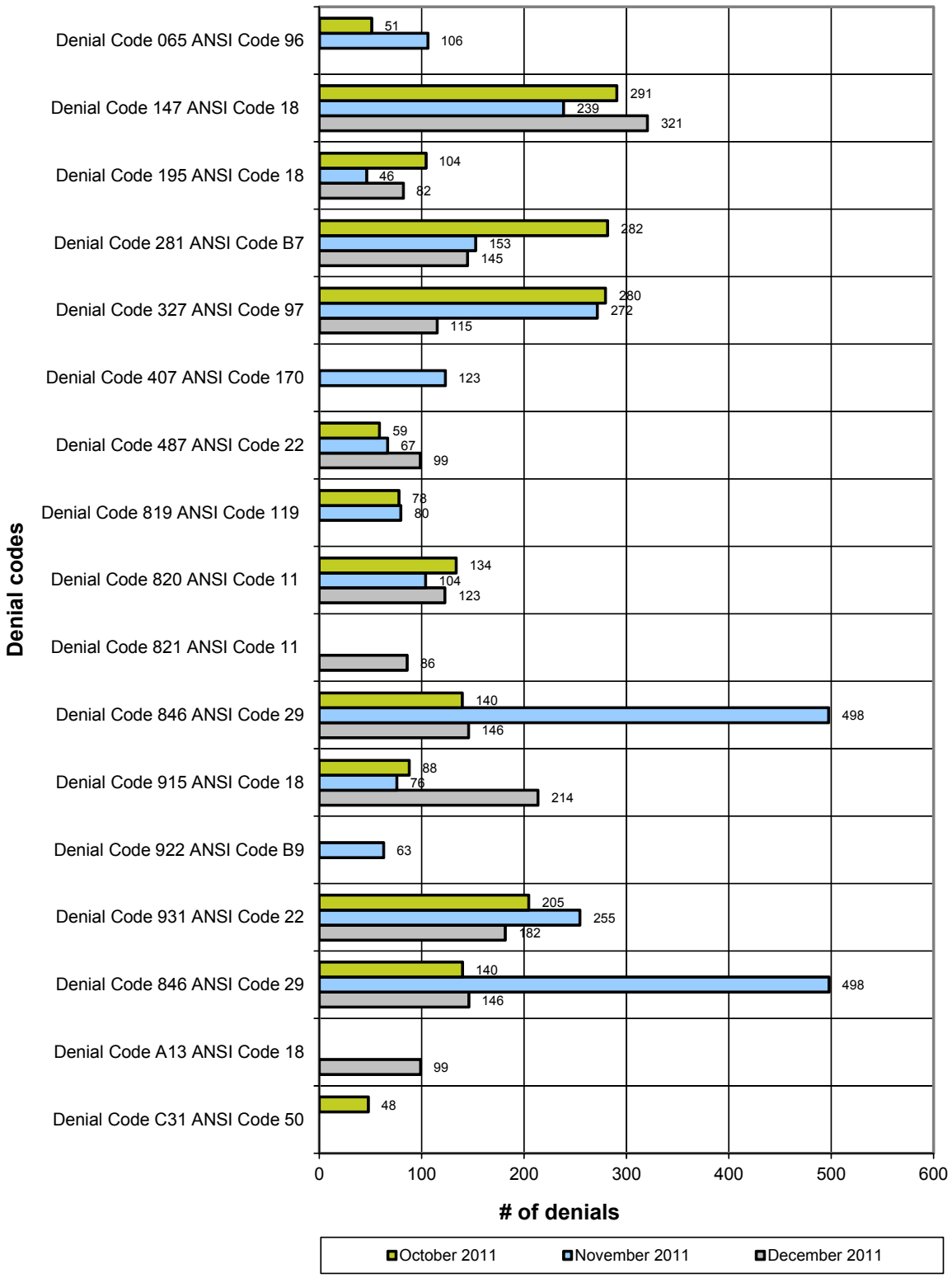
U.S. Virgin Islands Part B top denials for October-December 2011



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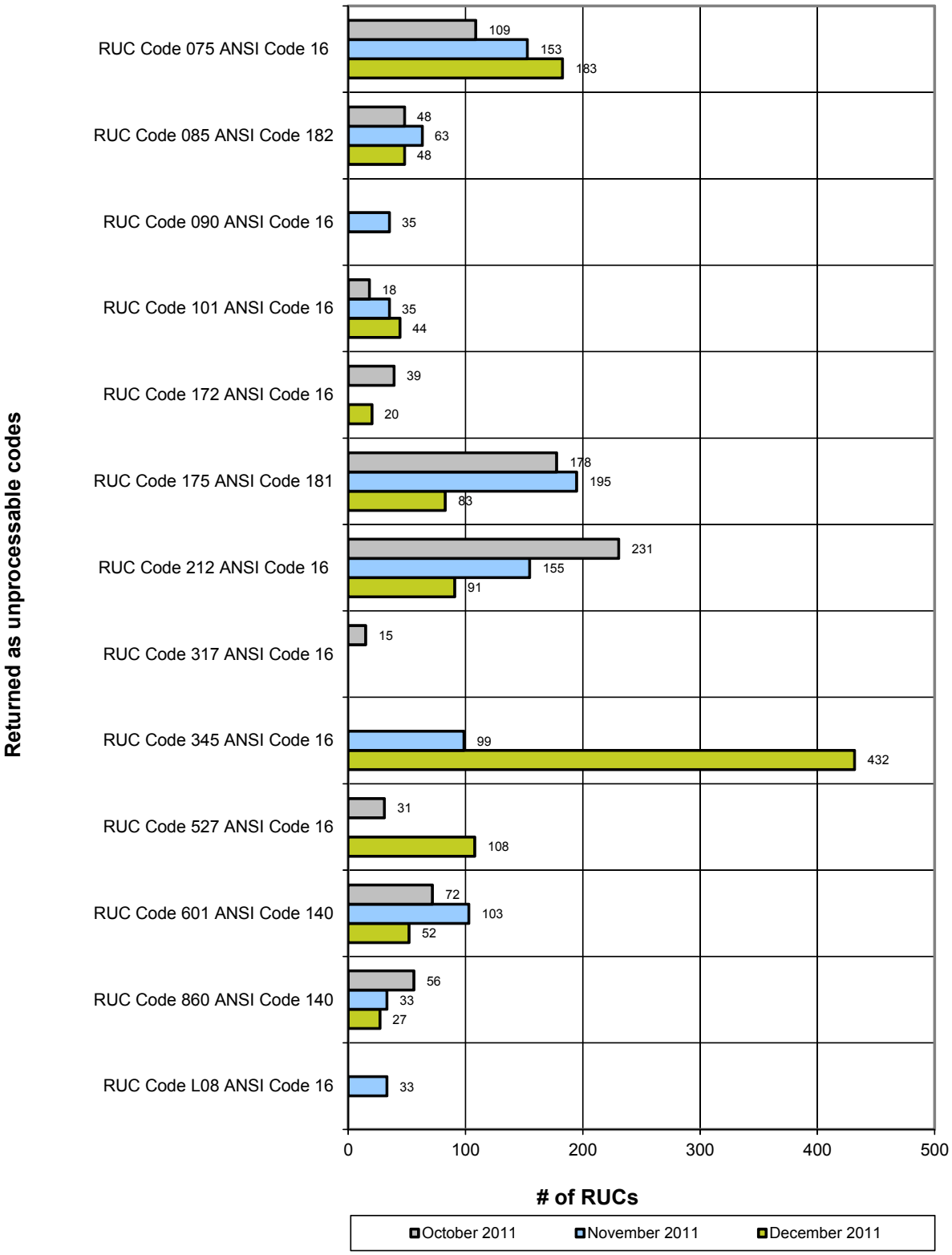
U.S. Virgin Islands Part B top return as unprocessable claims for October-December 2011



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Contents

Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

Revisions to LCDs

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

LCD ID number: L29097 (Florida)
LCD ID number: L29112 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbitux®) was most recently revised on February 21, 2011. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include the new Food and Drug Administration (FDA) labeled indication:

- Recurrent locoregional disease or metastatic squamous cell carcinoma of the head and neck in combination with platinum-based therapy with 5-FU.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 173.12, 173.22, 173.32, and 173.42 were added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after January 26, 2012**, for services rendered **on or after November 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please click *here*.

J9263: Oxaliplatin (Eloxatin®) – revision to the LCD

LCD ID number: L29248 (Florida)
LCD ID number: L29459 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was most recently revised on March 16, 2009. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical necessity" section of the LCD to include the off-label indication of relapsed or refractory non-Hodgkin's lymphoma, including diffuse large B-cell lymphoma when used with other Food and Drug Administration (FDA) or Centers for Medicare & Medicaid Services (CMS) approved compendia supported chemotherapy regimens. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code range 202.80-202.88 was added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after January 13, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please click *here*.

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.

Additional Information

Coverage requirements for collection of specimen and travel allowance

Based on language in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 16, Section 60.1, travel allowance (P9603, P9604) and specimen collection (P9612, P9615, *36415*) are not a Medicare benefit unless related to obtaining the specimen for a covered laboratory service.

Effective for claims processed on or after January 2, 2012, First Coast Service Options Inc. implemented editing to deny the following *CPT*/HCPCS codes when a laboratory test is denied and no other lab codes are paid on the same date of service or if no laboratory test(s) is billed on the same date of service.

Code	Description
P9603	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled
P9604	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge
P9612	Catheterization for collection of specimen, single patient, all places of service
P9615	Catheterization for collection of specimen(s) [multiple patients]
36415	Collection of venous blood by venipuncture

Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at *http://www.cms.gov/cmsforms/downloads/CMS588.pdf*.

Educational Events

Upcoming provider outreach and educational events
February 2012

Virtual Medifest 2012: Where Knowledge and Medicare Connect

When: February 28-March 1
Time: 10:00 a.m.-4:30 p.m. ET.

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

Two easy ways to register

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

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

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

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

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

New and revised preventive resources available from Medicare Learning Network®

"Medicare Preventive Services Series: Part 2," – WBT revised

This Web-based training course (WBT) is designed to provide education on Medicare preventive services. It includes information on Medicare's coverage for the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysm (AAA), screening electrocardiogram (EKG), annual wellness visit (AWV), cardiovascular screening blood tests, diabetes-related services, human immunodeficiency virus (HIV) screening, and smoking and tobacco-use cessation counseling services.

To access the WBT, visit the *MLN® products* page, scroll to the "Related Links Inside CMS," and select the "Web-Based Training (WBT) Courses."

"Preventive Services Educational Resources for Health Care Professionals" – *MLN Matters®* article

The *"Preventive Services Educational Resources for Health Care Professionals" MLN Matters® special edition article (#SE1142)* is designed to provide education on available educational resources related to Medicare-covered preventive services. It includes a list of *MLN®* products that can help Medicare fee-for-service (FFS) providers understand coverage, coding, reimbursement, and billing requirements related to these services.

Source: CMS PERL 201201-35

Other Educational Resources

Updates from the *Medicare Learning Network®*

New "Medicare Coverage of Radiology and Other Diagnostic Services" fact sheet released

A new *"Medicare Coverage of Radiology and Other Diagnostic Services"* fact sheet (ICN 907164) has been released in downloadable format. This fact sheet is designed to provide education on Medicare coverage and billing information for radiology and other diagnostic services, and it includes specific information concerning billing and coding requirements and an overview of coverage guidelines.

New fast fact on MLN® Provider Compliance Web page

A new fast fact is now available on the *MLN® Provider Compliance* Web page. This 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.

"Items and Services That Are Not Covered Under the Medicare Program" booklet and "Medicare Claim Submission Guidelines" fact sheet now available in hardcopy

The *"Items and Services That Are Not Covered Under the Medicare Program"* booklet (ICN 906765), available now in hardcopy, includes information about the four categories of items and services that are not covered under the Medicare program and applicable exceptions to exclusions and the advance beneficiary notice of non-coverage.

The *"Medicare Claim Submission Guidelines"* fact sheet (ICN 906764), available now in hardcopy as well, includes information about applying for a national provider identifier and enrolling in the Medicare program, filing Medicare claims, and private contracts with Medicare beneficiaries.

"Medicare Claim Review Programs" booklet revised

The revised *"Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC"* booklet (ICN 006973) is designed to provide education on the different Centers for Medicare & Medicaid Services (CMS) claim review

continued on next page

Updates ... (continued)

programs and assist providers in reducing payment errors, including, in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including medical review, recovery audit contractor, and the comprehensive error rate testing program.

"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet revised

This revised *"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)"* fact sheet (ICN 904084) is designed to provide education on SBIRT, an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

MLN® guided pathways (basic, A, and B) provider-specific resource booklets revised

The revised *MLN*® guided pathways curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-based PECOS equivalents). The resource booklets are:

- *MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers*
- *MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Providers (Part A)*
- *MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Professionals and Suppliers (Part B)*

MLN Guided Pathways Provider-Specific" resource booklet revised

The revised *"MLN Guided Pathways to Medicare Resources"* provider-specific resource booklet provides various specialties of health care professionals, (physicians, chiropractors, optometrists, podiatrists), nurses (advanced practice nurses, clinical nurse specialist, nurse practitioner, midwife) physician assistants, social workers, psychologists, therapists (occupational, physical, speech-language pathology), dietitians, nutritionists, suppliers (ambulance, ambulatory surgical center, durable medical equipment, prosthetics, orthotics, and supplies, federally qualified health center, rural health clinic, labs, mammography, radiation therapy, portable X-ray), and providers (community mental health center, comprehensive outpatient rehabilitation facility, end-stage renal disease, home health agency, hospice, outpatient physical therapy, pathology and skilled nursing facility) with resources specific to their specialty including Internet-Only Manuals (IOMs), *Medicare Learning Network*® publications, Centers for Medicare & Medicaid Services (CMS) Web pages, and more. This version includes the addition of pathways for anesthesiology assistants/certified registered nurse anesthetists, anesthesiologists, ophthalmologists, and optometrists along with a fully developed pathway for mass immunization roster biller.

All of the MLN® guided pathways booklets above are available at *http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp*.

"Advanced Payment Accountable Care Organization Model" fact sheet available

The new *"Advanced Payment Accountable Care Organization Model"* fact sheet (ICN 907403) is designed to provide education on the advance payment model for accountable care organizations (ACOs). It includes a summary of the advance payment ACO model, background, and information on the structure of payments, recoupment of advance payments, eligibility, and the application process.

"Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program" fact sheet available

The new *"Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program"* fact sheet (ICN 907404) is designed to provide education on the provisions of the final rule that implements the Medicare shared savings program with accountable care organizations (ACOs). It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs.

"Improving Quality of Care for Medicare Patients: Accountable Care Organizations" fact sheet available

The new *"Improving Quality of Care for Medicare Patients: Accountable Care Organizations"* fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

continued on next page

Updates ... (continued)

Provider exhibit program

Reminder – mark your calendars. The *Medicare Learning Network*® will be exhibiting at the following health care provider conferences in the coming weeks:

- American College of Preventive Medicine 2012

  Wednesday, February 22, 2012, through Saturday, February 25, 2012
  Buena Vista Palace; Orlando, Fla.
  Booth #11

- American Medical Group Association (AMGA) 2012 Annual Conference

  Wednesday, March 7, 2012, through Saturday, March 10, 2012
  Manchester Grand Hyatt; San Diego, Calif.
  American Medical Student Association
  Thursday, March 8, 2012, through Sunday, March 11, 2012
  Hyatt Regency Houston; Houston, Texas
  Booth #12

- American College of Cardiology (ACC.12) 61st Annual Scientific Session & Expo

  Saturday, March 24, 2012, through Monday, March 26, 2012
  Chicago, Ill.

- National Hospice and Palliative Care Organization

  Thursday, March 29, 2012, through Saturday, March 31, 2012
  National Harbor, Md.

Please make a note of these dates and locations and add them to your calendar. If you are interested in having a Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*® exhibit at your event, contact CMS at *MLNexhibits@cms.hhs.gov*.

Source: CMS PERL 201201-35

'Medicare Quarterly Provider Compliance Newsletter' released

The *"Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 2]" (ICN 907703)* has been released in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program and highlights the top issues of the particular quarter. Please visit *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf* to download, print, and search an archive of previously-issued newsletters.

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

Source: CMS PERL 201201-42

November 17 ICD-10 call – video slideshow presentation and podcasts

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation and podcasts from the November 17 national provider call on "ICD-10 Implementation Strategies and Planning."

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today.

YouTube video slideshow presentation

Did you miss the November 17 ICD-10 national provider call? The call presentation is now available on the CMS YouTube channel as a video slideshow that includes the call audio with captions.

To access the YouTube video slideshow presentation, select the link in the "Related Links Outside CMS" section of the Web page at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081*.

Podcasts

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are available from the November 17 ICD-10 call:

continued on next page

ICD-10 ... (continued)

- Podcast 1 of 4: Introduction, General ICD-10 Requirements, and CMS Implementation Planning
- Podcast 2 of 4: General Implementation Planning and Strategies
- Podcast 3 of 4: National Committee on Vital and Health Statistics (NCVHS) Meeting Update and Medicare fee-for-service (FFS) Claims Processing, Billing, and Reporting Guidelines
- Podcast 4 of 4: Question and Answer Session

The podcasts are available on the CMS website at *http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081*.

The four podcasts with corresponding written transcripts, as well as the complete audio file and complete written transcript can be accessed by scrolling to the "Downloads" section at the bottom of the Web page.

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

Source: CMS PERL 201201-07

Medicare Shared Savings Program video slideshow presentations and podcasts

Do you want to learn more about the Medicare Shared Savings Program (Shared Savings Program) and how to apply? The Centers for Medicare & Medicaid Services (CMS) has posted new resources on the "Shared Savings Program CMS Teleconferences and Events" Web page at *http://www.cms.gov/sharedsavingsprogram/40_Events.asp*.

Medicare Shared Savings Program Overview

A YouTube Video Slideshow Presentation

On December 7, John Pilotte, Director of the Performance-Based Payment Policy Group at CMS gave an overview of the Medicare Shared Savings Program, followed by a question and answer session. A video slideshow presentation of this call with audio and captioning is now available on the *CMS YouTube Channel*.

Medicare Shared Savings Program: "Application Process and Overview of the Advance Payment Model Application" national provider call

A YouTube Video Slideshow Presentation

Did you miss the November 15 national provider call on the "Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application"? The call presentation is available on the *CMS YouTube Channel* as a video slideshow. It includes the call audio and is captioned.

Podcasts

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts from the November 15 Shared Savings Program call are also available:

- Podcast 1 of 4: Introduction by Dr. Donald Berwick
- Podcast 2 of 4: Medicare Shared Savings Program application process
- Podcast 3 of 4: Advance payment model
- Podcast 4 of 4: Question and answer session

You can find links to these podcasts with corresponding written transcripts, as well as links to the YouTube video slideshow presentations, complete audio recording, and complete written transcript on the Shared Savings Program CMS Teleconferences and Events Web page at *http://www.cms.gov/sharedsavingsprogram/40_Events.asp*.

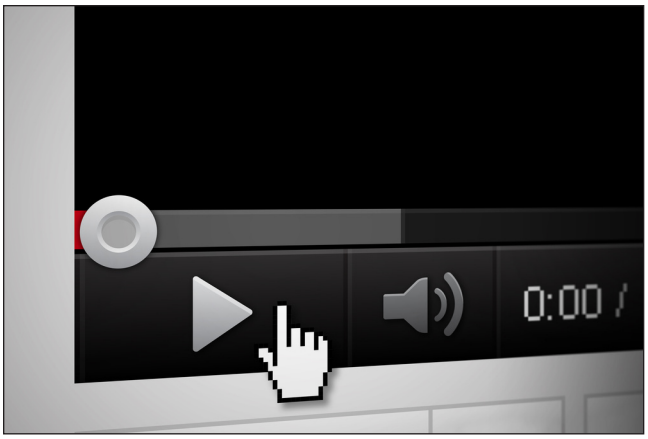
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-08

Video slideshow presentations from ICD-10 national provider calls available on CMS YouTube channel

Is your organization preparing for a smooth transition to ICD-10 on Tuesday, October 1, 2013? ICD-10 national provider calls, hosted by the Centers for Medicare & Medicaid Services (CMS) provider communications group, can help you prepare for the U.S. health care industry's change from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding.

Video slideshow presentations from the following national provider calls are available on the *CMS YouTube channel*. These video slideshows include the call slide presentation and audio with captions; each call includes presentations by CMS subject matter experts, followed by a question and answer session.



- ICD-10 Implementation Strategies and Planning –Thursday, November 17, 2011

The ICD-9-CM and ICD-10 Cooperating Parties – CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the Centers for Disease Control and Prevention (CDC) – discuss ICD-10 implementation strategies and planning, and the CMS provider billing group discuss the Medicare fee-for-service (FFS) claims processing guidance issued in August 2011.

- ICD-10 Implementation Strategies for Physicians – Wednesday, August 3, 2011

CMS subject matter experts discuss how physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding and provide updates on national ICD-10 implementation issues affecting all providers.

- CMS ICD-10 Conversion Activities – Wednesday, May 18, 2011

CMS subject matter experts discuss the ICD-10 conversion process currently taking place within CMS, including a case study from the coverage and analysis group on their transition to ICD-10 for the lab national coverage determinations (NCDs).

Podcasts, complete audio files, and complete written transcripts for these ICD-10 national provider calls are also available on the CMS ICD-10 Web page at *http://www.CMS.gov/ICD10/Tel10/list.asp*.

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today.

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

Source: CMS PERL 201201-32

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

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
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