Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

March 2012

In this issue

Health reform law ends lifetime limits for 105 million Americans

The Department of Health and Human Services (HHS) Secretary Sebelius released a new report on Monday, March 5 on how the health reform law has eliminated lifetime limits on coverage for more than 105 million Americans. Before health reform, many Americans with serious illnesses such as cancer risked hitting the lifetime limit on the dollar amount their insurance companies would cover for their health care benefits.

The end of lifetime limits is one of many new consumer rights and protections in the law for Americans nationwide. In the report, HHS provides data on the number of people in each state that benefit from this component of the law. The Obama administration also released updated state data on other ways the new law has impacted Americans, including the number of people with Medicare receiving new preventive benefits and the various grants awarded to states.

While some plans provided coverage without dollar limits on lifetime benefits, 105 million Americans were previously in health plans that had lifetime limits. HHS estimates that 70 million people in large employer plans, 25 million people in small employer plans, and 10 million people with individually-purchased health insurance had lifetime limits on their health benefits prior to the passage of the Affordable Care Act. This includes 39.5 million women and 28 million children; 11.8 million Latinos and 10.4 million African Americans.

To view the report on lifetime limits, visit *http://aspe.HHS.gov/health/reports/2012/LifetimeLimits/ib.shtml*. To view additional state-by-state data on the benefits of health reform, visit *http://www.WhiteHouse.gov/blog/2012/03/04/new-data-affordable-care-act-your-state*.

The full text of this excerpted HHS press release (issued Monday, March 5) can be found at *http://www.HHS.gov/news/press/2012pres/03/20120305a.html*.

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

Source: CMS PERL 201203-23

Find out first: Subscribe to FCSO eNews

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

Contents

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

Publication staff:
Terri Drury
Cindi Fox
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the *Medicare B Connection*

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

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

Who receives the Connection

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

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

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

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

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

Publication format

The Connection is arranged into distinct sections.

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

In addition to the above, other sections include:

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

The Medicare B Connection represents formal notice of coverage policies

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Annual *Medicare B Connection* hardcopy registration form

To receive free editions of the Part B publication in hardcopy or email format, you must complete this registration form. To receive a hardcopy or email of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by June 7, 2012.** Providers currently receiving hardcopy publications must renew by using this form. Providers who do not renew by the June 7 deadline will no longer receive free hardcopy versions after the September 2012 issue. The publication cycle begins every year on October 1 and concludes September 30.

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

Provider/facility name:

National provider identifier (NPI):

Address:

City, state, ZIP code:

Contact person/title:

Telephone number: Fax number: E-mail address:

Registration type: NEW ❑ RENEWAL ❑
Language preference: English ❑ Español ❑

Rationale for needing a hardcopy:
Does your office have Internet access? YES ❑ NO ❑

Will you accept publications via email? YES ❑ NO ❑

Other technical barrier or reason for needing hardcopy publications:

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

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

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

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

Ambulance

Claim processing issue related to Part B services for SNF patients

Because of a claim processing problem, Part B services related to ambulance code A0425 for skilled nursing facility (SNF) patients submitted to Medicare with dates of service on or after Sunday, January 1 through Wednesday February 22, 2012, may have been erroneously denied by Medicare's claim processing system. In other instances, the claim processing system may have paid and then identified a Medicare "overpayment" on these claims in error. **The situation was corrected as of Wednesday, February 22.**

The Centers for Medicare & Medicaid Services (CMS) is working with its Medicare administrative contractors (MACs) to identify all claims that were denied in error as well as any erroneously-identified overpayments that generated demand letters, so that appropriate claim adjustments can be made. Your MAC will advise you through its website and listserv messages when it expects to complete this process so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted. CMS thanks you for your patience and apologizes for any inconvenience.

If you have any additional questions please contact your Medicare carrier or Medicare administrative contractor.

Source: CMS PERL 201203-03

Additional provider and supplier enrollment requirements for fixed wing and helicopter air ambulance operators

Note: This article was revised on March 15, 2012, to reflect a revised change request (CR) 7363 issued on February 22. In the article, the bolded information in the *Background* section was added to conform to the revised CR. Also, the implementation date, CR release date, transmittal number, and the Web address for accessing CR 7363 were revised. All other information is the same. This information was previously published in the February 2012 *Medicare B Connection*, Pages 6-7.

Provider types affected

Ambulance suppliers submitting claims for air ambulance services to Medicare carriers and A/B Medicare administrative contractors (A/B MACs) are affected by this article.

Provider action needed

This article, based on change request (CR) 7363, informs you that, on November 29, 2010, the Centers for Medicare & Medicaid Services (CMS) published a final rule that clarified the reporting requirements for air ambulance suppliers. The rule states that within 30 days of any revocation or suspension of a federal or state license or certification including Federal Aviation Administration (FAA) certification, an air ambulance supplier must report the revocation or suspension of its license or certification to the applicable Medicare contractor. Air ambulance suppliers must maintain either directly or through appropriate arrangements, compliance with all applicable federal and state licenses, and certifications and report the following FAA certifications: Specific pilot certification, instrument and medical certifications, and air worthiness certification.

Background

Medicare contractors must ensure that the air ambulance suppliers remain in compliance with all licensure, and other pertinent federal and state requirements. The Medicare contractor evaluation process will include an evaluation of all documentation submitted with the CMS-855B provider enrollment application, and as appropriate, verification with the FAA website.

Attachment 1 to the CMS-855B Medicare Enrollment Application (Clinics/Group Practices and Certain other Suppliers (07/11) outlines the information that should be submitted with the initial or revalidation air ambulance application. (The CMS-855B application is available at *http://www.cms.gov/CMSforms/downloads/cms855b.pdf*.) In pertinent part Attachment 1 specifies the following additional information is to be submitted with the application:

- A written statement, signed by the president, chief executive officer, or chief operating officer of the airport from where the aircraft is hangared that gives the name and address of the facility; and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 certificate) for the aircraft being used as an air ambulance. **If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 certificate must be the same as the enrolling ambulance company's name on the enrollment application.**

(continued on next page)

Ambulance *(continued)*

If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany the enrollment application.

In addition, Medicare contractors will accept the following as acceptable proof:

- **If the air ambulance supplier or provider owns the aircraft, the owner's name on the FAA Part 135 certificate must be the same as the supplier's or provider's name on the enrollment application.**
- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 certificate must accompany the enrollment application.
- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

Additional information

The official instruction, CR 7363 issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R408PI.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: MM7363 *Revised*
Related Change Request (CR) #: 7363
Related CR Release Date: February 22, 2012
Effective Date: February 3, 2012
Related CR Transmittal #: R408PI
Implementation Date: March 9, 2012

Chiropractic Services

The comprehensive error rate testing and chiropractic services

Billing maintenance therapy as active treatment

First Coast Service Options (FCSO) is estimating an improper payment error rate of 39 percent for chiropractic services in J9 for the November 2011 CERT report. These payment errors often involve the billing of chiropractic manipulation services that represent maintenance care.

Providers' adherence to Medicare coverage guidelines for chiropractic services continues to be a significant issue in Florida, Puerto Rico, the U.S. Virgin Islands, and the nation. Based on previous national findings, CMS requested that CERT perform a special study of chiropractic services in 2010. The CERT special study on chiropractic services yielded an overall error rate of 86.91 percent for J9. The vast majority of the services reviewed were denied for insufficient documentation and for not being medically reasonable and necessary.

Aside from documentation issues, the primary reason for payment errors in chiropractic services is maintenance therapy being billed as active treatment. This continues to be an issue, even after CMS implemented an acute treatment modifier to allow providers to differentiate maintenance from active treatment on submitted claims.

To help reduce and prevent improper payment errors, FCSO is reviewing data to identify beneficiaries receiving chiropractic services at routine intervals for extended periods of time and will develop beneficiary specific edits.

FCSO will monitor the appeals data closely for these beneficiary specific edits, allowing ongoing edit adjustment when indicated.

Additional information

FCSO has a Web-based training (WBT) module for chiropractic services available on *FCSO University*. In addition, helpful information and links to chiropractic services resources can be found on the *FCSO provider website* and the *chiropractic services specialty page*. Also, a local coverage determination (LCD) was developed to assist providers in determining when Medicare will consider chiropractic manipulation of the spine medically reasonable and necessary. The LCD also provides guidance on documentation requirements. To access the LCD for Florida click *here*; for Puerto Rico and the U.S. Virgin Islands click *here*.

Source: Provider Outreach and Education

Drugs and Biologicals

Information regarding the billing and payment for administration of PROVENGE®

On Friday, January 6, 2012, the Centers for Medicare & Medicaid Services (CMS) reissued change request (CR) 7431, Transmittal 2380, for autologous cellular immunotherapy (PROVENGE®) treatment of metastatic prostate cancer with clarification regarding payment for the administration of PROVENGE® and allowing for separate payment for the cost of administration. However, there is an issue in the Medicare claims processing system that is causing claims for administration of PROVENGE® not to be paid separately from PROVENGE®. The *Current Procedural Terminology* (*CPT*) code *96365* is bundled when billed with Healthcare Common Procedure Coding (HCPCS) code Q2043. Providers of PROVENGE® may be affected by this situation.

To correct this problem, CMS will update current editing to allow *CPT* code *96365* to be paid separately when HCPCS code Q2043 is present on claims with dates of service on and after Friday, July 1, 2011. CMS has instructed Medicare contractors to adjust claims for dates of service on and after Friday, July 1 containing *CPT* code *96365* that were denied and not paid due to the bundle editing, when brought to their attention. Beginning Sunday, April 1, providers may request contractors to adjust claims for administration of PROVENGE® that were denied for this reason.

Source: CMS PERL 201203-38

April 2012 average sales price files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the April 2012 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. All are available for download at *http://www.CMS.gov/McrPartBDrugAvgSalesPrice/01a17_2012ASPFiles.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 201203-39

Be proactive: Use the PDS report

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

Accessible through FCSO's PDS portal at *http://medicare.fcso.com/reporting/index.asp*

Evaluation and Management

Provider inquiry screens regarding telehealth services eligibility dates

Provider types affected

This special edition *MLN Matters*® article is intended for physicians, non-physician practitioners (NPPs), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

This special edition article provides additional information related to telehealth services previously described in change request (CR) 7049. Some of those services have frequency limitations. When providers submit inquiries to Medicare, the Medicare systems respond with provider inquiry screens. These inquiry screens will provide the date on which the beneficiary is next eligible for these frequency-limited services. Specific examples of provider inquiry screens, including the next eligible date, are included in the *Background* section. Make sure your billing staffs are aware of this additional information.

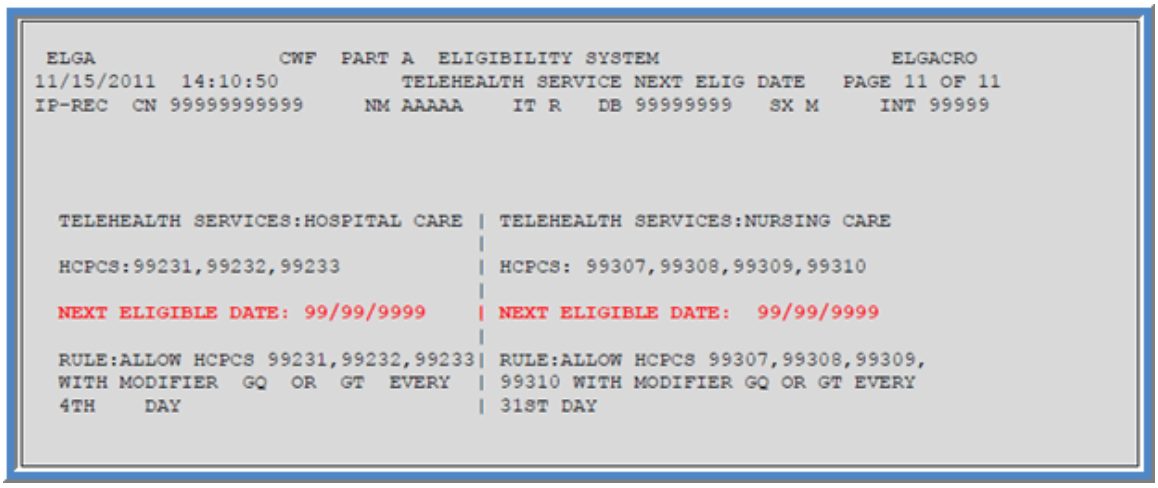
Background

CR 7049 added 14 codes to the list of Medicare distant site telehealth services. Claims frequency editing is performed by Medicare's common working file (CWF) system on seven of those 14 codes listed in CR 7049 as described below.

The use of telehealth is limited in two ways:

1. Subsequent hospital care services, with the limitation of one telehealth visit every three days (*Common Procedural Terminology* (*CPT*) codes *99231, 99232*, and *99233*)
2. Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days (*CPT* codes *99307, 99308, 99309*, and *99310*)

CWF displays the telehealth frequency limitations data on all CWF responses to provider query screens, including the next eligible date. Examples of these new CWF screens for telehealth services are displayed below for your reference.



```
 ELGA                CWF  PART A  ELIGIBILITY SYSTEM                    ELGACRO
11/15/2011  14:10:50          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 11 OF 11
IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

(continued on next page)

Telehealth *(continued)*

```
ELGB                CWF  PART B  ELIGIBILITY SYSTEM                    ELGBCRO
11/15/2011  14:12:57          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 11 OF 11
IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 17003



 TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                   |
 HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                   |
 NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                   |
 RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
 WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
 4TH    DAY                        | 31ST DAY
```

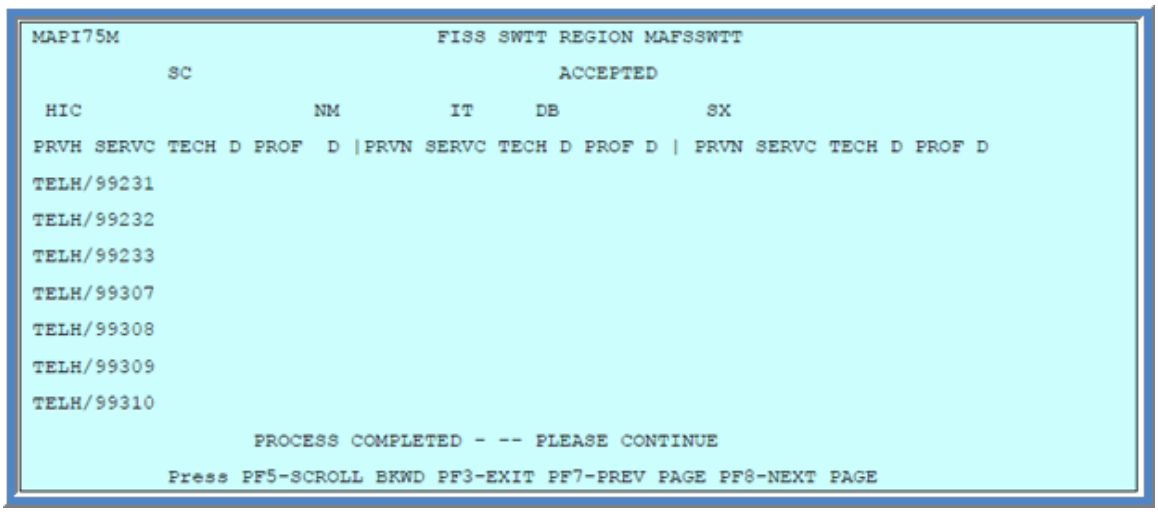
```
ELGH                CWF PART A   ELIGIBILITY SYSTEM                    ELGHCRO
00/00/0000  00:00:00          TELEHEALTH SERVICE NEXT ELIG DATE   PAGE 12 OF 12
 IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

```
      HIQACOP               CWF  PART A  INQUIRY REPLY           PAGE 12 OF 12

IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

```
      HIQHCOP               CWF          INQUIRY REPLY           PAGE 13 OF 13

IP-REC  CN 99999999999     NM AAAAA    IT R   DB 99999999   SX M     INT 99999



  TELEHEALTH SERVICES:HOSPITAL CARE | TELEHEALTH SERVICES:NURSING CARE
                                    |
  HCPCS:99231,99232,99233           | HCPCS: 99307,99308,99309,99310
                                    |
  NEXT ELIGIBLE DATE: 99/99/9999    | NEXT ELIGIBLE DATE:  99/99/9999
                                    |
  RULE:ALLOW HCPCS 99231,99232,99233| RULE:ALLOW HCPCS 99307,99308,99309,
  WITH MODIFIER  GQ  OR  GT  EVERY  | 99310 WITH MODIFIER GQ OR GT EVERY
  4TH    DAY                        | 31ST DAY
```

(continued on next page)

Telehealth *(continued)*



Additional Information

CR 7049 is available in two transmittals at *http://www.cms.gov/Transmittals/downloads/R2168CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R140BP.pdf*.

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

MLN Matters® Number: SE1209
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

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

Laboratory/Pathology

Laboratory demonstration for certain complex diagnostic tests

Remember that *MLN Matters*® article *MM7516, "Affordable Care Act, Section 3113 – Laboratory Demonstration for Certain Complex Diagnostic Tests (This Article Fully Rescinds and Replaces MM7413),"* is available in downloadable format. This article is designed to provide education on the demonstration project that the Centers for Medicare & Medicaid Services implemented for certain complex diagnostic laboratory tests, which began on Sunday, January 1, 2012, as outlined in change request 7516 and required under Section 3113 of the Affordable Care Act. It includes information about the provisions under Section 3113 and the demonstration, which will be conducted for two years, or until the $100 million payment ceiling established by the Affordable Care Act has been reached.

Source: CMS PERL 201203-50

Avoid deactivation of Medicare payments
Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup, available at *http://medicare.fcso.com/Enrollment/NPIandPTANLetterInput.asp*. You may search for revalidation requests by entering your NPI or your PTAN.

Preventive Services

Intensive behavioral therapy for obesity

Note: This article was **revised on February 15, 2012**, to add a note under "Billing Requirements" regarding *MLN Matters*® article MM7228. The article was also **revised on March 9, 2012**, to reflect the revised change request (CR) 7641, issued on March 7. This information was previously published in the February 2012 *Medicare B Connection*, Pages 16-20.

Provider types affected

This *MLN Matters*® article is intended for primary care physicians and other primary care practitioners billing Medicare contractors (carriers, fiscal intermediaries [FIs] and A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in a primary care setting.

Provider action needed

Stop – impact to you

This article is based on CR 7641, which informs Medicare contractors about implementing coverage of intensive behavioral therapy (IBT) for obesity.

Caution – what you need to know

Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as body mass index (BMI) equal to or greater than 30 kg/m2, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, are eligible for:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6, and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first six months.

Medicare coinsurance and Part B deductible are waived for this service.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this new coverage determination and that Healthcare Common Procedure Coding System (HCPCS) code G0447 (Face-to-Face Behavioral Counseling for Obesity, 15 minutes) will be used to bill for these services.

This code was effective November 29, 2011, and appeared in the January 2012 quarterly update of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (I/OCE).

Background

Based upon authority in the Social Security Act to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, and the services are reasonable and necessary for the prevention or early detection of illness or disability, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on IBT for obesity. Screening for obesity in adults is a "B" recommendation by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Medicare Part A and Part B.

In 2003, the USPSTF found good evidence that BMI "is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity." The USPSTF also found fair to good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥30 kg/m2) "produces modest, sustained weight loss."

Effective for claims with dates of service on or after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥30 kg/m2), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

(continued on next page)

Obesity *(continued)*

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months as discussed below.

At the six-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.), over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs.) during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six-month period.

IBT for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m2).
2. Dietary (nutritional) assessment.
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Intensive behavioral intervention for obesity should be consistent with the 5-A framework:

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

Billing requirements

Diagnostic codes

Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize HCPCS code G0447, Face-to-Face Behavioral Counseling for Obesity, 15 minutes. G0447 must be billed along with 1 of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45). The type of service (TOS) for G0447 is 1. (ICD-10 codes will be Z68.30-Z68.39, Z68.41- Z68.45)

Effective for claims with dates of service on or after November 29, 2011, Medicare contractors will deny claims for HCPCS G0447 that are not submitted with the appropriate diagnostic code (V85.30-V85.39, V85.41-V85.45).

Claims submitted with HCPCS G0447 that are not submitted with these diagnosis codes will be denied with the following messages:

- Claim adjustment reason code (CARC) 167 – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance advice remark code (RARC) N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file). If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

(continued on next page)

Obesity *(continued)*

Note: Per *MLN Matters*® article MM7228, when modifier GZ is used, contractors will use CARC 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.). This is true with all denials noted below that have the group code CO. MM7228 may be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*.

Specialty codes

Effective for services on or after November 29, 2011, Medicare will pay claims for G0447, only when services are submitted by the following provider specialty types found on the provider's Medicare enrollment record:

01 General practice

08 Family practice

11 Internal medicine

16 Obstetrics/gynecology

37 Pediatric medicine

38 Geriatric medicine

50 Nurse practitioner

89 Certified clinical nurse specialist

97 Physician assistant

If your specialty type is not one of the above, your claim will be denied using the following codes:

- **CARC of 185** – "The rendering provider is not eligible to perform the service billed. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.),"
- **RARC N95** – "This provider type/provider specialty may not bill this service."
- **Group code PR** (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- **Group code CO** (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: In addition, Medicare may cover behavioral counseling for obesity services when billed by the one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under our regulation at 42 CFR Section 410.26(b) (conditions for services and supplies incident to a physician's professional service) or 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician service).

Place of service (POS) codes

Effective for services on or after November 29, 2011, Medicare will pay for obesity counseling claims containing HCPCS G0447 only when services are provided with the following POS codes:

11 Physician's office

22 Outpatient hospital

49 Independent clinic

71 State or local public health clinic

Line items on claims for G0447 will be denied if not performed in these POSs using the following codes:

- CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid POS. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N428 – "Not covered when performed in this place of service."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file)
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

(continued on next page)

Obesity *(continued)*

Frequency limitation

Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22 limit will be denied using the following codes: (Note: When applying this frequency limitation, a claim for the professional service and a claim for a facility fee will be allowed.)

- CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Your contractor will not search their files for claims that may have been paid in error. However, contractors may adjust claims that are brought to their attention.

Institutional claims notes

Claims submitted with either a type of bill (TOB) 13x or TOB 85x (where the revenue code is not 096x, 097x, or 098x) will be identified as facility fee service claims.

Claims submitted with TOBs 71x, 77x, or 85x (where the revenue code is 096x, 097x, or 098x) will be identified as professional service claims.

Medicare will pay for G0447 on institutional claims in hospital outpatient departments TOB 13x based on OPPS and in critical access hospitals TOB 85x based on reasonable cost.

The CAH method II payment is for G0447 with revenue codes 096x, 097x, or 098x is based on 115 percent of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.

Medicare will line-item deny any claim submitted with G0447 when the TOB is not 13x, 71x, 77x, or 85x with the following:

- CARC 5 – "The procedure code/bill type is inconsistent with the Place of Service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC M77 – "Missing/incomplete/invalid place of service."
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file)
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file)

Note: Medicare will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting G0447.

Rural health clinics and federally qualified health centers claims notes

Rural health clinics, using TOB 71x, and federally qualified health centers, using TOB 77x, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not applied to this service. Such claims will be paid based on the all-inclusive payment rate.

For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item DOS, the service line with HCPCS G0447 will be denied with the following messages:

- CARC 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present"

(continued on next page)

Obesity *(continued)*

- Group code CO (contractual obligation)

Note: Obesity counseling is not separately payable with another encounter/visit on the same day. This does not apply for initial preventive physical examination (IPPE) claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services.

Additional information

The official instruction, CR 7641, issued to your FI, carrier, and A/B MAC regarding this change, was issued in two transmittals at *http://www.cms.gov/transmittals/downloads/R2421CP.pdf* and *http://www.cms.gov/transmittals/downloads/R142NCD.pdf*.

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

MLN Matters® Number: MM7641 *Revised*
Related Change Request (CR) #: 7641
Related CR Release Date: March 7, 2012
Effective Date: November 29, 2011
Related CR Transmittal #:R2421CP, R142NCD
Implementation Date: March 6, 2012, for non-shared system edits, July 2, 2012, for shared system edits, CWF provider screen, HICR, and MCSDT changes

General Coverage

President Obama signs the Middle Class Tax Relief and Job Creation Act of 2012

New law includes physician update fix through December 2012

On Wednesday, February 22, 2012, President Obama signed into law the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act). This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on March 1, 2012. The new law extends the current zero percent update for such services through December 31, 2012. President Obama remains committed to a permanent solution to eliminating the sustainable growth rate reductions, which result from the existing statutory methodology. The administration will continue to work with Congress to achieve this goal, as well as implement the policies in the Affordable Care Act to move toward a patient-centered, quality oriented system.

The new law extends several provisions of the Temporary Payroll Tax Cut Continuation Act of 2011 (Continuation Act) (*http://medicare.fcso.com/Publications_B/230079.pdf#page=29*). Specifically, the following Medicare fee-for-service policies have been extended. We also have included Medicare billing and claim processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, as some provisions are effective later in the year and more information about those provisions will be forthcoming.

Section 3003 – Physician Payment Update

The new law extends the current zero percent update for claims with dates of service on or after March 1, 2012, through December 31, 2012. However, the new law does not extend Sections 307 and 309 of the Continuation Act, the five percent physician fee schedule mental health add-on payment and the special 2011 payment rates for bone mass measurement, respectively. The Centers for Medicare & Medicaid Services (CMS) is currently revising the 2012 Medicare physician fee schedule (MPFS) to reflect the expiration of both of these provisions. In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold mental health and bone density claims with March 2012 dates of service for up to 10 business days. CMS expects these claims to be released into processing no later than March 15, 2012. Other March 2012 claims will be unaffected by this claim hold. Claims with dates of service prior to March 1, 2012, also are unaffected. Finally, Medicare contractors will be posting the new mental health and bone density rates on their websites no later than March 15, 2012.

(continued on next page)

Obama *(continued)*

Section 3004 – Extension of Medicare Physician Work Geographic Adjustment Floor

The existing 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2012. As with the physician payment update, this extension will be reflected in the revised 2012 MPFS.

Section 3001 – Extension of Medicare Modernization Act Section 508 Reclassifications

Section 3001 extends Section 508 reclassifications and certain special exception wage indexes from December 1, 2011, through March 31, 2012. For the period beginning on December 1, 2011, and ending on March 31, 2012, Section 3001 also requires (as did Section 302 of the Continuation Act) 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 receiving Section 508 reclassifications and inpatient special exception reclassifications under the Continuation Act and the Job Creation Act shall be assigned a special wage index effective for October 2011 through March 2012. CMS will apply these provisions to both inpatient and outpatient hospital payments. A special wage index will be applicable, from January 1, 2012, through June 30, 2012, for hospital outpatient payments, to special exception hospitals and reclassified hospitals affected by these extensions. Hospital inpatient and outpatient payments under both Section 302 of the Continuation Act and Section 3001 of the Job Creation Act will be made by June 30, 2012.

Section 3002 – Extension of Outpatient Hold Harmless Payments

Section 3002 extends outpatient hold harmless payments for rural hospitals and sole community hospitals with 100 or fewer beds through December 31, 2012. However, hold harmless payments for sole community hospitals with more than 100 beds were not extended by this provision and are set to expire on February 29, 2012.

Section 3005 – Extension of Exceptions Process for Medicare Therapy Services

Section 3005 extends the exceptions process for outpatient therapy caps from March 1, 2012, until December 31, 2012, with some modifications to current therapy policies. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2012. In addition, the new law includes changes related to therapy services furnished in a hospital outpatient department (OPD). These changes impact the annual therapy cap in 2012 as well as the applicability of the therapy cap exception process. More information about the changes affecting hospital OPDs will be forthcoming in a future issuance. Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 5, Section 10.3: *http://www.cms.gov/manuals/downloads/clm104c05.pdf*.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2012. For physical therapy and speech language pathology services combined, the 2012 limit for a beneficiary on incurred expenses is $1,880. There is a separate cap for occupational therapy services which is $1,880 for 2012. 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.

Section 3005 also mandates that Medicare perform manual medical review of therapy services furnished beginning on October 1, 2012, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds:

- Physical therapy and speech-language pathology services
- Occupational therapy services.

Finally, Section 3005 requires that all claims for therapy services furnished on or after October 1, 2012, include the national provider identifier of the physician who reviews the therapy plan.

CMS will issue additional information about all of these new requirements later in the year.

Section 3006 – Extension of Moratorium On Qualified Pathologists and Independent Laboratory Billing for the Technical Component of Physician Pathology Services Furnished to Hospital Patients

Section 3006 extends the moratorium through June 30, 2012. Therefore, those qualified pathologists and independent laboratories that are eligible may continue to submit claims to Medicare for the technical component 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 continues to be effective for claims with dates of service on or after March 1, 2012, through June 30, 2012.

(continued on next page)

Obama *(continued)*

Section 3007 – Extension of Ambulance Add-On Payments

Section 3007 extends through December 31, 2012, the following three Continuation Act ambulance payment provisions:

- 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
- The provision relating to air ambulance services that continues to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule
- The provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus).

Suppliers of ambulance services affected by these provisions may continue billing as usual.

Be on the alert for more information about the Job Creation Act and the provisions which take effect later in the year.

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

Source: CMS PERL 201202-70

ICD-9 and ICD-10 announcements

Announcements from the ICD-9-CM Coordination and Maintenance Committee

Summary report from committee meeting Monday, March 5, 2012

The summary report from the procedure part of the Monday, March 5 ICD-9-CM Coordination and Maintenance Committee meeting is now available at *http://www.CMS.gov/ICD9ProviderDiagnosticCodes/ICD9/list.asp*.

For information related to diagnosis code issues, please visit the *Classifications of Diseases, Functioning, and Disability* page on the Centers for Disease Control and Prevention's (CDC) website. The CDC will post the summary report of the diagnosis part of the meeting on this Web page.

Registration for meeting Wednesday, September 19 and Thursday, September 20, 2012

Registration for the ICD-9-CM Coordination and Maintenance Committee to be held Wednesday, September 19 and Thursday, September 20 will open on Friday, August 17. More information will be posted soon on the *ICD-9-CM Coordination and Maintenance Committee* Web page.

New materials now available for the ICD-10 MS-DRG conversion project

The Centers for Medicare & Medicaid Services (CMS) has posted v29 of the ICD-10 Medicare-severity diagnosis groups (MS-DRGs) and an updated version of the v27 Medicare code editor (MCE) on the *ICD-10 MS-DRG Conversion Project* Web page. These materials are available in the "Downloads" section.

The updated version of the v27 MCE is being referred to as v27.0 R1 (MCE v27 R1). This Wednesday, March 14 update corrects some errors in the documentation previously posted. The v27 MCE logic is used in the CMS Medicare severity grouper with MCE ICD-10 R1 pilot software (version 28.0) that is being sold by *National Technical Information Service (NTIS)*.

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

Source: CMS PERL 201203-54

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 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.

Use of revised remittance advice remark code N103 when denying services furnished to federally incarcerated beneficiaries

Note: This article was revised on March 9, 2012, to reflect the revised change request (CR) 7678 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7678 were revised. All other information is the same. This information was previously published in the January 2012 *Medicare B Connection*, Page 33.

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 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/R1054OTN.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 *Revised*
Related Change Request (CR) #: 7678
Related CR Release Date: March 7, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R1054OTN
Implementation Date: July 2, 2012

Extension of enforcement discretion period for updated HIPAA transaction standards through June 30

The Centers for Medicare & Medicaid Services' (CMS) Office of E-Health Standards and Services (OESS) announced that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012, compliance date. This was referred to as "enforcement discretion," and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing, and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare fee-for-service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to version 5010.

Covered entities are making similar progress with version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare administrative contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or health care providers requiring assistance in submitting and receiving version 5010 compliant transactions.

The Medicaid program staff at CMS will continue to work with individual states regarding their program readiness. Issues related to implementation problems with the states may be sent to *Medicaid5010@cms.hhs.gov*.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

Source: CMS PERL 201203-25

PWK delayed

The Centers for Medicare & Medicaid Services (CMS) is delaying implementation of the PWK (paperwork) segment of the X12N version 5010. PWK was due to be implemented on April 1, 2012, via change requests 7041, 7306, and 7330. The delay is being initiated in order to address system concerns and impacts raised by Medicare administrative contractors (MACs). MACs will continue to work through their user acceptance testing of PWK while the concerns and impacts are addressed. CMS will communicate the revised implementation date once determined.

The PWK delay does not affect any current processes in place for the submission of additional documentation with your claims.

Source: TDL 12303

HIPAA 5010 claim translation issues affecting Medicare crossover claims

Error codes H51108, H20203, and H45255

Currently, after A/B Medicare administrative contractors (MACs), durable medical equipment MACs (DME MACs), fiscal intermediaries (FIs), and carriers have finalized payment of incoming provider/physician/supplier claims, they transmit the adjudicated claims to the coordination of benefits contractor (COBC) for Medicare claim crossover purposes. The COBC translates the claim into the required HIPAA ANSI 837 claim formats for claim crossover purposes, then subjects them to HIPAA compliance validation; normally, it is within this module that HIPAA compliance problems are identified.

When the COBC identifies HIPAA compliance problems, it notifies the A/B MAC, DME MAC, FI, or carrier that its processed claim could not be crossed over. This entity, in turn, mails the affected provider/physician/or supplier a special letter that indicates "The claim(s) could not be crossed over due to claim data errors…" and includes the specific error code (e.g., H51000) with accompanying error description. The assumption is that once providers/physicians/suppliers receive these letters from Medicare, they will then take steps to bill their patients' supplemental payer for the balance owed after Medicare.

In recent weeks, three issues have arisen that were caused by defects in the COBC compliance validation process:

- **H51108**: '"37" is not a valid 'line level adjustment reason code'
  - **Issue**: COBC was incorrectly rejecting claims that contained a claim adjustment reason code (CARC) 237. The rejection occurred because COBC's vendor inadvertently did not have reason code 237 loaded to its CARC table.
  - **Fix date**: Monday, January 16
- **H20203**: Element CLM16 is present though marked "not used"
  - **Issue**: COBC's vendor's translation routine was copying the value from 2300 CLM20 and incorrectly creating that value within 2300 CLM16 ('not used')
  - **Projected fix date**: Monday, February 27
  - **Steps taken**: As of the week of Monday, February 13, the Centers for Medicare & Medicaid Services (CMS) asked its A/B MACs, DME MACs, FIs, and carriers to hold the letters they would normally generate that contain error code H20203. Effective Monday, February 27, Medicare contractors will be able to resend the affected claims to the COBC so that they may be successfully crossed over.
- **H45255**: The other subscriber primary identifier (2330A NM109) cannot be the same as the group or policy number (2320 SBR03)
  - **Resolution**: COBC scrubs the duplication that is present in 2320 SBR03
  - **Project fix date**: TBD, but hopefully not later than early April 2012
  - **Note**: Currently, error H45255 is prohibiting the sending of Medicare crossover claims to North Dakota Medicaid in certain instances.
  - **Steps taken**: CMS is requesting that Medicare contractors hold the letters that would normally be generated for error code H45255. Once a fix date is identified for this issue, CMS will notify the Medicare contractors to resend the affected claims to the COBC so that they may be successfully crossed over.

CMS sincerely regrets that the above error conditions have arisen. They are actively partnering with the COBC to address these problems as quickly as possible.

Source: CMS PERL 201202-73

Information concerning outreach efforts to supplemental payers directing their payments to incorrect addresses

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and other practitioners who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MACs]) for providing services to Medicare beneficiaries.

What you need to know

Over the past several weeks, many physician/practitioner billing offices have notified their servicing A/B Medicare administrative contractor or Part B carrier and the Centers for Medicare & Medicaid Services (CMS) that various supplemental payers have directed payment, arising from Medicare crossover claims, to incorrect payment addresses. The problem appears to have escalated as the supplemental payers have transitioned from receipt of crossover claims in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N version 4010A1 837 professional claims format to the version 5010A1 837 professional claims format. CMS believes it understands the full dimension of the problem and wishes to pass along those details to affected physician/practitioner billing offices through this article.

CMS directive governing addresses reflected on outbound crossover claims

Medicare makes direct electronic funds transfer (EFT) payments to physicians/practitioners, suppliers, and providers in connection with adjudicated Medicare claims. There is also a long-standing CMS directive to its Medicare fee-for-service contractors that governs the reporting of provider address information that must appear on outbound crossover claims:

- Medicare contractors are to populate both the 2010AA (bill-to provider) and 2010AB (pay-to provider) N3 and N4 segments with information retained within the Provider Enrollment Chain of Ownership System (PECOS) and within the internal Medicare claim processing systems' physician/practitioner, supplier, and provider files.

This means that the bill-to and pay-to address information reported on incoming claims to Medicare will not be what will be included on outbound Medicare crossover claims.

Physicians/practitioners, suppliers, and providers need to ensure that Medicare has the most up-to-date address information – most particularly, check and remittance advice (or pay-to) address information – correctly on file for their various offices. This will ensure that correct address information is reflected on outbound crossover claims.

Most likely reasons why supplemental payments are being directed to incorrect addresses

CMS has learned that many physician/practitioner billing offices have to return checks to supplemental payers to have them reissue checks to corrected addresses. There are at least three (3) possible causes for this problem:

Possible cause #1

For HIPAA ANSI X12-N 837 version 4010A1 professional claims, Medicare's Part B claim processing system (multi-carrier system or MCS) usually only created the 2010AA loop, including the N3 and N4 segments. Since the HIPAA 4010A1 837 Professional Claims Implementation Guide had no prohibition against reporting pay-to address-related information – such as lockbox or P.O. Box address information, as retained within PECOS and the internal physician/practitioner files as the physician/practitioner's "check or remittance address" – in the 2010AA N3 and N4 segments, the Part B claim system created 4010A1 837 professional outbound crossovers that only contained 2010AA loop address information.

Under HIPAA 5010 requirements, Medicare must now create a 2010AB loop, with N3 and N4 segments, if the pay-to provider address differs from the bill-to provider address. This means that the address that most often used to be reflected in the 2010AA loop N3 and N4 address segments (which in reality was the pay-to address) now has to be reflected in the 2010AB N3 and N4 segments. Now, under HIPAA 5010, the address that Medicare reflects in the 2010AA N3 and N4 loops is truly the bill-to provider address (or "master" and/or "physical address," as captured within PECOS and the internal Medicare files).

Conclusion tied to possible cause #1: Supplemental payers with coordination of benefits agreements (COBA) may systematically still be reading the 2010AA N3 and N4 loops as the basis for determining where to direct their supplemental payments.

Remedy to possible cause #1

- On August 19, 2011, and December 28, 2011, CMS issued broadcasts to all COBA supplemental payers concerning these changes between HIPAA 837 professional claim versions 4010A1 and 5010A1 for the benefit of all crossover trading partners. To try to mitigate this possibility, CMS has conducted outreach to the supplemental payer community, either directly or indirectly; i.e.:

(continued on next page)

Addresses *(continued)*

- On February 2, 2012, CMS enlisted the help of America's Health Insurance Plans (AHIP) and the Blue Cross/Blue Shield Association (BCBSA) in reminding their membership of these important changes during early February 2012. AHIP and BCBSA communicated the information that CMS shared with supplemental payers on December 28 as a means of reminding their membership of this important issue. This information is repeated here as follows:

  December 28, 2011

  To All COBA Trading Partners:

  COBVA Alert--Reminder Concerning Reporting of Pay-To Information on Version 5010 Coordination of Benefits (COB)/Crossover Claims

  The Centers for Medicare & Medicaid Services (CMS) and Coordination of Benefits Contractor (COBC) Coordination of Benefits Agreement (COBA) teams wish to remind all COBA trading partners of the following important information:

  As documented within pages 28-29 (top) of the CMS "Coordination of Benefits Agreement (COBA) Companion Guide for Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional and Professional Medicare Coordination of Benefits Version 5010 (COB)/Crossover Claim Transactions," there are differences between version 4010A1 and version 5010 837 professional claims with respect to reporting of provider address. Here are direct citations taken from the aforementioned source for direct reference by our COBA trading partners:

  - Typically, the Part B shared system now reflects a physician/practitioner's Pay-to Address in the N3 and N4 segments of loop 2010AA on current 4010A1 production claims and does not create a 2010AB (Pay-to Provider) loop. There are times, however, when the Part B system does create a separate 2010AB loop for version 4010A1 837 professional COB claims.
  - Contrastingly, in creating test 5010A1 837 professional claims, the Medicare Part B shared system will always populate the N3 and N4 segments in 2010AA with the physician or practitioner's practice or "master" address, which is on file with Medicare. And, for test 5010A1 COB claims, the Medicare Part B shared system will only create the 2010AB ("Pay-to Provider") loop if the physician/practitioner has supplied Medicare with a differing address for remittance or check payment purposes. (NOTE: The same results may be expected if Medicare created the 837 professional COB claims for trading partners in 5010A1 production mode.)

  Several billing vendors for various physician/practitioner and supplier offices have recently contacted CMS to advise that COBA trading partners are directing their supplemental payments to incorrect addresses. [NOTE: Fortunately, CMS is not receiving similar complaints from institutional providers as tied to Pay-to Address information reported on HIPAA 5010 837 institutional production COB/crossover claims.] Therefore, relative to production version 5010A1 837 professional COB/crossover claims, COBA trading partners should be taking the following steps:

  - Modify existing routines to use the 2010AB N3 and N4 segment information as the basis for directing COB payments in association with production HIPAA 5010 COB/crossover claims (as applicable); or
  - Make corrections to your internal provider files when used for direction of COB payments for situations in which billing vendors for providers, physicians/practitioners, or suppliers notify your organization that you are directing COB payments to an incorrect address.

  Both the CMS and the COBC COBA teams hope that this reminder COBVA will lessen the incidences in which COBA trading partner's direct payment to a physician/practitioner or supplier at an incorrect, no longer valid address.

  IMPORTANT NOTE APPLICABLE TO ENTITIES THAT DIRECT PAYMENT BASED UPON INFORMATION RECEIVED ON THE CROSSOVER CLAIMS:

  If it ever turns out that the address reported in 2010AB on outbound 837 institutional or professional COB/crossover claims is incorrect, as verified through conversations with a provider, physician/practitioner, or supplier's billing vendor, the COBA trading partner should direct the billing vendor to contact the local Medicare contractor to request the needed forms to have the provider, physician/practitioner, or supplier's remittance check address (which becomes the 2010AB Pay-to Address on outbound HIPAA 5010 Medicare COB/crossover claims) modified.

(continued on next page)

Addresses *(continued)*

Possible cause #2

The physician/practitioner's "check or remittance address," as maintained by Medicare is no longer valid. As previously mentioned, the "check or remittance address" becomes the 2010AB N3 and N4 segments on outbound version 5010A1 837 professional crossover claims.

Remedy for possible cause #2

If the address reflected in the 2010AB N3 and N4 segments is incorrect, the physician or practitioner will need to contact its servicing A/B MAC or carrier to have this information updated through appropriately established procedures.

Possible cause #3

There may be instances where the supplemental payer uses the address information that it maintains within its internal files as the basis for directing supplemental payments to a given physician or practitioner, and that information is out of date.

Remedy for possible cause #3

The physician/practitioner's billing office will need to address this matter with the supplemental payer directly for resolution.

Additional information

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

MLN Matters® Number: SE1212
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

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

Existing regulations at 42 Code of Federal Regulations (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 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 are required to submit the CMS-588 EFT form with the 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 201203-34

Version 5010 messages – ICD-10 and version 5010 implementation

ICD-10: It's closer than it seems – steps to take to refine your version 5010 upgrade

The version 5010 upgrade deadline was Sunday, January 1. The Centers for Medicare & Medicaid Services (CMS) initiated an enforcement discretion period for 90 days, which ends on Saturday, March 31. You should be finalizing your upgrade to version 5010 if you have not yet done so.

Once you have finished your upgrade to version 5010, you'll need to ensure your system continues to run properly. Providers should look for the following indicators to make sure there are no problems with their system upgrade:

An increase in rejections or denials of claims – an increase in rejections or denials of claims may be an indication that there is not sufficient or correct data provided to meet version 5010 standards. Partners, such as payers, also have a part in correcting this issue, since forwarding, converting, or formatting data can result in rejections or denials. Monitor your claims closely to determine the reasons for rejection or denial of claims and coordinate with payers to ensure that data is properly processed to avoid claim delays.

Issues with non-electronic funds transfer (non-EFT) payments – version 5010 includes changes to claims formatting, including a full nine-digit ZIP code and inclusion of provider billing address. Submitting claims with only a five-digit ZIP code will result in rejection. If your practice has not submitted the correct billing or mailing address as part of your version 5010 claim, your non-electronic funds transfer (EFT) payments or explanation of benefits (EOBs) information may be mailed to the wrong physical location. Make sure to coordinate with your payers to verify how they use enrollment information and process claims data, as this will also be affected by the mailing address on file. Being diligent in tracking your claims and remittances (EOBs) will help identify and address any issues that may arise.

Formatting discrepancies with partners – your trading partners should also have upgraded to version 5010; however, your organization may interpret the new standards differently than your external partners, which can result in rejected claims. You should coordinate with your payers and/or clearinghouse to determine any gaps or discrepancies in claims submissions. You and your partners should monitor claims that are automatically transferred between payers and address new response formats or data as claims are processed.

Make sure to take a look at the *Version 5010 section* of the ICD-10 website to find helpful factsheets on the upgrade to version 5010 and previous Listserv messages discussing the version 5010 upgrade.

Keep up to date on version 5010 and ICD-10. Visit the *ICD-10 website* for the latest news and resources to help you prepare, and to download and share the implementation *widget* today.

Important update – "HIPAA Version 5010/D.0 Implementation" document has been updated

Updates have been made to the recently-posted document titled "Important Update Regarding HIPAA Version 5010/D.0 Implementation" – specifically, CMS has modified information related to the diagnosis related group (DRG) code. The document can be found at the top of the HIPAA Versions 5010 & D.0 Overview Web page, at *http://www.CMS.gov/versions5010andd0/01_overview.asp*.

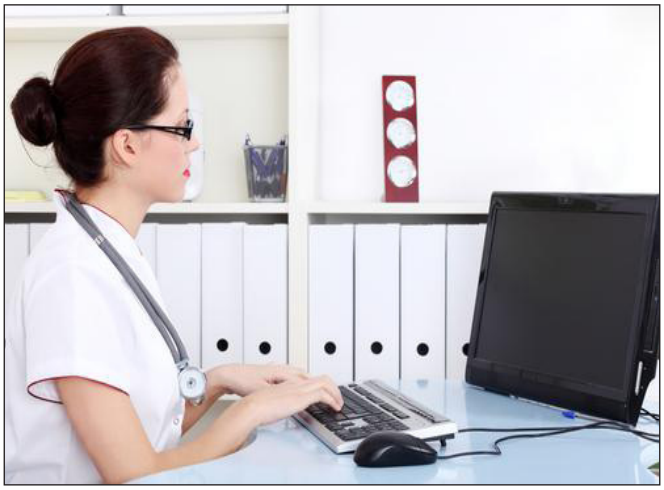
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201203-02

Crossover claims rejecting due to unnecessary billing of discharge date

According to the technical report version 3 (TR-3) for 5010A1 837 claims, a discharge date is required for inpatient claims when the patient was discharged from the facility and the discharge date is known. A discharge date is not to be sent unless required. For Part B physicians/practitioners and suppliers, the key to this requirement is being able to determine if the services were 'inpatient' by making reference to the place of service (POS) code, available at *http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html*. Only POS codes 21, 31, 51, and 61 contain either "inpatient' or 'inpatient services" in their description.

Currently, Medicare does not maintain an edit for inbound 837 professional claims to check that 2300 DTP03 (discharge date) is only billed when POS 21, 31, 51, and 61 are billed. However, the coordination of benefits contractor (COBC), which administers the Medicare claims crossover process on behalf of the Centers for Medicare & Medicaid Services (CMS), does have HIPAA 5010 editing that will activate when physician or practitioner billing offices include the following POS codes on Medicare Part B claims, as these POS codes are **clearly not 'inpatient' by definition**:



11 office

22 outpatient

23 emergency room, or

81 independent lab

Consequently, many physician/practitioner offices and DME suppliers are receiving provider notification letters from their servicing A/B Medicare administrative contractor (MAC), durable medical equipment (DME) MAC, or carrier that include an H40142 error code and the following description: "Discharge Date (DTP-01=096) was not expected because this claim is not for Inpatient Services."

For physician and practitioner offices, including those that bill Medicare via hardcopy claims, **the key to avoiding receipt of the HIPAA compliance error**, which prevents crossing over of the affected claims, is to **only include a discharge date, when known, if you are billing a Part B claim for services with POS codes 21, 31, 51, or 61**.

DME suppliers are instructed to include a discharge date on incoming claims when billing HCPCS E0935 (continuous passive motion [CPM] device). For such claims, the POS is most often 12 (home). To ensure that your DME claims for a CPM device will properly cross over, DME suppliers should include discharge date reporting within the 2400 NTE ("notes segment"), not in 2300 DTP03 on incoming version 5010A1 837 professional claims, when billing their DME MAC electronically.

CMS continues to pursue opportunities to ensure that front-end and back-end Medicare HIPAA 5010 compliance editing becomes more closely aligned.

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

Source: CMS PERL 201202-75

Avoid deactivation of Medicare payments

Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup, available at *http://medicare.fcso.com/Enrollment/NPIandPTANLetterInput.asp*. You may search for revalidation requests by entering your NPI or your PTAN.

Provider Enrollment

Were you sent a request to revalidate your Medicare enrollment?

Lists of providers sent notices to revalidate their Medicare enrollment may be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp* and in the links below. Information on revalidation letters sent in February will be posted in late March.

- *Revalidations mailed September through October 2011*
- *Revalidations mailed November through December 2011*
- *Revalidations mailed January 2012*

CMS is working to make this information available in Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) in mid-April.

You can also use the search option featured on First Coast Service Options' popular enrollment status lookup *http://medicare.fcso.com/PE_Revalidation/*; simply enter your NPI or your PTAN.

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

Source: CMS PERL 201202-76

Save time – submit your Medicare enrollment application through Internet-based PECOS, now with e-signature

The Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) now allows providers and suppliers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using Internet-based PECOS. (This feature does not change who is required to sign the application.)

In Internet-based PECOS, all individual provider applications that do not include new reassignments may e-sign the application as part of the submission process. This applies to physicians and non-physician practitioners, including those enrolling just to order and refer.

Any organizational provider applications that are submitted via Internet-based PECOS will require the user completing the application to provide an email address for the authorized official/delegated official (AO/DO) of the application as part of the submission process. The AO/DO can then follow the instructions in the email and electronically sign the application. This applies to institutional providers; clinics, group practices, and certain other suppliers; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers.

Any individual provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the AO/DO for the organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to their appropriate contractor).

Learn more about PECOS at *https://PECOS.CMS.hhs.gov*, and be on the look-out for more enhancements in the coming months. Questions concerning a system issue regarding PECOS should be referred to the CMS EUS help desk at 866-484-8049 or *EUSSupport@cgi.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 201202-77

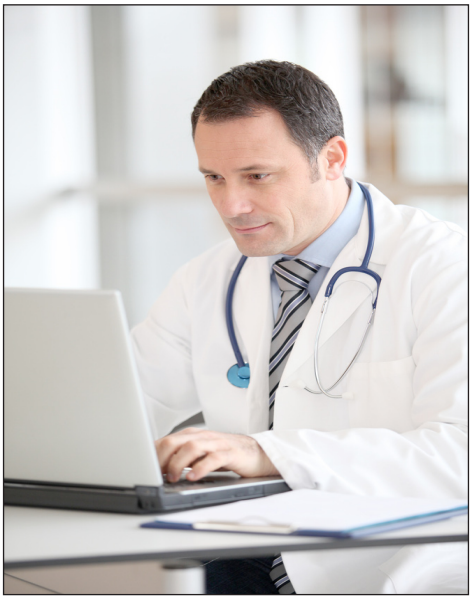
Instructions for processing form CMS-855O submissions

Provider types affected

This *MLN Matters*® article is intended for physicians and non-physician practitioners who submit a form CMS-855O for the sole purpose of ordering and referring items and/or services to beneficiaries in the Medicare program.

What you need to know

This article is based on change request (CR) 7723, which furnishes instructions to Medicare contractors (carriers and Medicare administrative contractors [A/B MACs]) regarding the processing of form CMS-855O submissions. Specific topics in CR 7723 include, but are not limited to: (1) initial applications, (2) changes of information, and (3) revocations. Model letters that Medicare contractors will use in communicating with providers on these issues are also provided in CR 7723, which is available at *http://www.cms.gov/Transmittals/downloads/R410PI.pdf*.



Background

Generally, depending upon state law, the following physicians and non-physician practitioners are permitted to order or refer items or services for Medicare beneficiaries:

- Doctors of medicine or osteopathy
- Doctors of dental surgery or dental medicine
- Doctors of podiatry
- Doctors of optometry
- Physician assistants
- Certified clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Certified nurse midwives
- Clinical social workers

Most physicians and non-physician practitioners enroll in Medicare so they can receive reimbursement for covered services to Medicare beneficiaries. However, some physicians and non-physician practitioners who are not enrolled in Medicare via the form CMS-855I may wish to order or refer items or services for Medicare beneficiaries. These individuals can become eligible to do so by completing the form CMS-855O via paper or the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) process.

It is important to note that physicians and non-physician practitioners that complete the form CMS-855O do not and will not send claims to a Medicare contractor for services they furnish. They are not afforded Medicare billing privileges for the purpose of submitting claims to Medicare directly for services that they furnish to beneficiaries.

Key points of CR 7723

- Upon receipt of an initial form CMS-855O or a form CMS-855O change of information request (or a certification statement for PECOS submissions), the Medicare contractor shall pre-screen the form.
- Unless stated otherwise in another CMS directive, the contractor shall verify all of the information on an initial form CMS-855O submission.
- If, at any time during the pre-screening or verification process for an initial form CMS-855O submission or a form CMS-855O change of information request, the contractor needs additional or clarifying information from the supplier, it shall follow existing CMS instructions for obtaining this data.
- Upon completion of its review of an initial form CMS-855O submission or a form CMS-855O change of information request, the contractor shall approve, deny, or reject the submission.
- The contractor shall reject an initial form CMS-855O submission or a form CMS-855O change of information request, if the supplier fails to furnish all required information on the form within 30 calendar days of the contractor's request to do so.

(continued on next page)

CMS-855O *(continued)*

- When denying or rejecting a form CMS-855O submission, the contractor shall: (1) switch the PECOS record to a "denied" or "rejected" status (as applicable), and (2) send a letter to the supplier notifying him or her of the denial or rejection and the reason(s) for it.
- For suppliers whose form CMS-855O submissions are approved, the contractor shall treat the supplier as a non-participating supplier.
- If the contractor approves an initial form CMS-855O submission, the contractor shall: (1) switch the PECOS record to an "approved" status, and (2) send a letter (via mail or e-mail) to the supplier notifying him or her of the approval.
- If the contractor determines that grounds exist for revoking a supplier's form CMS-855O enrollment, it shall: (1) switch the supplier's PECOS record to a "revoked" status, (2) end-date the PECOS record, and (3) send a letter to the supplier stating that his or her form CMS-855O enrollment has been revoked.

Additional information

The official instruction, CR 7723 issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R410PI.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: MM7723
Related Change Request (CR) #: 7723
Related CR Release Date: March 2, 2012
Effective Date: June 4, 2012
Related CR Transmittal #: R410PI
Implementation Date: June 4, 2012

CMS-855O Medicare enrollment application ordering and referring physicians or other eligible professionals

Provider types affected

This *Medicare Learning Network*® (*MLN*®) *Matters* special edition article is intended for physicians and eligible professionals who may need to enroll/register in the Medicare program for the sole purpose of ordering or referring Medicare-covered items and services to Medicare beneficiaries.

What you need to know

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program in order to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) permits such physicians or other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. The submission and approval of a completed, CMS-855O form or its Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) equivalent will register/enroll the physician or other eligible professional in the Medicare program for the sole purpose of ordering and referring specific services for Medicare beneficiaries.

Background

Most physicians or other eligible professionals enroll in the Medicare program to be reimbursed for the covered services they furnish to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, CMS permits certain physicians or other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. These physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish. The physicians or other eligible professionals who may wish to enroll in Medicare solely for the purpose of ordering and referring include, but are not limited to, those who are:

- Employed by the Department of Veterans Affairs (DVA)

(continued on next page)

Ordering/Referring *(continued)*

- Employed by federally qualified health centers (FQHCs), rural health clinics (RHCs)
- Employed by the Public Health Service (PHS) or critical access hospitals (CAHs)
- Employed by the Department of Defense DOD) TRICARE
- Licensed residents and physicians in a fellowship
- Dentists, including oral surgeons
- Employed by IHS or tribal organizations, and
- Pediatricians.

Physicians or other eligible professionals can apply for enrollment for the sole purpose of ordering and referring items and/or services to Medicare beneficiaries using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper enrollment application process (CMS-855O). The CMS-855O is available at *http://www.cms.gov/cmsforms/downloads/CMS855O.pdf*.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://NPPES.cms.hhs.gov*. For more information about NPI enumeration, visit *http://www.cms.gov/NationalProvIdentStand*.

Additional information

For additional information about the Medicare enrollment process, including Internet-based PECOS, go to *http://www.cms.gov/MedicareProviderSupEnroll*.

The CMS-855O is available at *http://www.cms.gov/cmsforms/downloads/CMS855O.pdf*. An updated version of the CMS-855O will be available and implemented in April 2012. The *Medicare Learning Network*® fact sheet titled "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*. If you have any questions, please contact your FI, carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1208
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

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.

Ordering/referring reports now contain complete NPI

In response to concerns raised by the provider community, the Centers for Medicare & Medicaid Services (CMS) is including the complete national provider identifier (NPI) on the following ordering/referring reports found on the CMS website at *http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp* (in the "Downloads" section of the page):

- Ordering/referring report
- Initial physician applications pending contractor review
- Initial non-physician applications pending contractor review

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

Source: CMS PERL 201203-15

CMS invites independent accrediting organizations to participate in the ADI supplier accreditation program

On Thursday, March 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a notice in the *Federal Register* inviting independent accreditation organizations to apply to become a CMS-designated accreditation organization for accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging (ADI) services. The notice also includes the application guidelines for approval of organizations wishing to accredit these suppliers. The solicitation is limited to accrediting organizations that have not previously applied to participate in the ADI supplier accreditation program. Applications will be accepted through Tuesday, May 1, 2012.

Section 135 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all suppliers of the TC of certain ADI services, including diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (e.g., positron emission tomography), to be accredited by a CMS-designated accreditation organization in order to be eligible to receive Medicare payment for these services on or after Sunday, January 1, 2012. This accreditation requirement applies only to the suppliers furnishing the imaging services, and not to the physician's interpretation of the images.

On Thursday January 28, 2010, after reviewing applications from prospective accrediting organizations to participate in the program, CMS announced that it was designating the following three national accreditation organizations to accredit suppliers of the TC of advanced diagnostic imaging services:

- The American College of Radiology (ACR)
- The Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC)

The notice – issued March 1 – offers additional organizations an opportunity to apply to become a CMS-designated accreditation organization under the program.

Source: CMS PERL 201203-04

Incentive Programs

2013 eRx payment adjustment update

On Thursday, March 1, the Centers for Medicare & Medicaid Services (CMS) reopened the Quality Reporting *Communication Support Page* to allow individual eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption for the 2013 electronic prescribing (eRx) payment adjustment. The Communication Support Page will accept hardship exemption requests now through Saturday, June 30, 2012.

The Quality Support Page *User Manual* is available to assist individual eligible professionals and CMS-selected group practices in submitting their request for a hardship exemption and can also be accessed from the "Help" icon on the *Communication Support Page*.

For additional information on the 2013 eRx payment adjustment, including who is subject to the payment adjustment and how to avoid the payment adjustment, visit the eRx Incentive Program website at *www.CMS.gov/eRxIncentive*. Specifically, eligible professionals should review *MLN Matters*® article *SE1206: "2012 eRx Incentive Program: Future Payment Adjustments."*

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

Source: CMS PERL 201203-12

2012 Rx payment adjustment update

The Centers for Medicare & Medicaid Services (CMS) continues to receive inquiries about the Medicare electronic prescribing (eRx) incentive program and the 2012 eRx payment adjustment. This message seeks to clarify the issues CMS has heard from physicians and other health care professionals.

Statutory authority/background

CMS is required to adjust the payments of eligible professionals who are not successful electronic prescribers beginning in 2012. This requirement is outlined in Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

CMS listed the requirements for being a successful e-prescriber for purposes of avoiding the 2012 payment adjustment in the 2011 physician fee schedule final rule. In February 2012, all eligible professionals who did not meet these requirements were sent a letter notifying them of this fact.

Significant hardship exemption requests

In response to stakeholder feedback, CMS also published a standalone eRx rule on Tuesday, September 6, 2011, to provide additional circumstances under which eligible professionals would qualify for hardship exemptions. Eligible professionals initially had until Tuesday, November 1, 2011, to submit a request for a hardship exemption for the 2012 eRx payment adjustment via the newly-created Quality Reporting *Communication Support Page*; this deadline was later extended to Tuesday, November 8, 2011. CMS finished its review of these requests in February 2012 and continues to notify requestors via email whether their request was approved or denied.

Questions and concerns

Although there is no appeal or review process established for the eRx incentive program and payment adjustment, CMS encourages eligible professionals with questions or concerns about the eRx payment adjustment and hardship exemption requests to contact the QualityNet help desk. Through the QualityNet help desk, CMS is working with eligible professionals and CMS-selected group practices that have questions about eRx payment adjustments and/or hardship exemption decisions. CMS is handling all hardship exemption requests and any questions or concerns on a case-by-case basis. Contact the QualityNet help desk if you have issues relating to the eRx payment adjustment and/or the rationale for denial of your hardship exemption request.

The QualityNet help desk can be reached Monday-Friday, 7 a.m.-7 p.m. CMT, at 866-288-8912 or *QNetSupport@sdps.org*.

2013 & 2014 eRx payment adjustment

Please note that payment adjustments under the eRx incentive program run until 2014. For information on how to avoid the 2013 and 2014 eRx payment adjustments, please visit the *Electronic Prescribing Incentive Program Web page* and review *Medicare Learning Network (MLN) Matters® article #SE1206*.

Source: CMS PERL 201203-56

Take a look at new EHR testimonial videos from the 2011 AOA Conference

The Centers for Medicare & Medicaid Services (CMS) has posted a series of new videos about the Medicare and Medicaid electronic health record (EHR) incentive programs to the *CMS YouTube channel*. At the 2011 American Osteopathic Association (AOA) Conference, CMS filmed seven conference attendees who provided their stories about EHRs and the EHR incentive programs. In the series, the testimonial videos discuss topics such as benefits of EHRs and navigating the incentive programs.

Also take a look at CMS's additional EHR videos on the *CMS YouTube channel*, including additional provider testimonials and EHR incentive payment highlights.

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

Source: CMS PERL 201203-46

HHS Secretary Sebelius announces next stage for providers adopting EHRs

On Friday, February 24, Health and Human Services Secretary Kathleen Sebelius announced the next steps for providers who are using electronic health record (EHR) technology and receiving incentive payments from Medicare and Medicaid. These proposed rules, from the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), will govern stage 2 of the Medicare and Medicaid EHR incentive programs.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009, eligible healthcare professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it in a meaningful way. What is considered "meaningful use" is evolving in three stages:

- **Stage 1** (which began in 2011 and remains the starting point for all providers): "meaningful use" consists of transferring data to EHRs and being able to share information, including electronic copies and visit summaries for patients.
- **Stage 2** (to be implemented in 2014 under the proposed rule): "meaningful use" includes new standards such as online access for patients to their health information, and electronic health information exchange between providers.
- **Stage 3** (expected to be implemented in 2016): "meaningful use" includes demonstrating that the quality of health care has been improved.

The CMS proposed rule specifies the stage 2 criteria that eligible providers must meet in order to qualify for Medicare and/or Medicaid EHR incentive payments. It also specifies Medicare payment adjustments that, beginning in 2015, providers will face if they fail to demonstrate meaningful use of certified EHR technology and fail to meet other program participation requirements. Under the proposed rule, stage 1 has been extended an additional year, allowing providers to attest to stage 2 in 2014, instead of in 2013.

ONC's rule proposes capabilities and related standards and implementation specifications that certified EHR technology (CEHRT) will need to include to support the achievement of "meaningful use" by eligible healthcare providers for the EHR reporting periods beginning in fiscal year / calendar year (FY/CY) 2014 and beyond. The rule proposes a redefinition of CEHRT and a revised certification processes to reduce burden and add flexibility, and requests public input to improve safety, data portability, and transparency.

The ONC and CMS proposed rules are available at *http://www.OFR.gov/inspection.aspx*. The comment period for both proposed rules will close on Monday, May 7, 2012. Additional information on the Medicare and Medicaid EHR incentive programs can be found at *http://www.CMS.gov/EHRIncentivePrograms*.

The full text of this excerpted HHS press release (issued Friday, February 24), as well as links to relevant media fact sheets, can be found at *http://www.HHS.gov/news/press/2012pres/02/20120224a.html*.

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

Source: CMS PERL 201202-79

Physician Quality Reporting System and eRx incentive program announcements

Communication support page

On Thursday, March 1, the Centers for Medicare & Medicaid Services (CMS) reopened the Quality Reporting *Communication Support Page* to allow individual eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption for the 2013 electronic prescribing (eRx) payment adjustment. The *Communication Support Page* will accept hardship exemption requests now through Saturday, June 30. A *user manual* is available to assist individual eligible professionals and CMS-selected group practices in submitting their request for a hardship exemption.

For additional information on the 2013 eRx payment adjustment, including who is subject to and how to avoid the payment adjustment, eligible professionals should review the *MLN Matters*® article *#SE1206, "2012 eRx Incentive Program: Future Payment Adjustments*," or visit the *eRx Incentive Program* Web page.

2011 eRx 10-month feedback report

Taxpayer identification number (TIN)-level interim 2011 eRx feedback reports are available for 2013 payment adjustment on the *Physician Quality Reporting System Portal*. Please note that TIN-level reports require an

(continued on next page)

Quality *(continued)*

"Individuals Authorized Access to CMS Computer Services" (IACS) account. Eligible professionals can request their individual national provider identifier (NPI)-level reports by submitting a request via the Quality Reporting *Communication Support Page*.

Feedback report request process

Please be advised that the alternative feedback report request process that enabled individual eligible professionals to request their NPI-level feedback reports through their carrier/Medicare administrative contractor (MAC) ended on Friday, March 16. This was the last day carrier/MACs would have accepted requests for Physician Quality Reporting System and eRx incentive program feedback reports. Individual eligible professionals can request their NPI-level feedback reports through the Quality Reporting *Communication Support Page*.

EHR submission

CMS would like to remind all eligible professionals that the *Physician Quality Reporting System Portal* for program year 2011 electronic health record (EHR) submissions is now open.

Eligible professionals have until Monday, April 30 to submit their EHR data. Additionally, all eligible professionals submitting EHR data will need to obtain an IACS account. Additional information related to obtaining an IACS account can be found in the "Quick Reference Guides" on the *Physician Quality Reporting System Portal*.

Error with measure #235

CMS has recently identified an error related to the submission of measure #235 "Hypertension: Plan of Care" for the 2012 Physician Quality Reporting System. "Hypertension: Plan of Care" is a claims/registry measure with six G-codes and one *Current Procedural Terminology*® (*CPT*®) II code that are inactive due to an error found on the Healthcare Common Procedure Coding System (HCPCS) tape. Consequently, this has resulted in claims containing the G-codes or *CPT*® II code associated with the measure being rejected by the carrier/MACs or denied.

The G-codes G8675, G8676, G8677, G8678, G8679, G8680 and the *CPT*® II code *4050F* will be reactivated with the next update of the HCPCS tape in April 2012. For 2012 claims-based reporting, the Physician Quality Reporting System requires at least three measures to each be reported at a 50 percent reporting rate. In the interim, eligible professionals who had intended to report this measure via claims for the 2012 Physician Quality Reporting System may want to consider taking the following steps:

- Eligible professionals may want to consider reporting additional measures to substitute for #235 "Hypertension: Plan of Care."
- "Hypertension: Plan of Care" is a per-visit measure, which requires reporting for 50 percent of eligible patient visits. Therefore, eligible professionals could report the measure on more than 50 percent of eligible visits from April through December 2012 to increase the likelihood for successful reporting of the measure.

Source: CMS PERL 201203-41

General Information

Happy second anniversary to the Affordable Care Act

Two years after the passage of the Affordable Care Act, it has continued to provide thousands of Americans with insurance protections, preventive benefits, and resources to improve care. For more information on the benefits of the law in a particular state, please visit *http://www.HealthCare.gov/law/resources/index.html*.

The Affordable Care Act has the potential to bring considerable financial and clinical benefits for providers across the healthcare spectrum. The law enacts comprehensive reforms that will hold health insurance companies accountable, protect you and your patients, and guarantee choice and control. Here are five specific ways you and your practice can benefit:

- New consumer protections hold health insurers accountable.
- Expanded insurance coverage to more than 34 million people.
- Reduced administrative burdens and more time seeing patients.
- New models create more opportunities to coordinate care.
- New protections strengthen patient coverage, your practice, and the entire healthcare system.

(continued on next page)

Anniversary *(continued)*

Read *"Healthcare Providers: The Top Five Things You Need to Know About the Affordable Care Act"* to find out more.

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

Source: CMS PERL 201203-52

New initiative to bolster primary care workforce – demonstration will assist with training of APRNs

On Wednesday, March 21, the Centers for Medicare & Medicaid Services (CMS) announced a call for applications for a new Affordable Care Act initiative designed to strengthen primary care in the United States. Under the graduate nurse education demonstration, CMS will provide hospitals working with nursing schools to train advanced practice registered nurses (APRNs) with payments of up to $200 million over four years to cover the costs of APRNs' clinical training.

APRNs – whether they are nurse practitioners, clinical nurse specialists, nurse anesthetists, or nurse midwives – play a pivotal role in primary care. This new initiative will provide funds to eligible hospitals to increase the availability of clinical training settings that will bolster the skills and supply of APRNs. Payments to the participating hospitals will be linked directly to the number of additional APRNs that the hospitals and their partnering entities are able to train as a result of their participation in the demonstration.

The demonstration requires that half of clinical training occur in non-hospital settings in the community. Most clinical training in large hospitals already includes some rotations in settings that treat minority and underserved populations; this demonstration sets a higher requirement for training in non-hospital community-based settings. Students receiving training funded by the demonstration will be encouraged to practice in non-hospital community-based settings, including in underserved areas.

CMS will select up to five eligible hospitals to participate in the demonstration, which is expected to run for four years. The demonstration was authorized by the Affordable Care Act, and will be operated by the Center for Medicare & Medicaid Innovation. It is part of the administration's overall effort to strengthen the health care workforce.

For more information, including how to apply, visit *http://innovation.CMS.gov/initiatives/GNE*.

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

Source: CMS PERL 201203-55

CMS responds to feedback from Medicare beneficiaries with a redesign of the MSN

As part of "National Consumer Protection Week," the Centers for Medicare & Medicaid Services (CMS) Acting Administrator, Marilyn Tavenner, announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare services and benefits. The redesigned statement, known as the Medicare summary notice (MSN), will be available online and, starting in 2013, mailed out quarterly to beneficiaries.

This MSN redesign is part of a new initiative – "Your Medicare Information: Clearer, Simpler, At Your Fingertips" – which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for seniors and people with disabilities who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

To see a side-by-side comparison of the former and redesigned MSNs, please visit *http://www.CMS.gov/apps/files/msn_changes.pdf*.

The redesigned MSN will soon be available to beneficiaries on – *www.MyMedicare.gov* – Medicare's secure online service for personalized information regarding Medicare benefits and services. In early 2013, paper copies of the redesigned MSN will begin to replace the version currently being mailed.

(continued on next page)

MSN *(continued)*

The full text of this excerpted CMS press release (issued Wednesday, March 7) can be found at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4298*.

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

Source: CMS PERL 201203-20

New information on the Medicare Shared Savings Program is now available

On Thursday, October 20, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program. The following new information about this program is now available on the *Shared Savings Program website*:

- The *Shared Savings Program Application Web page* includes an updated version of the Medicare Shared Savings Program Application and appendices for the July 1, 2012, program start date.
- A new *Shared Savings Program ACO Agreement Web page* has been added that includes a link to the agreement that approved applicants will be required to sign.
- On Thursday, March 8, CMS hosted a national provider call on the Medicare Shared Savings Program electronic application submission through the health plan management system (HPMS). Presentation materials are available on the *Shared Savings Program CMS Teleconferences and Events Web page*.
- Also, the *Shared Savings Program Quality Measures and Performance Standards Web page has been updated with the "Guide to Participation of CMS Accountable Care Organizations in the 2012 Physician Quality Reporting System and 2012 Electronic Prescribing Incentive Program Group Practice Reporting Option"*.

Source: CMS PERL 201203-27

New partners named in community-based care transitions program

CMS continues effort to improve quality of care for people with Medicare

As part of the new health care law's policies to improve the quality of care available to people with Medicare and all Americans, on Wednesday, March 14, the Centers for Medicare & Medicaid Services (CMS) announced 23 additional participants in the community-based care transitions program (CCTP). These participants will join seven other community-based organizations already working with local hospitals and other health care and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care setting.

CCTP is designed specifically to provide support for high-risk Medicare beneficiaries following a hospital discharge. These 23 sites will work with CMS and local hospitals to provide support for patients as they move from hospitals to new settings, including skilled nursing facilities and home. Community organizations will help these patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. This announcement will support more than 126 local hospitals and help more than 223,000 Medicare beneficiaries in 19 states across the country.

CCTP is part of the Partnership for Patients, a public-private partnership aiming to cut preventable errors in hospitals by 40 percent and reduce preventable hospital readmissions by 20 percent over a three-year period. Achieving these goals has the potential to save up to 60,000 lives, prevent millions of injuries and unnecessary complications in patient care, and save up to $50 billion for Medicare over ten years. To date, more than 8,000 partners have pledged their commitment to the aims of the Partnership for Patients, including more than 3800 hospitals.

As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high-risk for readmission to the hospital. The 23 sites will join the seven organizations announced in November 2011, bringing the total number of sites to 30. This is the second round of CCTP participants announced since the program was launched in April 2011.

More information on the CCTP is available at *http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313*. More information about the work the Department of Health and Human Services is

(continued on next page)

Partners *(continued)*

doing to improve care for Medicare, Medicaid, and CHIP beneficiaries and, by extension, all Americans through the broader Partnership for Patients initiative is available at *http://www.HealthCare.gov/PartnershipForPatients*.

The full text of this excerpted CMS press release (issued Wednesday, March 14) can be found at *http://www.CMS.gov/apps/media/press/release.asp?Counter=4302*.

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

Source: CMS PERL 201203-35

Audio recording and written transcript from March 1 Medicare shared savings program provider call now available

The Centers for Medicare & Medicaid Services (CMS) has posted an audio recording and written transcript from the "Medicare Shared Savings Program and Advance Payment Model Application Process" national provider call, originally hosted on Thursday, March 1, to the *call detail page* on the CMS national provider call website.

Source: CMS PERL 201203-51

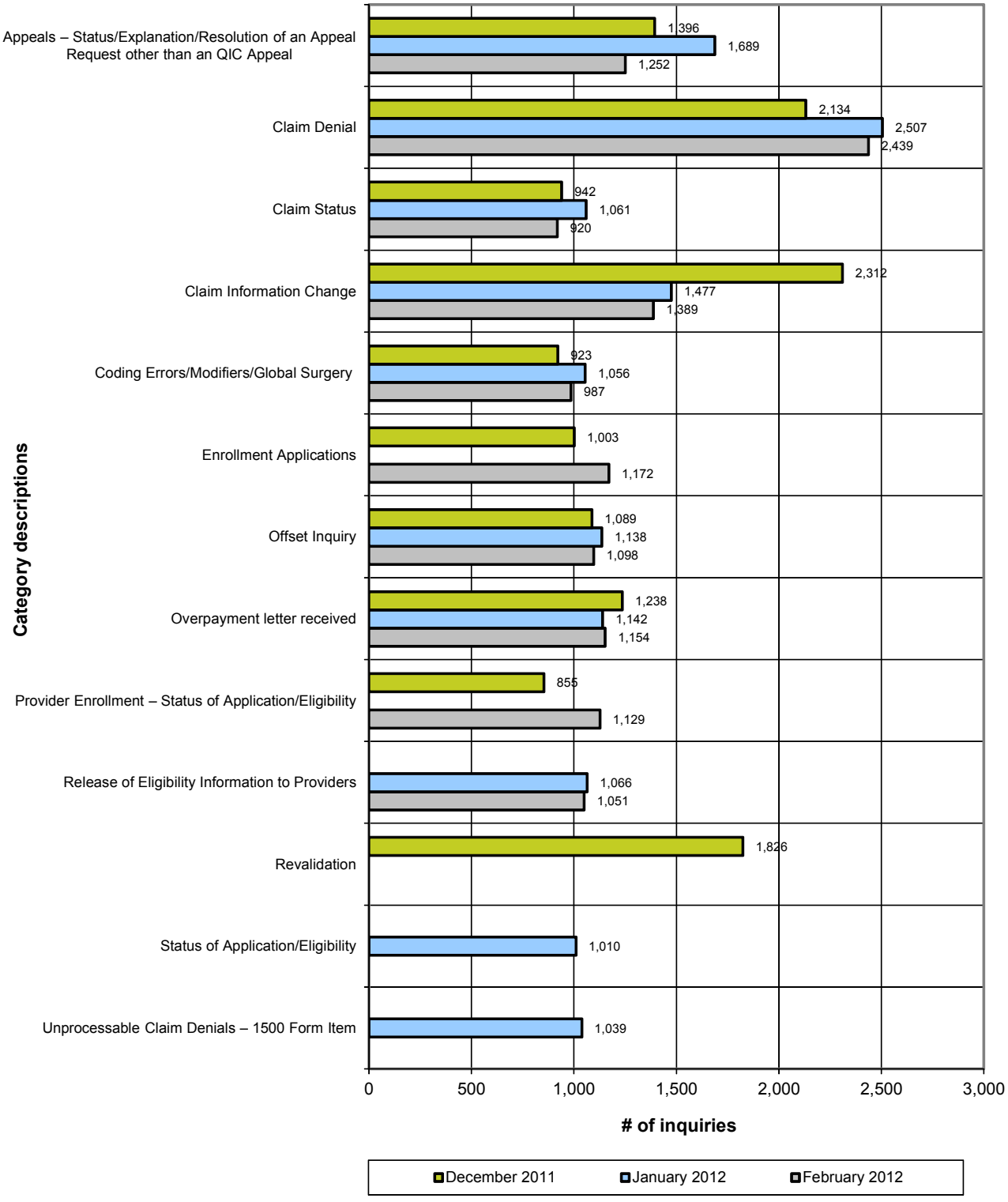
Find out first: Subscribe to FCSO eNews

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.

Top inquiries, denials, and return unprocessable claims

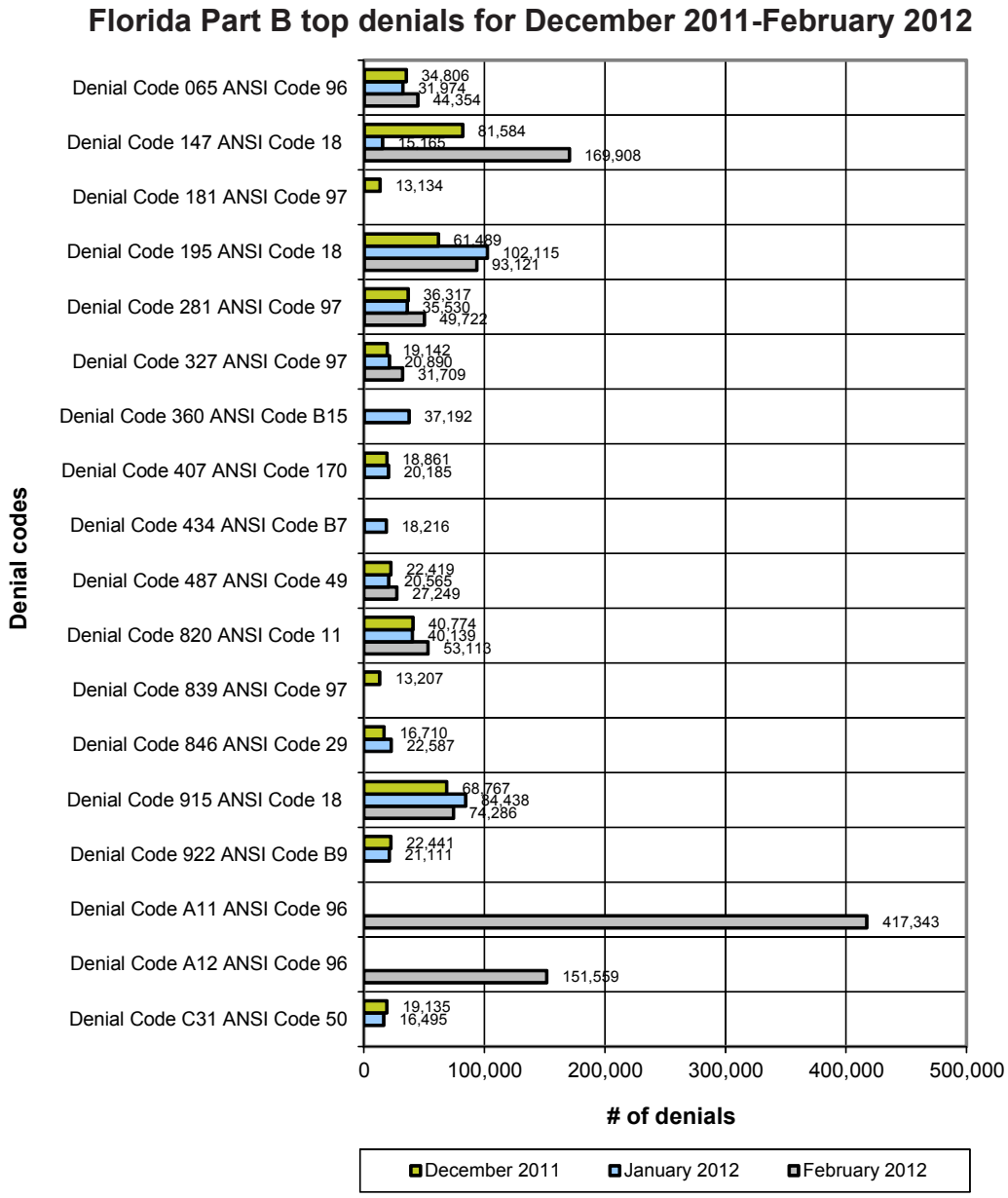
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during December 2011-February 2012. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part B top inquiries for December 2011-February 2012



(continued on next page)

Top *(continued)*



What to do when your claim is denied

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

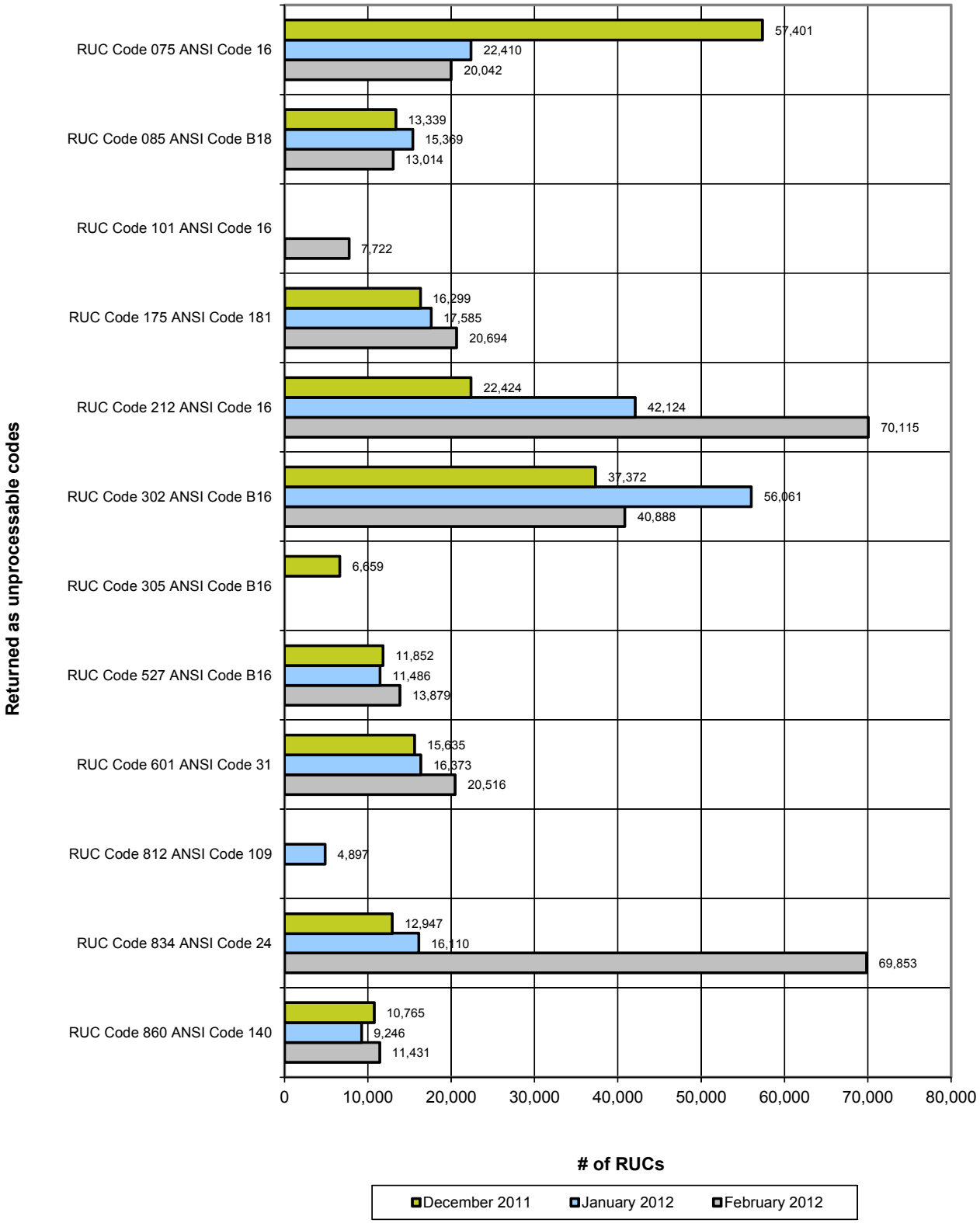
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top *(continued)*

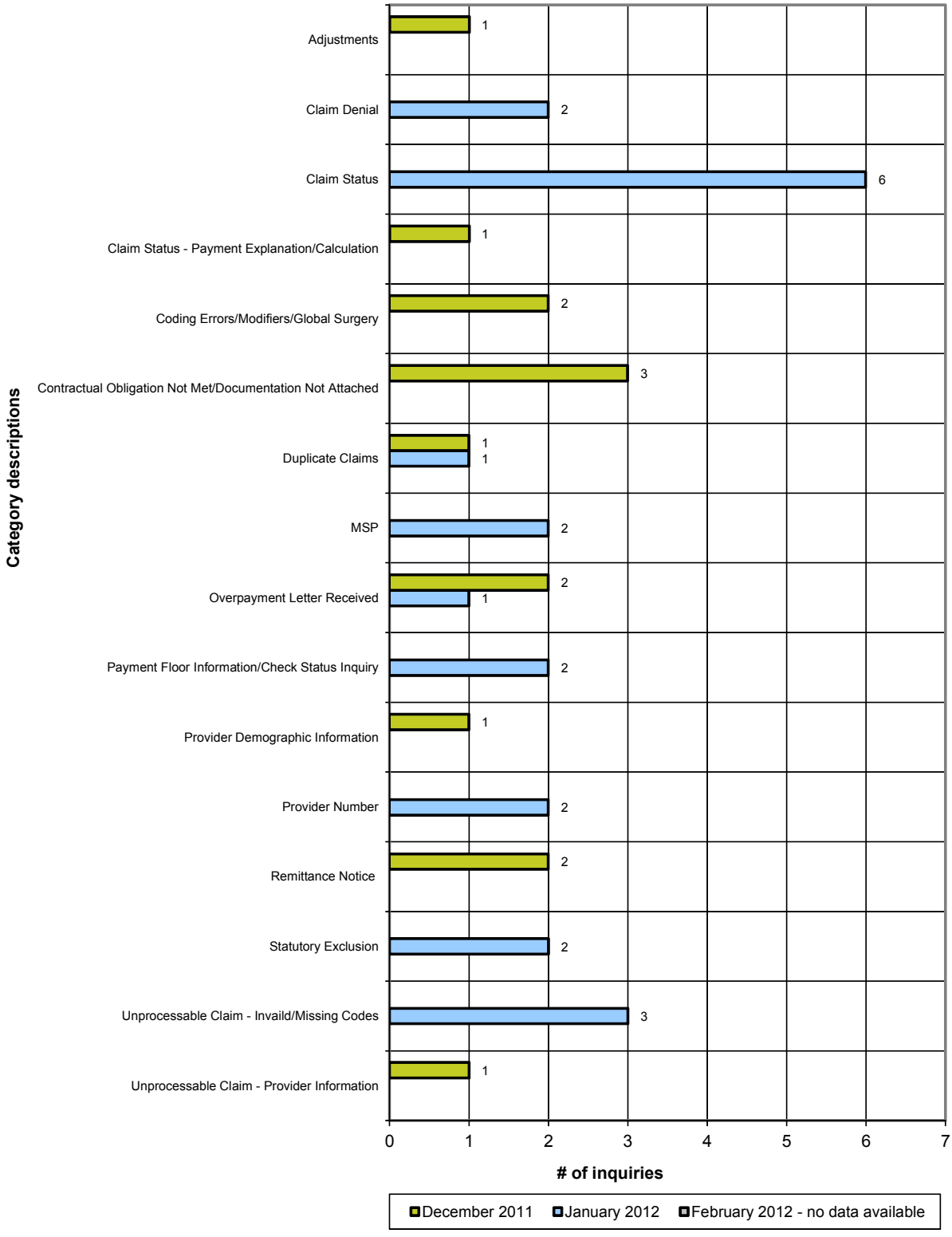
Florida Part B top return as unprocessable claims for December 2011-February 2012



(continued on next page)

Top *(continued)*

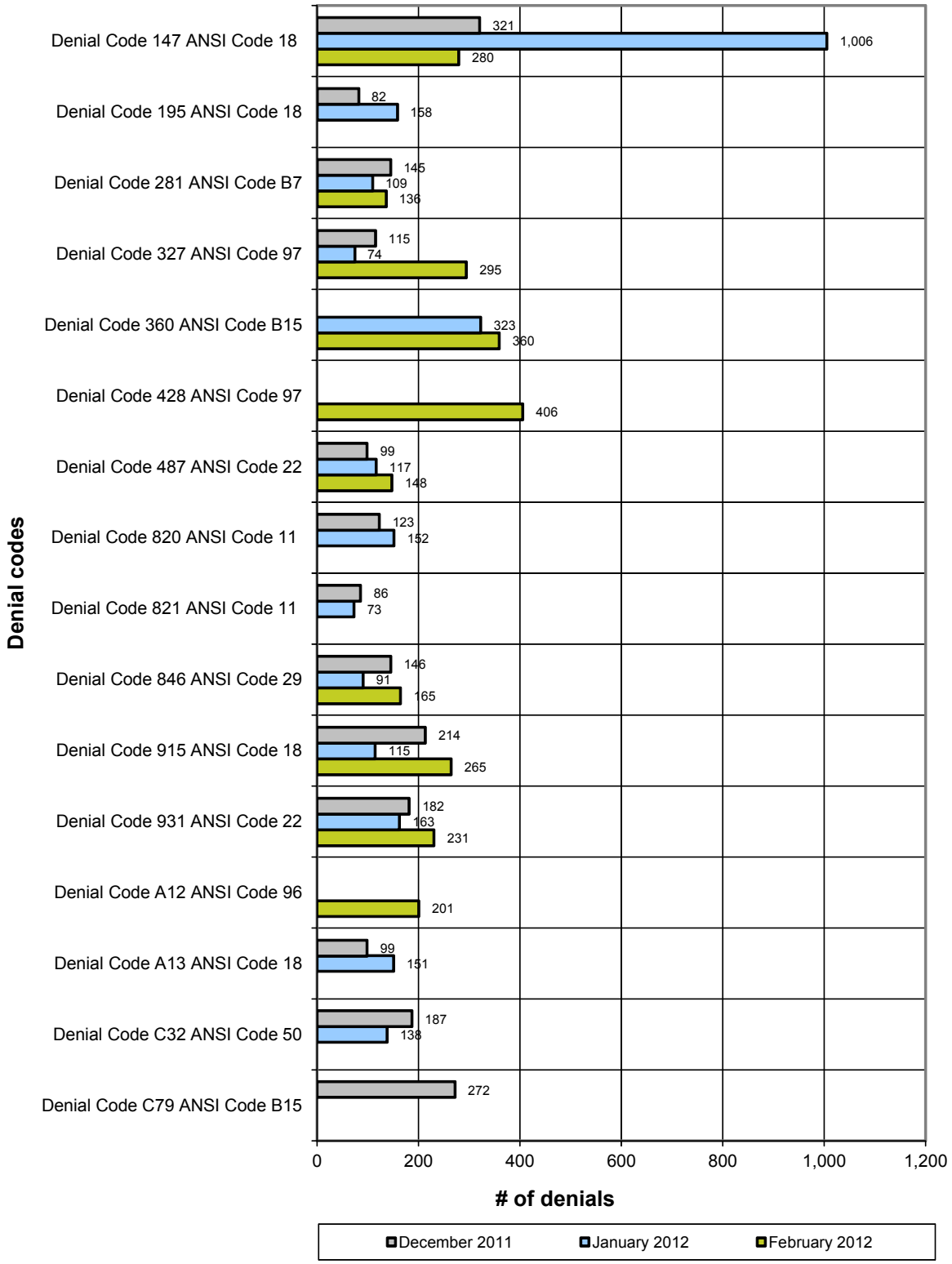
U.S. Virgin Islands Part B top inquiries for December 2011-February 2012



(continued on next page)

Top *(continued)*

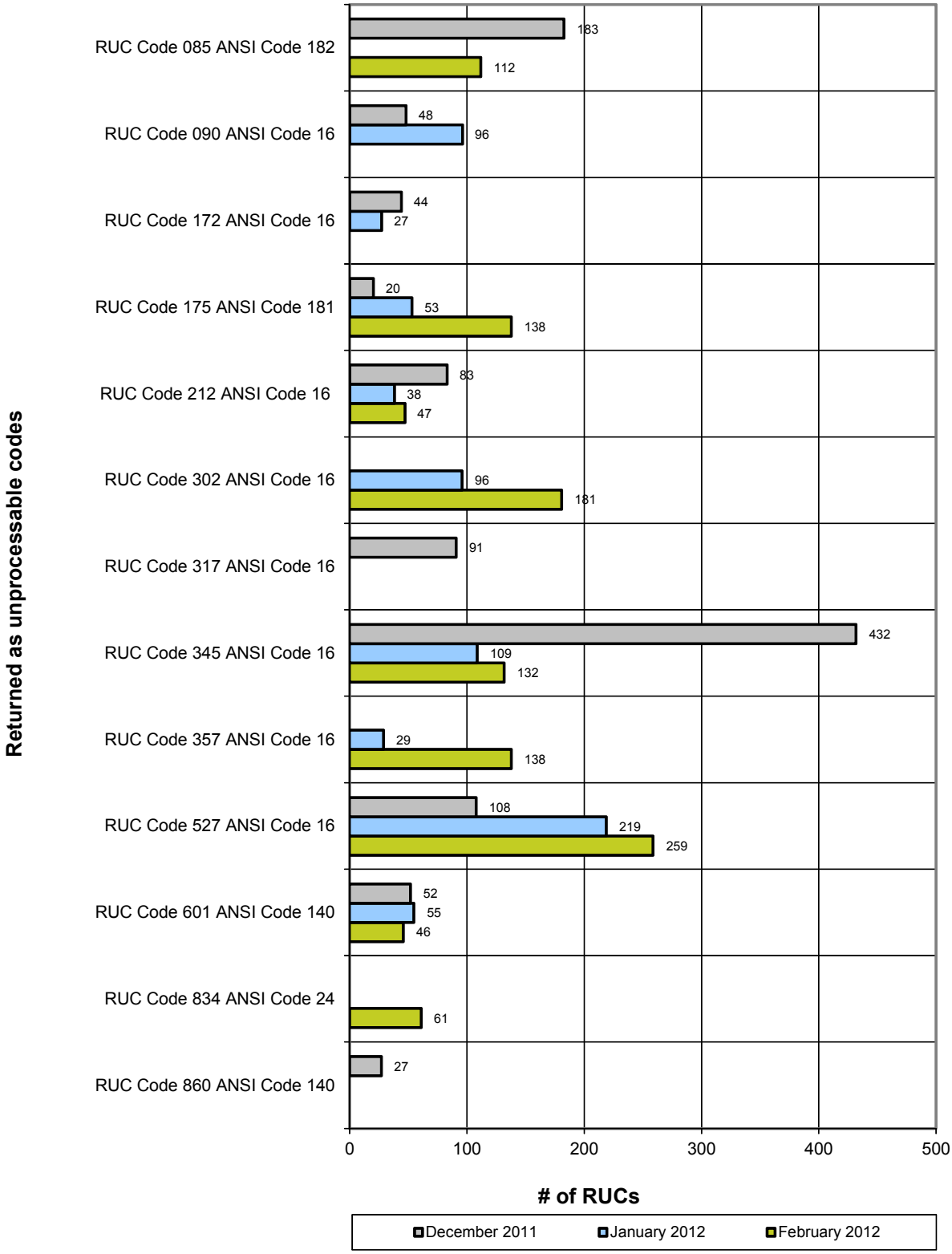
U.S. Virgin Islands Part B top denials for December 2011-February 2012



(continued on next page)

Top *(continued)*

U.S. Virgin Islands Part B top return as unprocessable claims for December 2011-February 2012



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.

Retired LCDs

Multiple local coverage determinations (LCDs) being retired

LCD ID number: L29238, L29054, L29127, L29287, L29183, L29260 (Florida)
LCD ID number: L29371, L29072, L29145, L29397, L29433, L29468 (Puerto Rico/U.S. Virgin Islands)

Based on data analysis and a review of the local coverage determinations (LCDs), the following LCDs are being retired.

- 76514: Ocular Corneal Pachymetry
- ALEFACEPT: Alefacept
- J0850: Cytomegalovirus Immune Globulin (Human), Intravenous (CMV-IGIV)
- J1080: Testosterone Cypionate and Testosterone Enanthate
- J9300: Gemtuzumab Ozogamicin (Mylotarg™)
- J9600: Porfimer (Photofrin®)

Effective date

The retirement of these LCDs is effective for services rendered **on or after March 22, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

Revisions to LCDs

IDTF: Independent diagnostic testing facility (IDTF) – revision to the LCD "Coding Guidelines" attachment

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised January 1, 2012. Since that time, the "Credentialing Matrix" in the LCD "Coding Guidelines" attachment has been revised. Revisions include the following:

- The "Supervising Physician and Interpreting Physician Qualification Requirements" have been revised for HCPCS code G0389 to read: Board Certified (ABMS) Cardiologist or Radiologist.
- The "Technician Qualification Requirements" have been revised for HCPCS code G0389 to read: Credentialed by ARDMS: RVT or RDMS - Abdomen, ARRT: VS or R.T. - S, or CCI: RVS.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for services rendered **on or after February 23, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

J2796: Romiplostim (Nplate®) – revision to the LCD

LCD ID number: L30878 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for romiplostim (Nplate®) was effective for services rendered on or after June 7, 2010, for Florida, Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, revisions have been made to the LCD related to label changes that have been made by the U.S. Food and Drug Administration (FDA) for Nplate®. Revisions include the following:

- The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to reflect chronic immune thrombocytopenia instead of chronic immune (idiopathic) thrombocytopenic purpura (ITP).
- The "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD have been revised to remove all statements related to the Nplate® NEXUS program.

Effective date

This LCD revision is effective for claims processed **on or after February 23, 2012**, for services rendered **on or after December 6, 2011**.First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

NCSVCS: Noncovered Services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised January 31, 2012. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2402, change request (CR) 7610, dated January 26, 2012. Based on this CR, the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Laboratory Procedures" section of LCD was revised to add the following language (Not medically reasonable and necessary except when billed with diagnosis V74.5 or V73.89) for *CPT* codes *87270* and *87320*.

Effective date

This LCD revision is effective for claims processed **on or after February 27, 2012,** for services rendered **on or after November 8, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

0279T: Circulating tumor cell testing – revision to the LCD

LCD ID number: L32098 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for circulating tumor cell testing was most recently revised January 1, 2012. Since that time, the LCD has been revised to update language to clarify coverage under the sections of the LCD titled "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements". The LCD requires a signed statement by the patient and the physician to confirm a change in the chemotherapy regimen (treatment plan). Therefore, the "Utilization Guidelines" section of the LCD was updated with an example of an acceptable statement to include in the medical record.

Effective date

This LCD revision is effective for services rendered **on or after March 20, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

93268: Patient demand single or multiple event recorder – revision to the LCD

LCD ID number: L29253 (Florida)
LCD ID number: L29379 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for patient demand single or multiple event recorder was most recently revised January 1, 2011. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" and the "Documentation Requirements" sections of the LCD to clarify language for coverage for the use of the event recorder. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following ICD-9-CM codes/code ranges with descriptors were added:

- 427.81-427.89: Other specified cardiac dysrhythmias
- 427.9: Cardiac dysrhythmia, unspecified
- 786.09: Other dyspnea and respiratory abnormalities
- 786.50-786.59: Chest pain

In addition to the above, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Providers whose claims were denied based on the diagnoses that are now being added to the LCD do not need to take any action. First Coast Service Options Inc. (FCSO) will perform adjustments on all the affected claims. We apologize for any inconvenience this may have caused.

Effective date

This LCD revision is effective for claims processed **on or after March 1, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

Additional Information

Part B: Eylea® (aflibercept)

Eylea® (aflibercept) is indicated for the treatment of patients with Neovascular (Wet) age-related macular degeneration. Eylea® was approved by the Food and Drug Administration (FDA) November 18, 2011.

Eylea® is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL. As approved by the FDA, the recommended dose for EyleaA® is 2 mg (0.05 mL) administered by intravitreal injection every four weeks (monthly) for the first three months, followed by 2 mg (0.05 mL) via intravitreal injection once every eight weeks (two months). Payment for Eylea® is for the entire content of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial must be used and the sterile field, syringe, gloves, drapes, eyelid speculum, filter, and injection needles must be changed before Eylea® is administered to the other eye. After injection, any unused product must be discarded.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self- administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis of Neovascular (Wet) age-related macular degeneration, using the appropriate ICD-9-CM code of 362.52 and FDA guidance for use as well as the administration.

Screening vs. diagnostic breast imaging services

Data analysis at First Coast Service Options Inc. (FCSO) previously identified an increase in utilization of *CPT* code *77056* (*Mammography; bilateral*). FCSO published an educational article in November 2010 detailing the nationally covered indications for screening and diagnostic mammography services in accordance with the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) for mammograms located in CMS Publication 100-03, Chapter 1, Part 4, Section 220.4.

Data indicates that providers are also performing breast ultrasounds (*CPT* code *76645*) on the same date of service as a diagnostic mammogram. Data also shows that providers are performing digital diagnostic mammograms (HCPCS code G0204) on the same date of service as *CPT* code *76645*.

These patterns of utilization remain evident in current Puerto Rico Part B claims data. Due to the high risk of improper claim payment, FCSO will implement prepayment edits to prevent payment of services for noncovered and/or inaccurately coded services.

Effective date

The local coverage determination (LCD) for screening and diagnostic mammography (L29329) is available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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.

Educational Events

Upcoming provider outreach and educational events
May 2012

Keeping you informed: 2012 Medicare Update Seminar

When: Tuesday-Wednesday, May 1 & 2
Time: 9:00 a.m.-1:00 p.m.
Focus: U.S. Virgin Islands

Medicare Part B "Ask-the-Contractor" teleconference

When: Wednesday, May 9
Time: 2:00 p.m.-3:30 p.m.

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

Two easy ways to register

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

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

Your recommendation matters during 'National Colorectal Cancer Awareness Month'

Studies have repeatedly demonstrated that a physician's recommendation is the most powerful factor in a patient's decision to receive preventive and screening services. March is "National Colorectal Cancer Awareness Month"; encourage your patients age 50 and older to get screened.

Resources to support decision-making

Cancer screening decisions, like other medical decisions, require weighing the harms and benefits, especially among chronically-ill patients. These persons may be at risk for adverse screening outcomes or have a life expectancy that is shorter than any survival benefit from cancer screening. In addition, patient preferences and values must be considered in decisions regarding screening and which test is most appropriate. Several articles shed some light on these issues:

- Walters LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision-making. JAMA. 2001, Jun 6; 285(21):2750-6.
- Walters LC, Lewis CL, Barton MB. Screening for colorectal, breast, and cervical cancer in the elderly: a review of the evidence. Am J Med. 2005, Oct; 118(10):1078-86.

The American Cancer Society has developed materials to help support practitioners in discussing colorectal cancer screening with their patients. These resources include reminder letters, phone reminder scripts, brochures, and wall charts, and are available for *download or order*.

The National Colorectal Cancer Roundtable has also published a report that describes the components of a quality screening colonoscopy referral system in primary care practice:

- Sifri R, Wender R, Lieberman D, Potter M, Peterson K, Smith R. *"Developing a Quality Screening Colonoscopy Referral System in Primary Care Practice: A Report from the National Colorectal Cancer Roundtable"*. CA Cancer J Clin 2010; 60; 40-49; originally published online December 18, 2009.

What can you do?

Discussing colorectal cancer screening and the various options available can be challenging, especially with older, chronically-ill patients. Engage patients in decision-making regarding their options, as it is important for promoting appropriate screening among older adults. Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened -- it could save their lives.

More information for health care professionals

- *MLN® Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 11)*
- *MLN® Preventive Services Educational Products Web page*
- *MLN® Cancer Screenings Brochure*
- *MLN® Quick Reference Information: Medicare Preventive Services*
- *National Colorectal Cancer Roundtable*
- *National Colorectal Cancer Awareness Month website*

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened – it could save their lives.

CMS.gov website upgrade – please take note that the Centers for Medicare & Medicaid Services (CMS) is in the process of making upgrades to the *www.CMS.gov* website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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

Source: CMS PERL 201203-48

March is 'National Colorectal Cancer Awareness Month'

Of cancers that affect both men and women, colorectal cancer is the second leading cause of cancer-related deaths in the United States and the third most common cancer in men and in women. More than 140,000 Americans are diagnosed, and more than 50,000 die from the disease each year. Colorectal cancer affects all racial and ethnic groups. It is most often found in people aged 50 years or older, and the risk for developing this cancer increases with age.

To help combat this disease, Medicare provides coverage for screening and the early detection of colorectal cancer. All Medicare beneficiaries aged 50 and older are covered; however, when a beneficiary is at high risk, there is no minimum age required to receive a screening colonoscopy (or a barium enema rendered as an alternative). Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp
- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of adenomatous polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis

Medicare pays for the following colorectal cancer screening services:

- Fecal occult blood test
- Flexible sigmoidoscopy
- Colonoscopy
- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy or a screening colonoscopy)

What can you do?

About nine out of every 10 people whose colorectal cancer is found early and treated are still alive five years later. The Centers for Medicare & Medicaid Services (CMS) needs your help to promote the early detection and prevention of colorectal cancer. As a provider of health care services to seniors and other people with Medicare, you can help increase their awareness of colorectal cancer. Talk with them about colorectal cancer. Inform them about their risk factors and help them understand the importance of early detection. Encourage seniors to take full advantage of colorectal cancer screenings covered by Medicare, as appropriate. Your recommendation can help save lives. Colorectal cancer is preventable, treatable, and beatable.

More information for health care professionals:

- *MLN® Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 11)*
- *MLN® Preventive Services Educational Products Web page*
- *MLN® Cancer Screenings brochure*
- *MLN® Quick Reference Information: Medicare Preventive Services*
- *National Colorectal Cancer Roundtable*
- *National Colorectal Cancer Awareness Month website*

Source: CMS PERL 201203-10

Get organized to support National Colorectal Cancer Awareness Month

Is your practice or office organized to support either the delivery of, or referrals for, colorectal cancer screening and follow-up? Several resources are available to help practitioners and their office staffs improve their practices' support for colorectal cancer screening.

What can you do?

To help improve office practice to support either the delivery of or recommendations for colorectal cancer screening, please review the *"What You Should Know about Screening for Colorectal Cancer: A Primary Care Clinician's Evidence-Based Toolbox and Guide,"* which was developed by the American Cancer Society, Thomas Jefferson University, and the National Colorectal Cancer Roundtable.

More information for health care professionals

- *MLN® Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 11)*
- *MLN® Preventive Services Educational Products Web page*
- *MLN® Cancer Screenings Brochure*
- *MLN® Quick Reference Information: Medicare Preventive Services*
- *National Colorectal Cancer Roundtable*
- *National Colorectal Cancer Awareness Month website*

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened – it could save their lives.

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

Source: CMS PERL 201203-32

New MLN® fact sheets available in hardcopy

"Mass Immunizers and Roster Billing" fact sheet available in hardcopy

The *"Mass Immunizers and Roster Billing"* fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on mass immunizers and roster billing, and includes information on simplified billing procedures for the influenza **and** pneumococcal vaccinations. To place your order for any of *Medicare Learning Network*® products available in print, visit *http://www.CMS.gov/MLNProducts* and click on "MLN Product Ordering Page" under "Related Links Inside CMS" at the bottom of the Web page.

"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention" fact sheet available in hardcopy

The revised *"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)"* fact sheet (ICN 904084) is designed to provide education on substance (other than tobacco) abuse structured assessment and brief intervention (SBIRT), and includes 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. To order hardcopies of this fact sheet, visit *http://www.CMS.gov/MLNProducts* and click on the "MLN Product Ordering Page" under "Related Links Inside CMS" 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 201203-05

March is 'National Nutrition Month®'

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that March is "National Nutrition Month®" – a campaign focused on the importance of making informed food choices and developing sound eating and physical activity habits. More than 35 percent of American men and women are obese, and adult obesity is associated with a number of serious health conditions, including heart disease, hypertension, diabetes, and some cancers.

Medicare provides coverage for the following nutrition-related health services:

Intensive behavioral therapy (IBT) for obesity – effective Tuesday, November 29, 2011

- Medicare provides coverage of IBT for obesity for qualifying beneficiaries whose body mass index (BMI) is equal to or greater than 30 kg/m2. This coverage includes screening for obesity in adults using measurement of BMI, a dietary (nutritional) assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. This coverage includes one face-to-face visit every week for the first month, one face-to-face visit every other week for months 2-6, and one face-to-face visit every month for months 7-12 (if the beneficiary meets the 3kg. (6.6 lbs.) weight-loss requirement during the first six months).

Intensive behavioral therapy for cardiovascular disease – effective Tuesday, November 8, 2011

- Medicare provides coverage of IBT for cardiovascular disease (referred to as a CVD risk reduction visit). The visit consists of the following three components:
- Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years
- Screening for high blood pressure in adults age 18 years and older
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Medical nutrition therapy (MNT)

- Medicare provides coverage of MNT for certain beneficiaries diagnosed with diabetes and/or renal disease*, when referred by the treating physician and provided by a registered dietitian or nutrition professional.

Diabetes self-management training (DSMT)

- Medicare provides coverage of DSMT services for beneficiaries who have been diagnosed with diabetes. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes (among its other services) education about nutrition, diet, and exercise.

Annual wellness visit (AWV)

- The AWV presents an opportunity for health professionals to provide eligible beneficiaries with personalized health advice and referrals, as appropriate, to health education, preventive counseling services, and community-based lifestyle interventions, focusing on reducing health risks and promoting self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

What can you do?

You can help your Medicare patients live healthier lives in 2012 by encouraging the use of the above Medicare-covered services. These services present excellent opportunities to begin a dialogue with your Medicare patients about their dietary habits and how their eating habits may affect their health and make recommendations for preventive services that can help them reach their nutritional and dietary goals. Remember to provide any appropriate written referrals.

More information for health care professionals

- *MLN® Guide to Medicare Preventive Services (see Chapter 6)*
- *MLN® Diabetes-Related Services fact sheet*
- *National Coverage Determination (NCD) for Medical Nutrition Therapy*
- *National Diabetes Education Program*
- *National Nutrition Month website*
- *Nutrition Education Resources*
- *Million Hearts™ campaign website*

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

Source: CMS PERL 201203-21

Raise awareness in March about kidney disease

"National Kidney Month®"

Please join the Centers for Medicare & Medicaid Services (CMS) during "National Kidney Month®" in raising awareness about chronic kidney disease. Millions of Americans are at risk for chronic kidney disease and diabetes and may be able to prevent the need for dialysis and kidney transplantation with early identification and a dedication to healthy lifestyle habits. Early disease detection is key, and the kidney disease-related services covered by Medicare are a great starting point for beneficiaries.

The incidence of kidney failure or end-stage renal disease (ESRD) is rising fast in America with more than 546,000 patients currently receiving treatment. Medicare covers a range of related services for eligible Medicare beneficiaries including diabetes screening tests, diabetes self-management training, medical nutrition therapy, kidney disease education services, dialysis, and transplant services.

What can you do?

- Use services like the "Welcome to Medicare" preventive visit and the annual wellness visit as opportunities to talk with your Medicare patients about their risk factors for disease and to provide referrals, as appropriate.
- Help them understand that the early detection and treatment of kidney disease can prevent or delay many associated illnesses and complications.
- Help protect the health of your Medicare-covered patients by informing them of Medicare-covered kidney disease and diabetes-related services, as appropriate.
- Remember, many of these services require an order or referral for coverage by Medicare; please ensure that you provide your Medicare patients with the appropriate documentation, so they can receive the services needed to help prevent, treat, and manage kidney disease and its complications.

More information for health care professionals

- *The Guide to Medicare Preventive Services*
  - *Chapter 1: Initial Preventive Physical Exam (commonly known as the "Welcome to Medicare" Preventive Visit)*
  - *Chapter 4: Annual Wellness Visit*
  - *Chapter 6: Diabetes-related services*
- *Medicare Preventive Services Quick Reference Information Chart*
- *MLN® Diabetes-Related Services fact sheet*
- *End-Stage Renal Disease Prospective Payment System fact sheet series*
- *National Kidney Foundation website*
- *National Kidney Foundation – "Chronic Kidney Disease on the Rise"*
- *National Diabetes Education Program Healthcare Professionals website*
- *2011 National Diabetes fact sheet*

Thank you for joining with CMS to help increase awareness and educate about kidney and diabetes-related services covered by Medicare.

Source: CMS PERL 201203-22

Prevention modules to be included in Medscape CMEPulse mailers

Effective Monday, March 26, the following Centers for Medicare & Medicaid Services (CMS) prevention modules are included in Medscape's CMEPulse mailers. These modules provide information and continuing medical education (CME) about Medicare's preventive services and can be accessed on Medscape with a free registration.

- *Clinical Anthology: Implementing Medicare Preventive Services* – *http://www.Medscape.org/viewprogram/32124?src=cmsaca6*
- *Video Expert Interview: Making Preventive Services Part of your Practices* – *http://www.Medscape.org/viewarticle/751965?src=cmsaca7*
- *Advisory: Making the Most out of Medicare Preventive Services* – *http://www.Medscape.org/viewarticle/743624?src=cmsaca8*

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

Source: CMS PERL 201203-53

Other Educational Resources

CMS requests your patience during website upgrades

The Centers for Medicare & Medicaid Services (CMS) is in the process of making upgrades to the *www.CMS.gov* website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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

Source: CMS PERL 201203-37

February 2012 version of *Medicare Learning Network*® products catalog now available

The February 2012 version of the *MLN*® products catalog is now available. The *MLN*® products catalog is a free interactive downloadable document that links you to online versions of MLN® products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available." The catalog can be found at *http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf*.

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

Source: CMS PERL 201203-05

Video stream broadcast on behavioral health and antipsychotic medications in nursing homes

The Centers for Medicare & Medicaid Services (CMS) launched a new initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. As part of the initiative, CMS is developing a national action plan that will use a multidimensional approach including:

- Public reporting
- Raising public awareness
- Regulatory oversight
- Technical assistance/training, and
- Research

The action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors.

The following experts provided an overview of this national initiative and resources for technical assistance, discussion of behavioral health opportunities, and plans for upcoming training sessions:

- Patrick Conway (MD, MSc, Chief Medical Officer for CMS and Director of the Office of Clinical Standards and Quality)
- Shari Ling (MD, CMS, Deputy Chief Medical Officer serving in the Office of Clinical Standards and Quality)
- Alice Bonner (PhD, RN, Director for the Division of Nursing Homes in the Office for Clinical Standards and Quality)

Handouts from the broadcast are available at *http://surveyortraining.CMS.hhs.gov*.

Target audience: State survey agencies, residents and family members, nursing home staff, clinicians, providers, advocates, CMS regional offices, and others

(continued on next page)

Video *(continued)*

Viewing instructions can be found at *http://surveyortraining.CMS.hhs.gov*. **The program will continue to be available for viewing for up to one year following Thursday, March 29.**

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

Source: CMS PERL 201203-30

Updates from the Medicare Learning Network®

New fast fact on MLN Provider Compliance Web page

A new fast fact is now available on the *Medicare Learning Network®* (*MLN®*) *Provider Compliance Web page*. This Web page provides the latest MLN® 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.

"CMS Website Wheel" educational tool revised

The "CMS Website Wheel" educational tool (ICN 006212) has been revised; this educational tool is available only in hardcopy. It is designed to provide a variety of the Centers for Medicare & Medicaid Services (CMS) Medicare related website addresses, including URLs for topics such as ICD-10, e-Prescribing, 5010, and more. To order hardcopies of this product, visit *http://www.CMS.gov/MLNProducts* and click on "MLN Product Ordering Page" under "Related Links Inside CMS" at the bottom of the Web page.

"Basics of DMEPOS Accreditation" fact sheet revised

"The Basics of DMEPOS Accreditation" fact sheet (ICN 905710) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and includes information so suppliers can meet DMEPOS quality standards established by the CMS and become accredited by a CMS-approved independent national accreditation organization. It also includes information on the types of providers who are exempt.

Now available – Medicare billing certificate programs for Part A and Part B providers

Learn about the Medicare program, and the specifics for your provider type with a special focus on Medicare billing, and receive a certificate in Medicare billing from CMS for successful completion of the program. Successful completion consists of completion of all required Web-based training courses, required readings, and a 75 percent or higher score on the post-assessment.

To participate in either the Part A or Part B provider type program, visit *http://www.CMS.gov/MLNproducts* and click on "Web-Based Training Modules" under "Related Links Inside CMS."

"DMEPOS Information for Pharmacies" fact sheet revised

The *"DMEPOS Information for Pharmacies" fact sheet (ICN 905711)* has been revised and is now available in downloadable format. This fact sheet is designed to provide education for pharmacies on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and includes information on accreditation by a CMS-approved independent national accreditation organization as well as information for pharmacies want to be considered for an exemption from the accreditation requirements.

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

Source: CMS PERL 201203-50

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
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2011 through September 2012.	40300260	$33		
2012 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2012, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

Medicare B Connection

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

Attention Billing Manager