Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

June 2012

In this issue

Suggestions being accepted for potential Physician Quality Reporting System measures

The Center for Medicare & Medicaid Services (CMS) is currently accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures, visit the *CMS Measures Management System Web page*.

For measures to be considered into the Physician Quality Reporting System**, provide the required documentation for each measure submitted for consideration to** *mailto:PHYSICIAN_REPORTING_TEMP@cms.hhs.gov*, **no later than 5:00 p.m. (ET), August 1, 2012.**

Required information includes:

- National Quality Form (NQF) Measure Endorsement Status
- Measure Submitted for Consideration Form
- Measure specifications (measure title, description, numerator and denominator, including exclusions, exceptions, and inclusions)
- Specification and data tables for electronic health record (EHR)-specified candidate measures.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the Physician Quality Reporting System. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the Physician Quality Reporting System.

Source: CMS PERL 201206-06

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: August 21 or September 11, 2012.

Contents

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

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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.

Modifying the timely filing exceptions on retroactive Medicare entitlement

Provider types affected

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

What you need to know

This article is based on change request (CR) 7834, which advises you that the Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare Claims Processing Manual* to specify that, if a provider, supplier, or beneficiary is unable to provide the Medicare contractor with an official Social Security Administration (SSA) letter, the contractor must check the common working file (CWF) database in order to verify a beneficiary's retroactive Medicare entitlement date. Be sure that your staffs are aware of this change.

Background

The Medicare regulations at 42 *Code of Federal Regulations* (CFR), Section 424.44, specify the time limits for filing Part A and Part B fee-for-service (FFS) claims. Section 424.44 also identifies certain exceptions to the claim filing time limit. If the requirements for satisfying a timely filing exception are met, an extension to file the claims may be granted. Section 6404 of the Affordable Care Act reduced the maximum period for the submission of all Medicare FFS claims to no more than 12 months, or one calendar year, after the date a service is furnished. Section 6404 also gave the Secretary of Health and Human Services the authority to create exceptions to the 12-month timely filing limit. As a result of this legislation, revisions were made to the timely filing regulations at 42 CFR, Section 424.44, and the relevant Internet-only manual sections. (See Transmittal 2140/change request 7270, published January 21, 2011, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads//R2140CP.pdf*.)

The *Medicare Claims Processing Manual* currently requires that, in order to be granted a timely filing extension, the provider, supplier, or beneficiary must furnish an official letter from the SSA to the beneficiary in order to meet one of the conditions that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service. The purpose of CR 7834 is to revise Sections 70.7, 70.7.2, and 70.7.3 of the manual to specify that, if an official SSA letter to the beneficiary is not submitted, Medicare contractors must check the CWF database and may interpret the CWF data in order to verify that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service. Consequently, CR 7834 requires the Medicare contractors to accept the SSA letter or, in the absence of such letter, to check the CWF database for a beneficiary's date of Medicare entitlement. Contractors may interpret the CWF data in order to verify retroactive Medicare entitlement that may permit a claim to be processed after the 12-month timely filing limit.

Additional information

The official instruction, CR 7834, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2477CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7834
Related Change Request (CR) #: 7834
Related CR Release Date: May 25, 2012
Effective Date: August 27, 2012
Related CR Transmittal #: R2477CP
Implementation Date: August 27, 2012

Ambulatory Surgical Center

July 2012 update of the ASC payment system

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MACs]) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7854, which informs Medicare contractors about the changes to and billing instructions for various payment policies implemented in the July 2012 ambulatory surgical center (ASC) update. CR 7854 applies to Chapter 14, Section 10 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

1. New category III CPT codes that are separately payable under the ASC payment system, effective July 1, 2012

The American Medical Association (AMA) releases category III *Current Procedural Terminology* (*CPT*) codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. The mid-year implementation of category III *CPT* codes in ASCs began with the implementation of the revised ASC payment system in January 2008.

For the July 2012 quarterly update, the Centers for Medicare & Medicaid Services (CMS) is implementing seven category III *CPT* codes that the AMA released in January 2012 for implementation July 1, 2012. Five of the seven category III *CPT* codes are separately payable under the ASC payment system. The category III *CPT* codes and payment indicators are shown in Table 1. The payment rates, effective July 1, 2012, will be included in the July 2012 update of the ASC payment system, addendum AA, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html* and also in the July 2012 ambulatory surgical center fee schedule (ASCFS) file.

Table 1: Category III *CPT* codes implemented as of July 1, 2012

CPT code	Long descriptor	Short descriptor	ASC payment indicator (PI)
0302T	*Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; complete system (includes device and electrode)*	Icar ischm mntrng sys compl	J8
0303T	*Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; electrode only*	Icar ischm mntrng sys eltrd	G2
0304T	*Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; device only*	Icar ischm mntrng sys device	J8
0307T	*Removal of intracardiac ischemia monitoring device*	Rmvl icar ischm mntrng dvce	G2

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ASC *(continued)*

CPT code	Long descriptor	Short descriptor	ASC payment indicator (PI)
*0308T**	*Insertion of ocular telescope prosthesis including removal of crystalline lens*	Insj ocular telescope prosth	G2

*Healthcare Common Procedure Coding System (HCPCS) code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) was deleted June 30, 2012, and replaced with *CPT* code *0308T*, effective July 1, 2012.

2. Instructions for device pass-through category C1840

Effective July 1, 2012, device pass-through category C1840 must be billed with *CPT* code *0308T* (*Insertion of ocular telescope prosthesis including removal of crystalline lens*) to receive pass-through payment, because C9732 is deleted effective June 30, 2012, and replaced with *CPT* code *0308T*. The ASC code pair file will be revised for the July 2012 update to reflect this change.

3. Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP), effective July 1, 2012

Payment for separately payable drugs and biologicals based on the ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the July 2012 release of the ASC DRUG file. The updated payment rates, effective July 1, 2012, will be included in the July 2012 update of the ASC payment system addendum BB, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

b. New HCPCS codes for drugs and biologicals separately payable under the ASC payment system, effective July 1, 2012

Two drugs and biologicals have been granted ASC payment status effective July 1, 2012. These items, along with their descriptors and APC assignments, are identified in Table 2.

Table 2: New separately payable drugs and biologicals, effective July 1, 2012

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9368*	Grafix core, per square centimeter	Grafix core	K2
C9369*	Grafix prime, per square centimeter	Grafix prime	K2

Note: The HCPCS codes identified with an "*" indicate that these are new codes, effective July 1, 2012.

c. New HCPCS codes, effective July 1, 2012, for separately payable drugs and biologicals

Six new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed in Table 2) in the ASC payment system effective for services furnished on or after July 1, 2012. Five of the six HCPCS codes are separately payable under the ASC payment system. These codes are listed in Table 3 and will be included in the July 2012 update of the ASC payment system, addendum BB, which will be posted on the CMS website and also in the July 2012 ASCFS file.

Table 3: New HCPCS codes for certain drugs and biologicals, effective July 1, 2012

HCPCS code	Long descriptor	Short descriptor	ASC PI
Q2045*	Injection, human fibrinogen concentrate, 1 mg	Human fibrinogen conc inj	K2
Q2046**	Injection, aflibercept, 1 mg	Aflibercept injection	K2
Q2048***	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	Doxil injection	K2
Q2049	Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg	Imported Lipodox inj	K2
Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu)	Agriflu vaccine	L1

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ASC *(continued)*

* Level II HCPCS code J1680 (Injection, human fibrinogen concentrate, 100 mg) will be replaced with HCPCS code Q2045, effective July 1, 2012. The ASC payment indicator for HCPCS code J1680 will change to Y5, "Not payable by Medicare," effective July 1, 2012.

**Level II HCPCS code C9291 (Injection, aflibercept, 2 mg vial) will be deleted June 30, 2012, and replaced with HCPCS code Q2046, effective July 1, 2012.

***Level II HCPCS code J9001 (Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg) will be replaced with HCPCS code Q2048, effective July 1, 2012. The ASC payment indicator for HCPCS code J9001 will change to Y5, "Not payable by Medicare.," effective July 1, 2012.

d. Adjustment to the payment indicator for certain HCPCS codes, effective April 1, 2012

Effective April 1, 2012, the status indicators for several HCPCS codes listed in Table 4 will change from ASC PI=Y5 (Not payable by Medicare) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.). For the remainder of CY 2012, these HCPCS codes will be separately paid and the price will be updated on a quarterly basis. The payment rates for these HCPCS codes are listed in Table 4 and have been included in the revised April 2012 ASC drug file effective for services furnished April 1, 2012, through the implementation of the July 2012 ASC quarterly update. Suppliers who have received an incorrect payment for dates of service April 1, 2012, through June 30, 2012, may request contractor adjustment of the previously processed claims.

Table 4: Adjustment to ASC payment indicator for certain drugs and biologicals, effective April 1, 2012

HCPCS code	Long descriptor	Short descriptor	ASC PI, effective 4/1/12
90581	*Anthrax vaccine, for subcutaneous or intramuscular use*	Anthrax vaccine sc or im	K2
J2265	Injection, minocycline hydrochloride, 1 mg	Minocycline hydrochloride	K2
J8650	Nabilone, oral, 1 mg	Nabilone oral	K2
Q0174	Thiethylperazine maleate, 10 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Thiethylperazine maleate 10mg	K2
Q4123	Alloskin rt, per square centimeter	Alloskin	K2
Q4125	Arthroflex, per square centimeter	Arthroflex	K2
Q4128	Flexhd or allopatch hd, per square centimeter	Flexhd or allopatch hd	K2
Q4129	Unite biomatrix, per sqaure centimeter	Unite biomatrix	K2

Additional information

The official instruction, CR 7854 issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2491CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Related Change Request (CR) #: CR 7854
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Implementation Date: July 2, 2012

Consolidated Billing

October quarterly update to 2012 HCPCS codes for SNF consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs] and durable medical equipment [DME] MACs) for skilled nursing facility (SNF) services provided to Medicare beneficiaries.

Provider action needed

The changes noted in change request (CR) 7856, which apply to the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 10.1 (Consolidated Billing Requirement for SNFs), allow for correct processing of claims under the Skilled Nursing Facility Consolidated Billing provisions.

For the October 2012 update, the only change is the addition of Healthcare Common Procedure Coding System (HCPCS) code J9033 (Injection, bendamustine hcl, 1 mg) to the File 1 Coding List for SNF Consolidated Billing (CB) for dates of service on or after January 1, 2012. Please note that, when brought to their attention, your Medicare contractor will re-open and re-process claims for J9033 with dates of service on or after January 1, 2012, that have been previously denied prior to the implementation of CR 7856.

Background

Section 1888 of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*) codifies the skilled nursing facility prospective payment system (SNF PPS) and consolidated billing (CB); and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. These updates (which do not add any additional services) are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when, and if, they occur.

To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries that are both included and excluded from SNF CB. You should be aware that Medicare will not pay any providers (other than SNFs) for services included in SNF CB that appear on claims submitted to Medicare carriers, A/B MACs, and DME MACs. However services excluded from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay.

SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay; but applies to non-therapy services only when the services are furnished to a SNF resident during a covered Part A stay.

Additional information

The official instruction, CR 7856 issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2492CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7856
Related Change Request (CR) #: CR 7856
Related CR Release Date: June 27, 2012
Effective Date: : January 1, 2012
Related CR Transmittal #: R2492CP
Implementation Date: October 1, 2012

Correction to skilled nursing facility consolidated billing file

When the 2012 annual update of Healthcare Common Procedure Code System (HCPCS) codes for skilled nursing facility consolidated billing was implemented in January 2012, the code J9033 was not included in file # 1-Physician Services. The Medicare claim processing system will update the edit associated with this file on October 1, 2012. The updated edit will be effective for services provided in 2012.

Providers may choose to refrain from billing for 2012 services with this code until the update is effective on October 1. However, if the service is billed and denied prior to October 1, contact your Medicare administrative contractor or carrier to have the claim reopened and reprocessed. If you have any additional questions, please contact your Medicare administrative contractor or carrier.

Source: CMS PERL 201206-46

Drugs and Biologicals

July 2012 average sales price files now available

The Center for Medicare & Medicaid Services (CMS) has posted the July 2012 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. All are available for download on the *2012 ASP Drug Pricing Files* Web page.

Source: CMS PERL 201206-16

Durable Medical Equipment

Get ready for DMEPOS competitive bidding round 1 recompete

Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 1 recompete is coming soon.

Summer 2012

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

Fall 2012

- Bidding begins

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

- Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up-to-date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. If you want to bid, you will need to register even if you registered for a previous round. DMEPOS suppliers should review and update:
- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding), and

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Competitive *(continued)*

- The correspondence address.

DMEPOS suppliers can update their enrollment file via the Internet-based provider enrollment, chain and ownership system (PECOS) or by using the July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the *PECOS* website or reviewing the *PECOS fact sheet*. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found in the *change of information guide* on the NSC website.

- **Get licensed**: Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a competitive bidding area (CBA), you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by the close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- **Get accredited**: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited for all items in the product category.

More information about the DMEPOS accreditation requirements may be found on the *CMS website*.

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

Source: CMS PERL 201206-20

CMS will host a meeting to discuss Medicare fee schedule amounts for retail diabetic testing supplies July 23

Monday, July 23, 9 a.m.-1 p.m. ET

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Md. 21244

The Centers for Medicare & Medicaid Services (CMS) has announced that it will host a public meeting that provides an opportunity for consultation with representatives of suppliers and other interested parties regarding options to adjust the Medicare payment amounts for non-mail order diabetic testing supplies. This meeting will provide the public an opportunity to offer oral and written comments.

For more information about the meeting, please view the meeting notice "Public Meeting Regarding Inherent Reasonableness of Medicare Fee Schedule Amounts for Non-Mail Order (Retail) Diabetic Testing Supplies (CMS-1445-N)," *published in the Federal Register June 26, 2012*.

If you would like to attend the meeting, you must register on the *CMS website*.

Meeting attendees should allow plenty of time to ensure access to the CMS facility. CMS security procedures require that all visitors are subject to a vehicular search and can only gain access through the Central Building main lobby. All visitors must also be in possession of a valid, government-issued form of photo identification, such as a driver's license, age of majority card, passport, or visa.

Source: CMS PERL 201206-62

Evaluation and Management

Documentation is required when billing modifier 24

Based on three recent widespread probes of office evaluation and management (E/M) services, First Coast Service Options (FCSO) has discovered that the 24 modifier for E/M services, when billing within a global surgery period, has been billed incorrectly at least 60 percent of the time. Clinical review of documentation demonstrates that modifier 24 was either not supported for the encounter, or was improperly applied (i.e., a different modifier should have been submitted).

To address this widespread improper billing, FCSO implemented a pre-payment edit **on April 16, 2012**, that is applied to office visit E/M claims (codes *99201-99205* and *99212-99215*) billed with the 24 modifier.

Claims

For claims containing modifier 24 received on or after April 16, FCSO began developing to the provider to provide supporting documentation that justifies the use of the 24 modifier. Providers must respond within the specified timeframe included in the development letter. Failure to submit the documentation timely may result in a claim denial.

Reopenings

Also effective April 16, FCSO no longer accepts the following:

- Telephone requests via the interactive voice response or a customer service representative to add or change the 24 modifier on a previously denied claim.
- Written or fax requests (processed on or after April 16) to add or change the 24 modifier without supporting documentation. The provider will be sent a written notification that their request could not be completed.

Redeterminations

Redeterminations processed on or after April 16 to add or change the 24 modifier without supporting documentation will be affirmed.

Educational resources

Providers currently billing E/M services with the 24 modifier are encouraged to review the Medicare guidelines as outlined in the Centers for Medicare & Medicaid Services Internet-only manuals, Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.6:

"Carriers pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (*CPT* codes *99221-99238*) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with *CPT* modifier "*-24*," and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment".

The following Web-based training courses are available on *FCSO University* to help providers learn about the proper billing of the 24 modifier as well as the documentation requirements to support the necessity and/or validity of its use:

- "Introduction to Global Surgery"
- "Medical Documentation Errors"
- "Medical Documentation Request"
- "Modifier 24"
- "Modifier 25"
- "Modifier 58"
- "Modifier 78"
- "Modifier 79"

Medicare Physician Fee Schedule Database

July update to the CY 2012 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 7844 and instructs Medicare contractors to download and implement a new MPFSDB as of July 2, 2012. Affected providers should be aware that Medicare contractors will only adjust claims processed before July 2, but impacted by changes effective prior to July 2, if you bring such claims to their attention. Please make sure your billing staff is aware of these changes.

Background

Payment files were issued to contractors based upon the CY 2012 MPFS final rule, published in the *Federal Register* on November 28, 2011, as modified by the final rule correction notice, published in the *Federal Register* January 4, 2012, and relevant statutory changes applicable January 1, 2012. On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the Medicare physician fee schedule from January 1, 2012, until February 29, 2012. On February 22, 2012, The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) was signed into law and extended the zero percent update to the end of the calendar year, to December 31, 2012. CR 7844 is the July amendment to those payment files.

Key changes are as follows:

HCPCS codes with revised Medicare physician fee schedule payment indicators, effective July 1, 2012

Code	Short descriptor
J1680	Human fibrinogen conc inj
J9001	Doxorubicin hcl liposome inj
15777	Acellular derm matrix implt
38205*	Harvest allogeneic stem cells
57155*	Insert uteri tandem/ovoids
94729*	CO diffuse capacity

* Only a short descriptor correction - AMA errata

New HCPCS codes to be added with the effective date of April 1, 2012

HCPCS code	Procedure status	Short descriptor
G8907	X	Pt doc no events on discharge
G8908	X	Pt doc w burn prior to D/C
G8909	X	Pt doc no burn prior to D/C
G8910	X	Pt doc to have fall in ASC
G8911	X	Pt doc no fall in ASC
G8912	X	Pt doc with wrong event
G8913	X	Pt doc no wrong event
G8914	X	Pt trans to hosp post D/C
G8915	X	Pt not trans to hosp at D/C
G8916	X	Pt w IV AB given on time

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July *(continued)*

HCPCS code	Procedure status	Short descriptor
G8917	X	Pt w IV AB not given on time
G8918	X	Pt w/o preop order IV AB prop

Note that the various indicators, relative value unit (RVU) values, long descriptors, and payment amounts are included in a table in CR 7844.

New HCPCS codes to be added to the MPFSDB with the effective date of July 1, 2012

HCPCS code	Procedure status	Short descriptor
Q2034	X	Agriflu vaccine
Q2045	E	Human fibrinogen conc inj
Q2046	E	Aflibercept injection
Q2047	E	Peginesatide injection
Q2048	E	Doxil injection
Q2049	E	Imported Lipodox inj
0302T	C	Icar ischm mntrng sys compl
0303T	C	Icar ischm mntrng sys eltrd
0304T	C	Icar ischm mntrng sys device
0305T	C	Icar ischm mntrng prgrm eval
0306T	C	Icar ischm mntrng interr eval
0307T	C	Rmvl icar ischm mntrng dvce
0308T	C	Insj ocular telescope prosth

Note that the various indicators, relative value unit (RVU) values, long descriptors, and payment amounts are included in a table in CR 7844.

Additional information

The official instruction, CR 7844 issued to your carrier, FI, RHHI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2481CP.pdf*.

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

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Related CR Transmittal #: R2841
Implementation Date: July 2, 2012

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

Medicare physician fee schedule booklet reminder

This is a reminder that the *How to Use the Searchable Medicare Physician Fee Schedule* booklet, ICN 901344, is available in downloadable format. This booklet is designed to provide education on how to use the Medicare physician fee schedule (MPFS). It includes steps to search for payment information, pricing, relative value units (RVUs), and payment policies.

If you like this booklet, you may also want to review *How to Use the Medicare Coverage Database* and *How to Use the National Correct Coding Initiative (NCCI) Tools* from the *Medicare Learning Network*®.

Source: CMS PERL 201206-11

Mental Health

Screening for sexually-transmitted infections and high-intensity behavioral counseling for prevention

Provider types affected

Note: This article was revised on May 29, 2012, to reflect a revised change request (CR) 7610 issued on May 23. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7610 were revised. All other information is the same. This information was previously published in the February 2012 *Medicare B Connection*, Pages 20-24.

This *MLN Matters*® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MACs]) for Medicare beneficiaries.

Provider action needed

Effective for dates of service on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover screening for sexually-transmitted infections (STIs) - specifically chlamydia, gonorrhea, syphilis, and hepatitis B - with the appropriate Food and Drug Administration (FDA) approved/cleared laboratory tests when ordered by the primary care provider. The tests must be used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare provider for these services.

In addition, Medicare will cover high intensity behavioral counseling (HIBC) to prevent STIs. Ensure that your billing staffs are aware of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must be:

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

CMS reviewed the USPSTF recommendations and supporting evidence for screening for STIs and HIBC to prevent STIs and determined that the criteria listed above were met, enabling CMS to cover these preventive services. Therefore, effective November 8, 2011, CMS will cover screening for the indicated STIs and HIBC to prevent STIs. The covered screening lab tests must be ordered by the primary care provider. The HIBC must be provided by primary care providers in primary care settings such as by the beneficiary's family practice physician, internal medicine physician, or nurse practitioner (NP) in the doctor's office.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0445 (high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes), has been created for use when reporting HIBC to prevent STIs, effective November 8, 2011. This code is included in the January 2012 Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE) updates.

This code may be paid on the same date of service as an annual wellness visit (AWV), evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.

The appropriate screening diagnosis code (ICD-9-CM V74.5 (screening bacterial – sexually transmitted) or V73.89 (screening, disease or disorder, viral, specified type NEC)), when used with the screening lab tests identified by change request (CR) 7610, will indicate that the test is a screening test covered by Medicare.

Diagnosis code V69.8 (other problems related to life style) is used to indicate that the beneficiary is at high/increased risk for STIs. Providers should also use

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STI *(continued)*

V69.8 for sexually active adolescents when billing G0445 counseling services.

Diagnosis code V69.8 (other problems related to life style) is used to indicate that the beneficiary is at high/increased risk for STIs. Providers should also use V69.8 for sexually active adolescents when billing G0445 counseling services.

Diagnosis codes V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy) are also to be used when appropriate.

For services provided on an annual basis, this is defined as a 12-month period.

Further details

CMS will cover screening for:

- Chlamydia (*86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800* [used for combined Chlamydia and gonorrhea testing])
- Gonorrhea (*87590, 87591, 87850, 87800* [used for combined Chlamydia and gonorrhea testing]), and
- Hepatitis B (hepatitis B surface antigen [87340, 87341]) with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the CLIA regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services.

As per the requirements, the presence of V74.5 or V73.89 and V69.8, denoting STI screening and high-risk behavior, respectively, and/or V22.0, V22.1, or V23.9, denoting pregnancy as appropriate, must also be present on the claim for STI services along with one of the procedure codes above.

Screening for chlamydia and gonorrhea

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test;
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test; and
- Women at increased risk for STIs annually.

Screening for syphilis

- Pregnant women when the diagnosis of pregnancy is known and then repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening test; and
- Men and women at increased risk for STIs annually.

Screening for hepatitis B

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known and then re-screening at the time of delivery for those with new or continuing risk factors.

Coverage for HIBC

CMS will also cover up to two, individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs (G0445) for all sexually active adolescents and for adults at increased risk for STIs (V69.8), if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements:

- Education
- Skills training, and
- Guidance on how to change sexual behavior.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs
- Having sex in exchange for money or drugs
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (hepatitis B only)
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age

Community social factors such as high prevalence of STIs in the community populations should also be considered in determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending HIBC.

High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient's sexual history which is part of any complete medical history, typically part of an AWV or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible

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STI *(continued)*

health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

For the purposes of this NCD, a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (Sections 1833(u)(6), 1833(x)(2)(A)(i)(I) and 1833(x)(2)(A)(i)(II)), as follows:

- 1833(u) (6) Physician Defined: For purposes of this paragraph, the term "physician" means a physician described in Section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.
- 1833(x)(2)(A)(i) (I) is a physician (as described in Section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in Section 1861(aa)(5)).

Billing reminders

- Institutional providers should note that coverage requires services be performed in a primary care setting. Consequently, if STI services are billed on types of bill (TOB) other than 13x, 14x and 85x (when the revenue code on the 85x is not 096x, 097x, or 098x), OR, if G0445 is submitted on a TOB other than 13x, 71x, 77x, or 85x, payment for the services will be denied using the following:
  - Claim adjustment reason code (CARC) 170 – "Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - Remittance advice remark code (RARC) N428 – "This service was denied because Medicare only covers this service in certain settings."
- When applying frequency limitations to HIBC services, contractors will allow both a claim for the professional service and a claim for the facility fee. Institutional claims may be identified as facility fee claims for screening services if they contain G0445, and TOB 13x or TOB 85x (when the revenue code is not 096x, 097x, or 098x). All other claims should be identified as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71x or 77x, or 85x when the revenue code is 096x, 097x, or 098x.
- Contractors will allow institutional claims, TOBs 71x and 77x, to submit additional revenue lines on claims with G0445. Also, HCPCS G0445 will not pay separately with another encounter/visit on the same day for TOBs 71x and 77x with the exception of: initial preventive physical claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services. If HCPCS G0445 is present on revenue lines along with an encounter/visit with the same line-item date of service, contractors will assign group code CO and reason code 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 Services Payment Information REF), if present."
- on institutional claims in hospital outpatient departments (TOB 13x) are paid based on OPPS, in critical access hospitals (TOB 85x, not equal to 096x, 097x, or 098x) based on reasonable cost. HCPCS G0445 with revenue codes 096x, 097x, or 098x, when billed on TOB 85x method II is paid based on 115 percent of the lesser of the MPFS amount or submitted charge.
- Medicare will enforce the frequency requirement for STI services, as mentioned above. Medicare will deny line items that exceed the coverage frequency requirements using the following:
  - CARC 119 – "Benefit maximum for this period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
- Medicare will deny line items on claims submitted for screening for STIs if the claim lacks the appropriate ICD-9-CM code as mentioned earlier. Such services will be denied payment using:
  - CARC 50 – "These are non-covered services because this is not deemed a "medical necessity" by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N386 – "This decision was based on a National Coverage Determination (NCD), An NCD provides a coverage determination as to whether a specific item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*. If you do not have Web access, you may contact the contractor to request a copy of the NCD."

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STI *(continued)*

- The presence of ICD-9 code V74.5 or V73.89 identifies STI laboratory tests as screening lab tests payable under CR 7610 rather than as diagnostic tests.
- Screening for STIs must be ordered by a primary care provider, and HIBC services, G0445, must be performed by a primary care provider in a primary care setting, with one of the following specialty codes:
  - 01 – General practice
  - 08 – Family practice
  - 11 – Internal medicine
  - 16 – Obstetrics/gynecology
  - 37 – Pediatric medicine
  - 38 – Geriatric medicine
  - 42 – Certified nurse midwife
  - 50 – Nurse practitioner
  - 89 – Certified clinical nurse specialist
  - 97 – Physician assistant
- STI screenings ordered by other than the above types of providers will be denied payment when submitted on professional claims using:
  - CARC 184 – "The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Medicare will deny line items for G0445 if performed by other than the above types of providers when submitted on professional claims using:
  - CARC 185 – "The rendering provider is not eligible to perform the service billed. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N95 – "This provider type/provider specialty may not bill this service."
- Claims for G0445 must be for services performed in the following places of service (POS):
  - 11 – Physician office
  - 22 – Outpatient hospital
  - 49 – Independent clinic
  - 71 – State or local public health clinic
- Medicare will deny line items for G0445 if the POS code is other than 11, 22, 49, or 71, using the following:
  - CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N428 – "Not covered when performed in this Place of Service."
- Upon full implementation in Medicare systems on July 2, 2012, providers may submit eligibility inquiries in order to identify the next eligible date that beneficiaries may receive these services.
- Until systems are implemented, contractors will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0445, or TOBs 13x, 14x, and 85x, when the revenue code is not 096x, 097x, or 098x, for STI services.
- Effective for dates of service on or after November 8, 2011, contractors will not apply deductible or coinsurance to claim lines containing HCPCS G0445, HIBC services.
- Contractors will load HCPCS G0445 to their HCPCS file with effective date November 8, 2011.

Additional information

The official instruction, CR 7610, was issued to your FI, carrier and A/B MAC regarding this change via two transmittals. The first updates the "Medicare Claims Processing Manual" and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2476CP.pdf*. The second transmittal conveys the NCD and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141NCD.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7610 *Revised*
Related Change Request (CR) #: 7610
Related CR Release Date: May 23, 2012
Effective Date: November 8, 2011
Related CR Transmittal #: R2476CP and R141NCD
Implementation Date: July 2, 2012 for full implementation

Additional instructions related to screening and behavioral counseling interventions in primary care to reduce alcohol misuse (CR 7633)

Note: This article was revised June 22, 2012, to reflect a revised change request (CR) 7791 issued June 21. The CR transmittal number, release date, and the Web address for accessing the CR have been changed. Also, the second sentence was added to the very last paragraph of the *Background* section. All other information is the same. This information was previously published in the May 2012 *Medicare B Connection*, Pages 15-16.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to fiscal intermediaries (FI), carriers and A/B Medicare administrative contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

What you need to know

If a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in Medicare's claims history within a prior 12 month period, change request (CR) 7791 requires contractors to deny these claims. Be sure to inform your staff of these changes.

Background

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

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

In the Medicare population, Saitz (2005) defined risky use as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age, and >14 standard drinks per week or >4 drinks per occasion for men ≤65 years of age. Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 "Clinician's Guide" from the National Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12 month period. It requires contractors to deny such claims with the following specific messages:

- Claim adjustment reason code (CARC) B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed advanced beneficiary notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

Also, remember that Medicare will only pay for up to four G0443 services within a 12-month period. Claims for G0443 that exceed that four session limit in a 12-month period will be rejected. In addition, Medicare will continue to reject incoming claims when G0442 (PROF) and G0443 (PROF) are billed on the same day on types of bills 71x, 77x, and 85x with revenue codes 096x, 097x, and 098x.

Additional information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2488CP.pdf*.

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CMS announces 'Partnership to Improve Dementia Care'

Government partnering with providers, caregivers, patients to ensure appropriate use of antipsychotic medications in nursing homes

On May 30, the Centers for Medicare & Medicaid Services (CMS) Acting Administrator Marilyn Tavenner announced the "Partnership to Improve Dementia Care," an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership – among federal and state partners, nursing homes and other providers, advocacy groups and caregivers – has set a national goal of reducing use of antipsychotic drugs in nursing home residents by 15 percent by the end of 2012.

Unnecessary antipsychotic drug use is a significant challenge in ensuring appropriate dementia care. CMS data show that in 2010 more than 17 percent of nursing home patients had daily doses exceeding recommended levels.

CMS and industry and advocacy partners are taking several steps to achieve this goal of improved care:

- **Enhanced training**: CMS has developed Hand in Hand, a training series for nursing homes that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training focused on behavioral health to state and federal surveyors;
- **Increased transparency**: CMS is making data on each nursing home's antipsychotic drug use available on Nursing Home Compare starting in July of this year, and will update this data;
- **Alternatives to antipsychotic medication**: CMS is emphasizing non-pharmacological alternatives for nursing home residents, including potential approaches such as consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.

These efforts will help achieve the 15 percent reduction goal by the end of this year. In addition, to address this challenge in the long-term CMS is conducting research to better understand the decision to use or not to use antipsychotic drugs in residents with dementia. A study is underway in 20 to 25 nursing homes, evaluating this decision-making process. Findings will be used to target and implement approaches to improve the overall management of residents with dementia, including reducing the use of antipsychotic drugs in this population.

Full text of this excerpted *CMS press release* (issued May 30).

Source: CMS PERL 201205-69

Alcohol *(continued)*

The *MLN Matters*® article MM7663, titled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7791 *Revised*
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Related CR Transmittal #: R2488CP
Implementation Date: October 1, 2012

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Mental Health Services booklet revised

The *Mental Health Services Booklet (ICN 903195)* has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on mental health services. It includes the following information: covered mental health services, mental health services that are not covered, eligible professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services. To access a new or revised product available for order in hard copy format, go to *"MLN Products"* and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the Web page.

Source: CMS PERL 201206-44

Surgery

Appropriate use of assistant at surgery modifiers and payment indicators

First Coast Service Options Inc. (FCSO) would like to remind providers within jurisdiction 9 (J9) of the appropriate use of assistant at surgery modifiers and payment under the Medicare physician fee schedule (MPFS).

An assistant at surgery is a provider who actively assists the physician in charge of a case in performing a surgical procedure. A physician, nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under state law can serve as an assistant at surgery.

Medicare considers advanced registered nurse practitioner (ARNP), physician assistant (PA), and clinical nurse specialist (CNS) as non-physician practitioners. Medicare does not recognize a registered nurse first assistant (RNFA) as a qualified Medicare provider.

To report services of an assistant surgeon, the following surgical modifiers should be appended:

- **80 – Assistant surgeon**: This modifier pertains to physician's services only. A physician's surgical assistant services may be identified by adding the modifier 80 to the usual procedure code. This modifier describes an assistant surgeon providing full assistance to the primary surgeon, and is not intended for use by non-physician providers.
- **81 – Assistant surgeon**: This modifier pertains to physician's services only. Minimal surgical assistance may be identified by adding the modifier 81 to the usual procedure code, and describes an assistant surgeon providing minimal assistance to the primary surgeon. This modifier is not intended for use by non-physician providers.

  Note: This modifier is used in the private insurance industry and is not commonly used in Medicare billing.
- **82 – Assistant surgeon (when a qualified resident surgeon is not available in a teaching facility)**: This modifier applies to physician's services only. The unavailability of a qualified resident surgeon is a prerequisite for use of this modifier and the service must have been performed in a teaching facility. The circumstance explaining that a resident surgeon was not available must be documented in the medical record. This modifier is not intended for use by non-physician providers.
- **AS – Non-physician provider as assistant at surgery**: This modifier applies when the assistant at surgery services are provided by a PA, ARNP, or CNS.

Payment information

Medicare reimburses services rendered for assistant at surgery by a physician performing as a surgical assistant at 16 percent of the MPFS amount. Services rendered for assistant at surgery by non-physician providers are reimbursed at 85 percent of 16 percent (i.e., 13.6 percent) of the MPFS amount.

When reporting services provided by non-physician practitioners acting as assistants at surgery, append modifier AS to the procedure code used to report the surgeon's service.

If a physician appends modifier AS to procedure codes for which he/she acted as assistant at surgery, these codes will be denied (see above for modifiers that should be used by physicians).

Medicare physician fee schedule database (MPFSDB) assistant at surgery payment indicators

The MPFSDB is a file layout that carriers and A/B MACs use to display the total fee schedule amount, related component parts, and payment policy indicators. The assistant at surgery payment indicator describes when assistant at surgery may be paid or not. Valid indicators are:

- 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
- 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
- 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
- 9 = Concept does not apply.

If multiple services are submitted with modifiers indicating assistants at surgery, each service is independently reviewed (based on the above-listed indicators) to determine payment.

For additional information related to the MPFSDB click *here*.

Extracorporeal photopheresis

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing extracorporeal photopheresis procedures for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Provider action needed

Effective for claims with dates of service on and after April 30, 2012, Medicare will cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation, but only when provided under an approved clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. You should make sure that your billing staffs are aware of the expanded coverage provided in this NCD.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital (CAH) settings. In the procedure, some of a patient's removed white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. After UVA light exposure, the treated white blood cells are re-infused into the patient, stimulating their immune system in a series of cascading reactions. This activation of the immune system then impacts the illness being treated.

Currently, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of CTCL that has not responded to other therapy
- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

On August 4, 2011, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request for a reconsideration to add coverage for extracorporeal photopheresis treatment for patients who have received lung allografts and then developed progressive BOS refractory to immunosuppressive drug treatment.

As a result of the reconsideration, effective for claims with dates of service on and after April 30, 2012, Medicare will begin to cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation; but only when provided under a clinical research study that meets specific requirements to assess its effect in the treatment of BOS following lung allograft transplantation.

This is a national coverage determination (NCD). In keeping with this NCD, any clinical research study that includes Medicare coverage of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation must be approved by meeting the requirements listed below. Additionally, consistent with section 1142 of the Social Security Act, AHRQ supports clinical research studies that CMS determines meet these standards and address the research questions.

NCD clinical research study requirements

An approved clinical research study:

1. Must address one or more aspects of the following question:

Prospectively, do Medicare beneficiaries who have received lung allografts, developed BOS refractory to standard immunosuppressive therapy, and received extracorporeal photopheresis, experience improved patient-centered health outcomes as indicated by:

   a) Improved Forced Expiratory Volume in One Second (FEV1)

   b) Improved survival after transplant, and/or

   c) Improved quality of life?

2. Must adhere to the following standards of scientific integrity and relevance to the Medicare population:

   a) Its principal purpose is to test whether extracorporeal photopheresis potentially improves the participants' health outcomes.

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Extracorporeal *(continued)*

b) It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c) It does not unjustifiably duplicate existing studies.

d) Its design is appropriate to answer the research question being asked in the study.

e) It is sponsored by an organization or individual capable of successfully executing the proposed study.

f) It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 *Code of Federal Regulations* CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must also be in compliance with 21 CFR parts 50 and 56.

g) All of its aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org*).

h) It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED) coverage.

i) It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options.

j) It is registered on the *ClinicalTrials.gov* website (*http://clinicaltrials.gov*) by the principal sponsor/investigator prior to the enrollment of the first study subject.

k) Its protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*).

l) It explicitly discusses subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

m) Its study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Effective for claims with dates of service on and after April 30, 2012, your carrier, FI, or A/B MAC will accept and pay for hospital outpatient and physician claims containing Healthcare Common Procedure Coding System (HCPCS) procedure code *36522* along with one of the International Classification of Diseases (ICD-9-CM or ICD-10) diagnosis codes displayed in the following table.

Billing requirements

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for ECP coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant

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Extracorporeal *(continued)*

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
V70.7	Examination of participant in clinical trial	Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its Final Decision Memorandum (DM) on April 30, 2012.

Please note that your claims will only be paid when they also contain all of the following:

- Diagnosis code V70.7 (as secondary diagnosis)
- Condition code 30 (institutional claims only)
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study)
- Value code D4 with an 8-digit clinical trial number (optional)(FIs only)

Additionally, should your Medicare contractor return your claims as unprocessable because they are missing:

1) Diagnosis code V70.7 (as secondary diagnosis)
2) Condition code 30 (institutional claims only)
3) Clinical trial modifier Q0 (institutional claims only), and
4) Value code D4 with an 8-digit clinical trial number (optional) (FIs only); they will use the following messages:
    - CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
    - RARC MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
    - RARC M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Please keep in mind that your contractor will not retroactively adjust claims from April 30, 2012, processed prior to implementation of CR 7806. However, they may adjust claims that you bring to their attention.

Additional information

The official instruction, CR 7806, was issued in two transmittals. The first updates to the *Medicare National Coverage Determinations Manual* are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R143NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2473CP.pdf*.

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

MLN Matters® Number: MM7806
Related Change Request (CR) #: CR 7806
Related CR Release Date: May 18, 2012
Effective Date: April 30, 2012
Related CR Transmittal #: R143NCD and R2473CP
Implementation Date: October 1, 2012

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

General Coverage

Advance beneficiary notice of noncoverage – updated manual instructions

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers that submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], durable medical equipment Medicare administrative contractors [DME MACs], and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to beneficiaries enrolled in original Medicare.

What you need to know

This article is based on change request (CR) 7821 which clarifies the currently published instructions on advance beneficiary notice of noncoverage (ABN) use in the *Medicare Claims Processing Manual* (Chapter 30, Section 50). Make sure that your billing staff is aware of these ABN policy updates and clarifications that are summarized in this article.

> ABNs are issued to inform beneficiaries about possible charges for items or services that are not covered by Medicare.

Background

ABNs are issued by providers and suppliers to inform beneficiaries in original Medicare about possible charges for items or services that are not covered by Medicare. Issuance of the ABN is required in certain situations when limitation of liability (LOL) applies. You may review that information in the Social Security Act (Section 1879; see *http://www.ssa.gov/OP_Home/ssact/title18/1879.htm*). In 2008 CMS revised the notice and its instructions to streamline and simplify the notice process.

CR 7821 revises the current manual instructions on ABN use in the *Medicare Claims Processing Manual*, Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage [ABN]). The revised Chapter 30, Section 50 is included as an attachment to CR 7821. The last page of this article contains a "Quick Glance Guide" from the revised manual section, that may help you and your staff comply with ABN issuance requirements.

Key points from manual update

General information

Section 50 of the *Medicare Claims Processing Manual* establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, formerly the "Advance Beneficiary Notice."

Since March 1, 2009, the ABN-G (general) and ABN-L (laboratory) are no longer valid notices and have been replaced with the ABN.

ABN scope

The ABN is an Office of Management and Budget (OMB) approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only).

The ABN is given to beneficiaries enrolled in the Medicare fee-for-service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

Skilled nursing facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form 10055, is issued for Part A SNF items and services.

Home health agencies (HHAs) do not issue the ABN. HHAs issue the Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296.

Mandatory ABN uses

The following provisions of the Social Security Act necessitate delivery of the ABN:

- Section 1862(a)(1) of the Social Security Act (not reasonable and necessary); *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*;
- Section 1834(a)(17)(B) of the Social Security Act (violation of the prohibition on unsolicited telephone contacts); *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*;
- Section 1834(j)(1) of the Social Security Act (medical equipment and supplies supplier number requirements not met),
- Section 1834(a)(15) of the Social Security Act (medical equipment and/or supplies denied in advance),
- Section 1862(a)(9) of the Social Security Act (custodial care); (*http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*),

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ABN *(continued)*

- Section 1879(g)(2) of the Social Security Act (hospice patient who is not terminally ill); see *http://www.ssa.gov/OP_Home/ssact/title18/1879.htm*.

Expanded mandatory ABN use in 2011

In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=bf0153f6e9e8144f2e756fa2c467e5e7&rgn=div8&view=text&node=42:3.0.1.1.1.6.1.5&idno=42*) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a competitive bidding area (CBA) unless the beneficiary has signed an ABN. Although all other denial reasons triggering mandatory use of the ABN are found in Section 1879 of the Social Security Act, in this situation, Section 1847(b)(5)(D) (*http://www.ssa.gov/OP_Home/ssact/title18/1847.htm*) of the Social Security Act permits use of the ABN with respect to these items and services.

The Affordable Care Act, P.L. 111-148, Section 4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1) of the Act. Per Section 1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in *Section 1861(hhh)(1)*) that are performed more frequently than covered are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The limitation of liability (LOL) provisions of Section 1879 apply to this new subparagraph; thus, providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.

Voluntary ABN uses

ABN issuance is not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily.

The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below) when using the ABN for voluntary notification.

Note: Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.

ABN triggering events

Notifiers are required to issue the ABN when an item or service is expected to be denied based on one of the provisions in the "Mandatory use" section. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as "triggering events."

An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

A. Initiations

Example: *Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it. The physician's office personnel issue an ABN to Mrs. S. before the EKG is done.*

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this non-covered care.

B. Reductions

Example: *Mr. T is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy five days a week. He is willing to take financial responsibility for the costs of the two days of therapy per week that are no longer medically reasonable and necessary. An ABN would be issued prior to providing the additional days of therapy weekly.*

C. Terminations

A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Example*: Ms. X has been receiving covered outpatient speech therapy services, has met her treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with her even though continued therapy is not medically reasonable or necessary. Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.*

Completing the ABN

The ABN and step by step instructions for notice completion are posted on the CMS website at

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ABN *(continued)*

http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. Notifiers must follow the instructions posted on the CMS website to construct a valid notice.

Retention requirements

Retention periods for the ABN are five years from discharge/completion of delivery of care when there are no other applicable requirements under state law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. Electronic retention of the signed paper document is acceptable. Notifiers may scan the signed paper or "wet" version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

Clarification of period of effectiveness/repetitive or continuous non-covered care

An ABN can remain effective for up to one year. Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of non-covered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover. If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on the ABN within the one-year period, a new ABN must be given. If during the course of treatment additional non-covered items or services are needed, the notifier must give the beneficiary another ABN. The limit for use of a single ABN for an extended course of treatment is one year. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated; the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance.

Electronic issuance of the ABN

Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records. Electronic retention of the signed ABN is permitted.

ABN standards for upgraded DMEPOS

Notifiers must give an ABN before a beneficiary receives a Medicare covered item containing upgrade durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) components that are not medically reasonable and necessary and not paid for by the supplier. For example, an ABN must be issued when a notifier expects that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary.

ABNs for items listed in a DMEPOS competitive bidding program

The Social Security Act (Section 1862 (a)(17)(*http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*) excludes Medicare payment for competitive bidding program (CBP) items/services that are provided by a non-contract supplier in a competitive bidding area (CBA) except in special circumstances. A non-contracted supplier is permitted to provide a beneficiary with an item or service listed in the CBP when the supplier properly issues an ABN prior to delivery of the item or service per 42 CFR 414.408(e)(3)(ii) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl*). In order for the ABN to be considered valid when issued under these circumstances, the reason that Medicare may not pay must be clearly and fully explained on the ABN that is signed by the beneficiary.

Sample wording for the "Reason Medicare May Not Pay" blank of the ABN:

Since we are not a contracted supplier, Medicare will not pay for this item. If you get this item from a contracted supplier such as ABC Medical Supplies, Medicare will pay for it.

To be a valid ABN, the beneficiary must understand the meaning of the notice. Suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area. While some suppliers may be reluctant to direct beneficiaries to a specific contracted supplier, the non-contracted supplier should at least direct the beneficiary to 1-800-MEDICARE to find a local contracted supplier at the beneficiary's request.

Emergencies or urgent situations/ambulance transport

In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the emergency room (ER) may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

Issuance of the ABN is mandatory **if all of the following three criteria are met:**

1. The service being provided is a Medicare covered ambulance benefit under Section 1861(s)(7) of the

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ABN *(continued)*

Social Security Act (*http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) and regulations under this section as stipulated in 42 CFR 410.40 -.41 (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl*).

2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under Section 1862(a)(1)(A) for the beneficiary on that particular occasion.
3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)

Simplified, there are three questions to ask when determining if an ABN is required for an ambulance transport. If the answer to **all of the following three questions is "yes", an ABN must be issued:**

1. Is this service a covered ambulance benefit? AND
2. Will payment for part or all of this service be denied because it is not reasonable and necessary? AND
3. Is the patient stable and the transport non-emergent?

Example: *A beneficiary requires ambulance transportation from her skilled nursing facility (SNF) to dialysis but insists on being transported to a new dialysis center 10 miles beyond the nearest dialysis facility. Medicare covers this type of transport; however, since this particular transport is not to the nearest facility, it is not considered a covered Medicare benefit. Therefore, no ABN is required. As a courtesy to the beneficiary, an ABN could be issued as a voluntary notice alerting her to the financial responsibility.*

Example: *A beneficiary requires non-emergent ground transport from a local hospital to the nearest tertiary hospital facility; however, his family wants him taken by air ambulance. The ambulance service is a covered benefit, but the level of service (air transport) is not reasonable and necessary for this patient's condition. Therefore, an ABN MUST be issued prior to providing the service in order for the provider to shift liability to the beneficiary.*

ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.

Special issues associated with the ABN for hospice providers

General use – hospice

Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items and services billable to hospice. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction. The three situations that would require issuance of the ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in Section 1879(g)(2) of the Act;
- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either Section 1862(a)(1)(A) or 1862(a)(1)(C); or
- The level of hospice care is determined to be not reasonable or medically necessary as defined in Section 1862(a)(1)(A) or 1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

End of all Medicare-covered hospice care

When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is discharged from hospice, the hospice must issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the "FFS ED Notices" link on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* for details). If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the non-covered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

Hospice care delivered by non-hospice providers

It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

The ABN must not be issued when the face-to-face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill. However, in this situation, the hospice would be required to issue a Notice of Medicare Noncoverage (NOMNC), CMS 10123, before the end of all covered care. (See the "FFS ED Notices" link on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* for details.)

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ABN *(continued)*

Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

Special issues associated with the ABN for CORFs

Since comprehensive outpatient rehabilitation facility (CORF) services are billed under Part B, CORF providers must issue the ABN according to the instructions given in this section. The ABN is issued by CORFs before providing a service that is usually covered by Medicare but may not be paid for in a specific case because it is not medically reasonable and necessary.

When all Medicare covered CORF services end, CORF's are required to issue a notice regarding the beneficiary's right to an expedited determination called a Notice of Medicare Noncoverage (NOMNC), CMS 10123. Please see the "FFS ED Notices" link on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* for these notification requirements. Upon termination of all CORF care, the ABN would be issued only if the beneficiary wants to continue receiving some or all services that will not be covered by Medicare because they are no longer considered medically reasonable and necessary. An ABN would not be issued if no further CORF services are provided.

Additional information

The official instruction, CR 7821, issued to your Medicare carrier, FI, RHHI, DME MAC, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2480CP.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, DME MAC, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The ABN and instructions can be downloaded from *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*.

ABN - Quick Glance Guide[1]

Notice Name: Advance Beneficiary Notice of Noncoverage (ABN)

Notice Number: Form CMS-R-131

Issued by: Providers and suppliers of Medicare Part B items and services;
Hospice and Religious Non-medical HealthCare Institute (RNHCI) providing Medicare Part A items and services

Recipient: Original Medicare (fee for service) beneficiary

Additional Information:
The ABN, Form CMS-R-131 replaces the following notices:
- ABN-G
- ABN-L
- Notice of Exclusion of Medicare Benefits (NEMB)

Type of notice:	Must be issued:	Timing of notice:	Optional/Voluntary
Financial liability notice	• Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary • Prior to providing custodial care • For hospice providers, prior to caring for a patient who is not terminally ill • For DME suppliers, additional situations requiring issuance are outlined in Chapter 50.3.1 of the "Medicare Claims Processing Manual."	Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).

1 This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 50.

MLN Matters® Number: MM7821
Related Change Request (CR) #: CR 7821
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Effective Date: September 4, 2012
Related CR Transmittal #: R2480CP
Implementation Date: September 4, 2012

Helpful tips for successful submission of electronic medical documentation

Currently, Medicare contractors request medical documentation by sending a letter to the provider. The provider's only option to submit records is via the U.S. Postal Service. Effective September 2011, providers were given the opportunity to participate in Medicare's electronic submission of medical documentation (esMD) pilot project, which allows for the electronic transmission of documentation. This article provides a list of questions and answers to assist providers in this process and to alleviate current processing issues associated with electronic submission of records.

Note: The most important aspect of electronic transmission of records to Medicare is to ensure that the first page of the transmission is a copy of the automatic development request (ADR) letter. The ADR contains vital information that allows the contractor to match your records to the corresponding claims pending in the Medicare system that are awaiting the records.

Questions and answers

Q1. How can providers sign up for the esMD initiative?

A1. The provider would need to sign up to submit esMD transactions by a third-party vendor. A complete list of vendors is located at *http://go.usa.gov/kr4*. Instructions are also available in *special edition article SE1110*.

Q2. If records are submitted through the esMD portal, should paper documentation also be submitted?

A2. No. If the documentation has been sent electronically, do not submit paper documentation separately.

Q3. Should a copy of the ADR letter be submitted with the electronic documentation?

A3. First Coast Service Options (FCSO) strongly encourages the provider to include the ADR letter at the beginning of the transmission. This allows the contractor to match the documentation with the claims.

Q4. When should an electronic document be submitted?

A4. An electronic document should only be returned when an ADR is received from the contractor.

Q5. Are there plans for providers to be able to submit redetermination requests via the esMD portal in the future?

A5. Yes, but at this time there has not been a date established. More information on this will be provided as it becomes available.

Q6. If a provider submits a redetermination request via the esMD portal, will it be accepted?

A6. No, it will not be accepted. The provider will not receive any type of response on the request. It will be rejected through the portal.

Additional information

Refer to *special edition article SE1110* for a list of contractors participating in the pilot as well as health information handlers (HIHs) that offer esMD gateway services.

Additional information is also available on the esMD Web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Gateways.html*. You might also try the Twitter link, which is @ CMSGov (Look for #CMS_esMD).

2013 ICD-10 PCS files now available

The 2013 ICD-10-PCS files have been posted on the *2013 ICD-10 PCS and GEMs* Web page. This includes the 2013 index and tabular files, guidelines, code titles, addendum to reference manual, and slides. The 2013 ICD-10-Procedure Classification System (PCS) files contain information on the new procedure coding system, ICD-10-PCS, that is being developed as a replacement for ICD-9-CM, Volume 3.

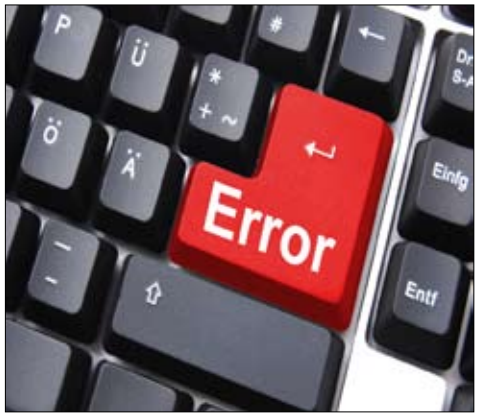
The 2013 GEMs, reimbursement mappings, and reference manual will be posted at a later date.

Source: CMS PERL 201206-41

How to avoid common version 5010 claims rejections

The deadline for the version 5010 upgrade was January 1, 2012, and the enforcement discretion period for all HIPAA-covered entities to complete their upgrade to the version 5010 electronic standards ended June 30, 2012. The version 5010 transaction standards have different requirements than those of version 4010 and 4010A. There are a few things to keep in mind for processing your version 5010 claims, which should help avoid unnecessary rejections:

1. **ZIP code**: You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your vendor to make sure that your system captures the full 9-digit ZIP.
2. **Billing provider address**: You need to use a physical address for your billing provider address. Version 5010 does not allow for use of a PO Box address for either professional or institutional claim formats. You can still use a PO Box, however, as your address for payments and correspondence from payers as long as you report this location as a pay-to address.
3. **National provider identifier (NPI)**: You were previously allowed to report an employer's identification number (Tax ID) or Social Security number (SSN) as a primary identifier for the billing provider. For version 5010 claims, however, you are only allowed to report an NPI as a primary identifier.



For additional help with your version 5010 upgrade and Medicare claims, you can contact your Medicare administrative contractor (MAC). The MACs work closely with clearinghouses, billing vendors, and health care providers who require assistance in submitting and receiving version 5010 compliant transactions. If you experience difficulty reaching a MAC, you should send a message describing your issue to *ProviderFeedback@cms.hhs.gov* with "5010 Extension" in the subject line.

The Medicare fee-for-service group has created a *fact sheet* that provides guidance to help providers troubleshoot some of the difficulties they may experience with version 5010 claims processing and links to each of the MAC websites, including lists of the top 10 edits for version 5010 claims.

Keep up to date on version 5010 and ICD-10

Please visit the *ICD-10 website* for the latest news and resources to help you prepare.

Source: CMS PERL 201205-64

Medicare fee-for-service version 5010 specialty types transition information

The Centers for Medicare & Medicaid Services (CMS) recently published information by provider specialty related to the transition activity of the Accredited Standards Committee (ASC) X12 version 005010. Please review the *specialty transition reports* on the CMS Web page.

Effective July 1, 2012, only ASC X12 version 5010 (version 5010) and NCPDP Telecom D.0 (NCPDP D.0), standard claim transactions are accepted by Medicare fee-for-service.

Provider associations may wish to review this material and assist their membership accordingly in order to avoid any interruption in claim filing and claim payment activities.

Special note regarding claims for ambulance services: The ASC has not previously required that diagnosis codes be reported on claims for ambulance services. However, as CMS has previously advised, with the implementation of version 5010, diagnosis codes will be required on all claims, including ambulance claims. Therefore, this message serves as a reminder that, with the implementation of version 5010, entities billing ambulance services are required to submit diagnosis codes on all claims for such services.

For more information on ASCX12 version 5010 and NCPDP D.0, please visit the *versions 5010 and D.0* Web page.

Source: CMS PERL 201206-28

5010 requirement for ambulance suppliers

Note: This article was revised June 15, 2012, to alert ambulance suppliers that enforcement of the HIPAA 5010/D.0 standards began July 1, 2012. As advised by this article originally, ambulance suppliers are reminded that they must include a diagnosis code on all 837P claims under the HIPAA 5010 standard. All other information remains the same. This information was previously published in the October 2010 *Medicare B Update!*, Page 33.

Provider types affected

This article is intended for ambulance suppliers submitting claims in the 5010 837P (professional) electronic claim format beginning January 1, 2011, to Medicare carriers or Part A/B Medicare administrative contractors (A/B MAC) for services rendered to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has decided upon early adoption of version 5010 of the 837P electronic claim format and will implement it January 1, 2011. If you are an ambulance supplier who plans early adoption of the new standard, this special edition article tells you how to submit your claims electronically in light of the new 837P, version 5010 diagnosis code reporting requirement.

Caution – what you need to know

Effective for claims submitted in the version 5010 837P electronic claim format on and after January 1, 2011, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement.

- **Option 1**: Suppliers may choose a code or codes from the medical conditions list provided by CMS that corresponds to the condition of the beneficiary at the time of pickup and report the code(s) in the diagnosis field on the claim. The medical conditions list and instructions for using this list can be found in the *Medicare Claims Processing Manual*, Chapter 15, Section 40, "Medical Conditions List and Instructions," available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf*. The codes in the medical conditions list are taken from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) diagnosis code set. Suppliers must continue to accurately maintain transport records to support any data reported on the claim.
- **Option 2**: Suppliers may report an ICD-9 (or ICD-10 when appropriate) diagnosis code that is provided to them by the treating physician or other practitioner.
- **Option 3**: Suppliers may report ICD-9 diagnosis code 799.9 (unspecified illness).

Note: Effective October 1, 2013, the new ICD-10 diagnosis code set will be implemented, thus making the ICD-9 code set obsolete.

- Suppliers choosing options 1 or 3 will be given further guidance upon implementation of the new code set.
- Suppliers choosing option 2 should ensure that they are provided with the appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2013.

Go – what you need to do

If you choose to submit claims in the version 5010 837P electronic claim format on and after January 1, 2011, you must comply with the requirement to include a diagnosis code. CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. You may continue to use the 4010A1 version of the 837P until December 31, 2011.

Background

The Administrative Simplification Compliance Act (ASCA) and its implementing regulation require that all initial claims for payment under Medicare be submitted electronically as of October 16, 2003, unless one of the statutory or regulatory exceptions applies. Electronic claim submissions are required to be in compliance with the claim standards adopted for national use under the Health Insurance Portability and Accountability Act of 1996.

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Ambulance *(continued)*

Ambulance suppliers currently use the American National Standards Institute (ANSI) 837P (professional), version 4010A1 to submit claims for payment.

The 4010A1 version of the 837P electronic claim does not require submission of a diagnosis code from the ICD-9CM code set in loop 2300, segment HI. Additionally, CMS does not currently require ambulance suppliers to submit a diagnosis code on claims for payment. However, the 5010 version of the 837P, which becomes effective January 1, 2012, requires that a diagnosis code be present on all 837P electronic claims, including ambulance claims.

Additional information

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Also see SE1106 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf*) for important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments. Another related article is SE1138, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf*.

You may want to review MM7489 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7489.pdf*), which alerts ambulance suppliers that Medicare contractors will begin supplying denial notices for billing secondary insurance for those HCPCS codes that identify Medicare statutorily excluded ambulance transportation services, effective January 1, 2012.

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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Important update regarding 5010/D.0 implementation – action needed now

Note: This article was revised June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards began July 1, 2012. Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same. This information was previously published in the October 2011 *Medicare B Connection*, Pages 13-14.

Provider types affected

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

Provider action needed

Stop – impact to you

You and your billing and software vendors must be ready to begin processing the Health Insurance Portability and Accountability Act (HIPAA), versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 11, 2012, all electronic claims, eligibility and claim status inquiries, must use versions 5010 or D.0. version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

Caution – what you need to know

You must comply with this important deadline to avoid delays in payments for Medicare fee-for-service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

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Action *(continued)*

Go – what you need to do

Contact your MACs to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/index.html*. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background

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

> Electronic transactions that do not use version 5010 are not compliant with HIPAA and will be rejected.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to version 5010 by January 1, 2012. Any electronic transaction for which a standard has been adopted must be submitted using version 5010 on or after January 1, 2012. Electronic transactions that do not use version 5010 are not compliant with HIPAA and will be rejected.

To allow time for testing, CMS began accepting electronic transactions using either version 4010/4010A or version 5010 standards January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with versions 5010 and D.0.

Note: HIPAA standards, including the ASC X12 version 5010 and version D.0 standards are national standards and apply to your transactions with all payers, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well.

Are you at risk of missing the deadline?

If you can answer **no** to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your version 4010 transactions to version 5010 (if not converting your older software)?
3. Have you identified changes to data reporting requirements?
4. Have you started to test with your trading partners, which began January 1, 2011?
5. Have you started testing with your MAC, which is required before being able to submit bills with the version 5010?
6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional information

MLN Matters® article MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7466.pdf*.

The *Medicare Learning Network*® (MLN) fact sheet, "Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0," is available at *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf*.

MLN Matters® special edition article SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf*.

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Action *(continued)*

MLN Matters® special edition article SE1138 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf*.

Additional educational resources about HIPAA 5010 & D.0 are available at *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html*.

If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, and DME MACs) at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

Important reminders about HIPAA 5010 & D.0 implementation

Note: This article was revised June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards began July 1, 2012. Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same. This information was previously published in the March 2011 *Medicare B Connection*, Pages 50-53.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

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Reminders *(continued)*

Background

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

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice. More information about Medicare's EDI requirements can be found in the *Medicare Claims Processing Manual*, Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf*. Electronic billing and EDI transaction information can be found at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html*. This section contains information on:

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

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

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

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

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

The CMS Medicare fee-for-service implementation schedule is:

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

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (version 4010/4010A1) with version 5010, and NCPDP EDI standards version 5.1 with version D.0. For more information see *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html*.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

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

Readiness assessment 1 – Have you done the following to be ready for 5010/D.0?

Are you ready for 5010/D.0? Testing with external trading partners began January of 2011. Testing with version

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Reminders *(continued)*

5010A1 Errata will began April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/readiness_1.pdf* to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once.

Be sure to start testing version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful Web links go to *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html*.

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

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

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

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

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

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

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html*
- Educational resources (i.e., *Medicare Learning Network®* (*MLN*) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html*
- The dedicated HIPAA 5010/D.0 Project Web page, which includes technical documents and communications at national conferences, can be found at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html*

Errata requirements and testing schedule

HIPAA version 5010 has new errata, which can be found at *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf*. According to the published regulation (*Federal Register*, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin January of 2011. Compliance with the errata must be achieved by the original regulation compliance date of January 1, 2012.

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 errata versions April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html*.

CMS 5010 provider outreach and education materials

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

- Version 5010 – the new version of the X12 standards for HIPAA transactions

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Reminders *(continued)*

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

The information posted at *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html* may be applicable to the health care industry at large, or may be specifically Medicare-related information. The "Overview" Web page is designed to distinguish the Medicare-related information from the industry related.

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

- **Federal Regulation & Notices** (*http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/Federal_Regulation_and_Notices.html*)

  This Web page contains general information related to federal regulations and notices and contains the following link to the final rule for X12 5010, D.0 and 3.0 document. See *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*.

- **CMS Communications** (*http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/CMS_Communications.html*)

  The CMS Communications Web page includes versions 5010 & D.0 implementation information and the following downloads:

  - **5010 Implementation Calendar** [PDF, 325KB]; see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/5010ImplementationCalendar.pdf*.
  - **Readiness assessment – What do you need to have in place to test with your MAC?** [PDF, 241KB]; see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Readiness_2.pdf*.

- **Educational resources** (*http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html*)

  The "Educational Resources" Web page includes information designed to increase national awareness and assist in the implementation of versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:

  - **Version 5010 Resource Card** [PDF, 243KB] (see *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*)
  - **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet** [PDF, 1208KB] (see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf*)
  - **Checklist for Level I Testing Activities** [PDF, 324 KB] (see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads//w5010PrepChklst.pdf*)
  - **Provider Action Checklist for a Smooth Transition** [PDF, 333KB] (see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010PvdrActionChklst.pdf*)
  - **Versions 5010 and D.0 *MLN Matters*® articles** [PDF, 31KB] (see *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf*).

- **5010 national calls**

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

Additional information

A special edition *MLN Matters*® article on the ICD-10 code set can be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0832.pdf*.

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Reminders *(continued)*

You may want to review *MLN Matters*® article SE1131 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1131.pdf*) that references the approaching deadline of January 1, 2012, for 5010 implementation. SE1131 urges providers to contact their MACS for the free version 5010 software and begin testing to avoid delays in payment for fee-for-service claims.

CMS is also using the open door forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the open door forums can be found at *http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html*.

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

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Medicare fee-for-service version 5010/D.0 update for the week of June 18

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanged health care transactions, Medicare fee-for-service (FFS) has the following update:

Version 5010/D.0 only accepted by Medicare FFS effective July 1, 2012

Effective July 1, 2012, only ASC X12 version 5010 (version 5010) or NCPDP telecom D.0 (NCPDP D.0) formats are being accepted by Medicare FFS. Providers that are still conducting one or more of the version 4010 transactions electronically (e.g., submitting a claim, checking claim status) or are relying on a software vendor, billing service, or clearinghouse to conduct them on their behalf, will be affected by this change. If you have not already done so, now is the time to contact your software vendor, billing service, or clearinghouse (as applicable) to ensure you are ready. Transactions conducted by Medicare administrative contractor (MAC), fiscal intermediary (FI), or carrier telephone interactive voice response (IVR) systems, direct data entry (DDE), or Internet portals (as applicable) will not be impacted.

Version 5010/D.0 transition statistics

The *Medicare FFS version 5010 transition statistics* are available on the Centers for Medicare & Medicaid Services (CMS) website. These statistics represent the transition of transaction standards adopted under HIPAA from ASC X12 4010 to 5010 and from NCPDP 5.1 to D.0. The transition statistics cover the following:

- Part A claims and remittances
- Part B/DME claims and remittances
- NCPDP claims
- Eligibility inquiries and responses
- Claim status inquiries and responses

In addition, Medicare FFS has recently published *information by provider specialty* related to the transition to ASC X12 version 5010.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *versions 5010 and D.0* website.

Source: CMS PERL 201206-33

Medicare fee-for-service version 5010/D.0 update for the week of June 11

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare fee-for-service (FFS) had the following updates for the week of June 11:

- Deadlines for using the new versions of HIPAA standards

Deadlines

Inbound transactions: After close of business, June 29, only the following versions can be submitted when sending Medicare FFS inbound transactions:

- Accredited Standards Committee (ASC) X12 version 005010 (5010)
  - Health care claim: professional (837P)
  - Health care claim: institutional (837I)
  - Heath care claim status request (276)
- National Council for Prescription Drug Program (NCPDP) version D.0 claim

Any inbound Medicare FFS transactions received by Medicare administrative contractors (MACs) in either version 4010/A1 or NCPDP 5.1 formats – after normal close of business June 29 – are rejected back to the submitter. If a claim transaction is rejected, the specific message received depends on the specific MAC receiving the claim file(s). Please visit the *CMS Important 4010 - 5.1 Rejection Information* Web page for a detailed list of rejection error messages.

Outbound transactions: In addition, beginning July 1, 2012, the coordination of benefits (outbound ASC X12 837) and health Care claim status response (ASC X12 277) transactions is sent in version 5010 only.

Medicare FFS is allowing an additional 30 days to complete the transition to the ASC X12 health care claim payment/advice (835), also called the remittance advice. Therefore, as of August 1, 2012, Medicare FFS will be generating only the 5010 version of the 835 remittance advice for all trading partners.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *versions 5010 and D.0* Web page.

Source: CMS PERL 201206-19

Go green to get your green faster

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

Fraud

Questionable billing by suppliers of lower limb prostheses

Note: This article was revised June 7, 2012, to include the full OIG recommendations, to make several minor clarifications, and to delete a reference to recent legislation requiring face-to-face encounters for certain DMEPOS. All other information is the same. This information was previously published in the April 2012 *Medicare B Connection*, Pages 61-63.

Provider types affected

This *MLN Matters*® special edition article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What you need to know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare administrative contractors (MACs), three zone program integrity contractors (ZPICs), and two DME program safeguard contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

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Prosthetics *(continued)*

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
    - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
    - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
    - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

OIG recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.

CMS response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.

CMS response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG recommendation 3: Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses. We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.

CMS response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG recommendation 4: Revise the requirements in the local coverage determination. CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions of beneficiaries' functional levels. Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.

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Prosthetics *(continued)*

CMS response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

OIG recommendation 5: Enhance screening for currently enrolled suppliers of lower limb prostheses. Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.

CMS response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.

CMS response: CMS concurred and stated it would share the information with the DME MACs and the Recovery audit contractors. Recovery audit contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key points

Medicare requirements for lower limb prostheses

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Note: If a supplier is replacing an old prosthesis and there is no upgrade in the model, the supplier does not need a physician order. Also, the "ordering" physician need not be a surgeon and may be the beneficiary's primary care physician.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers and the referring physicians must take into account the beneficiary's history, current overall medical condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain items that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited,

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Prosthetics *(continued)*

moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Note: You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review *MLN Matters*® article SE1201 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf* for important reminders on the requirements for ordering and referring physicians.

Additional information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at *http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf*.

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Two new fraud and abuse CME modules posted on Medscape

In early June, Medscape posted the following two new complete medical education (CME) modules:

- *Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients*
- *How CMS Is Fighting Fraud: Major Program Integrity Initiatives*

These modules highlight efforts by the Centers for Medicare & Medicaid Services to fight fraud and abuse and how health care professionals can be part of those efforts.

Source: CMS PERL 201206-42

'Medicare Fraud & Abuse: Prevention, Detection, and Reporting' podcast released

The *"Medicare Fraud & Abuse: Prevention, Detection, and Reporting" podcast (ICN 906509)* has been released and is now available in downloadable format. This podcast is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes information from the *Medicare Learning Network*® fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which describes relevant laws, regulations, and partnerships designed to combat fraud and abuse.

Source: CMS PERL 201206-44

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: August 21 or September 11, 2012.

Provider Enrollment

Phase 2 of ordering and referring requirement

Provider types affected

This special edition *MLN Matters*® article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers (including portable X-ray services) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to RHHIs, fiscal intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the ordering/referring edits. CMS does not have a date at this time.

Caution – what you need to know

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with phase 2 ordering/referring edits. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

Go – what you need to do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background

The Social Security Act (the Act) requires that all physicians and non-physician practitioners be uniquely identified for all claims for services that are ordered or referred. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the national provider identifier (NPI).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers as follows:

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

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

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)

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Phase 2 *(continued)*

- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name

N265 Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

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

- **Phase 2: CMS has not announced a date** when the edits for phase 2 will become active. CMS will give the provider community at least 60 days' notice prior to turning on these edits. During phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid.

Below are the denial edits for **Part B** providers and suppliers **who submit claims** to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer

255D Referring/Ordering Provider Mismatch

289D Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for **Part A HHA providers who submit claims**:

37236 – This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is "32" or "33"
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

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Phase 2 *(continued)*

37237 – This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is "32" or "33"
- The type of bill frequency code is "7" or "F-P"
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician file from PECOS or the specialty code is not a valid eligible code.

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," April 24, 2012, permitting phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement phase 2 edits.

Additional information

A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® fact sheet, "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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*.

You may find the following articles helpful in understanding this matter:

- *MLN Matters*® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf*.
- *MLN Matters*® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf*.
- *MLN Matters*® article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6856.pdf*.
- *MLN Matters*® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf*.
- *MLN Matters*® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf*.

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Phase 2 *(continued)*

- *MLN Matters*® special edition article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1011.pdf*.
- *MLN Matters*® special edition article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1201.pdf*.
- *MLN Matters*® special edition article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1208.pdf*.

If you have any questions, please contact your carrier, Part A/B MAC, RHHI, fiscal intermediary, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Delegated official signatures on CMS-855 revalidation applications

Effective with CMS-855 revalidation applications received on or after June 18, 2012, applications signed by the provider or supplier's delegated official will be accepted. Chapter 15 of the *Program Integrity Manual* will be updated to clarify that authorized and delegated officials may sign Form CMS-855 revalidation applications.

Note: This policy applies to paper and electronic applications and does not apply to initial applications, which must still be signed by an authorized official.

Source: TDL 12396

Major improvements to Medicare's Internet-based PECOS

The Centers for Medicare & Medicaid Services (CMS) has listened to your feedback about the Medicare online enrollment system – Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). As a result, CMS has made improvements to the electronic signature process to allow an authorized official (AO) or delegated official (DO) of an organization to e-sign your application within an authenticated Internet-based PECOS session.

The AO or DO of an organization listed in the "Individual Control" section of the organization's enrollment application will be permitted to e-sign the applicable certification and/or authorization statements as well as the CMS-588 (electronic funds transfer form) within Internet-based PECOS instead of being redirected to a separate PECOS e-signature application. However, if the AO or DO is not the individual completing the application or if they do not currently have access to PECOS, they will continue to receive an email directing them to the separate PECOS e-signature application. To see a sample of the email the AO or DO will receive and get helpful tips, see "Complete Signing Your Medicare Enrollment Application Electronically" in the *April 25* edition of CMS' e-News.

Source: CMS PERL 201206-01

National provider identifier registry tip

Users of the national provider identifier (NPI) registry are encouraged to exit the NPI registry search and search results pages once they have completed their searches. Users who do not exit off of the NPI registry search pages will get a "servlet error message" as a result of the timed-out session (if session is idle). Please be advised that a user can access the NPI registry again after being timed out and receiving the servlet error message. If users receive the servlet error message, they will need to click on the "Home" or "Logoff" link at the top right-hand corner of the Web page in order to get back to the NPPES homepage and access the NPI registry again to conduct additional NPI registry searches. Again, users should exit out of the NPI registry once they have completed their searches in order to avoid the timed out session and servlet error messages.

Source: CMS PERL 201206-29

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

Note: This *MLN Matters*® article was revised June 18 2012 (to reference change request (CR) 6856 and to update information throughout the article), and June 20, 2012 (to delete the first bullet point on page 3 and make several grammatical changes). This information was previously published in the August 2011 *Medicare B Connection*, Pages 31-35.

Provider types affected

This special edition *MLN Matters*® article is intended for physicians, non-physician practitioners (including interns, residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare administrative contractors (MACs), Part A regional home health intermediaries, fiscal intermediaries (FIs) who still have a home health agency (HHA) workload and durable medical equipment MACs (DME MACs) for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the *Background* and *Additional information* sections and make sure that your billing staffs are aware of these updates.

What providers need to know

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

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

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

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Background

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

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS, and

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

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry)
- Physician assistant

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Edits *(continued)*

- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Interns, residents, and fellows
- Certified nurse midwife
- Clinical social worker

Questions and answers relating to the edits

1. What will the edits do?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

- Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message[1] in the Medicare remittance advice[2] indicating that the claim failed the ordering/referring provider edits.

1 The informational messages vary depending on the claims processing system.
2 DMEPOS suppliers who submit paper claims will not receive an informational message on the remittance advice.

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264 Missing/incomplete/invalid ordering physician provider name
N265 Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.

For Part A HHA providers who order and refer the claims system shall initially process the claim and add the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

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

Phase 2: CMS has not announced a date when the edits for phase 2 will become active. CMS will give the provider community at least 60 days' notice prior to turning on these edits. In phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. The denial edits are identified as follows:

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Edits *(continued)*

Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D Referring/Ordering Provider Not Allowed To Refer
255D Referring/Ordering Provider Mismatch
289D Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is "32" or "33"
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

37237 – This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on.
- The type of bill is "32" or "33"
- The type of bill frequency code is "7" or "F-P"
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

CMS has taken actions to reduce the number of informational messages.

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

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

[3] NPIs were added only when the matching criteria verified the NPI.

Effect of edits on providers

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

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

1. **You have a current Medicare enrollment record.**
   - If you are not sure you are enrolled in Medicare, you may: (1) check the ordering referring report (previously mentioned), and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). If you choose (3), please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

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Edits *(continued)*

2. **If you do not have an enrollment record in Medicare:**

   - You need to submit an enrollment application to Medicare in one of two ways:

   a) **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to either e-sign the certification statement or mail a printed, signed, and dated certification statement and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.

   b) **Submit an electronic application through the use of Internet-based PECOS or obtain a paper enrollment application**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via Internet-based PECOS or as PDFs for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

Note: About physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit).

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

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

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

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

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

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Edits *(continued)*

Billing providers should be aware that claims that are denied because they failed the ordering referring provider would expose the Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate.**

Additional guidance

1. **A note on terminology**: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents.** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

You may want to review *MLN Matters*® article SE1201 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf*) for important reminders on the requirements for ordering referring physicians.

If you have questions, please contact your Medicare carrier, Part A/B MAC, or DME MAC, at their toll- free numbers, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Appealing denied claims submitted by an opt-out ordering and referring physician/non-physician practitioners

Provider types affected

This *MLN Matters*® special edition article is intended for opt-out physicians/non-physician practitioners who elect to order and refer and are excluded by the Office of Inspector General (OIG) and who are listed as an eligible professional on a provider submitted claim to Medicare contractors (carriers, fiscal intermediaries who maintain an HHA workload, RHHIs, and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries which meet exceptions described at 42 CFR 1001.1901(c).

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to inform opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the Office of Inspector General (OIG) that Medicare will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. Opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the OIG should file an appeal for any claim denials to their carriers and A/B MACs that they believe meets one of the exceptions described at 42 CFR 1001.1901(c).

Caution – what you need to know

The claims appeal should follow guidelines contained in the "Medicare Claims Processing Manual", Chapter 29, Section 290. The appeal should include documentation that proves one of the exceptions described at 42 CFR 1001.1901(c) has been met.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for more details.

Background

Medicare requirements for opting out can be found in the *Medicare Benefit Policy Manual*, Chapter 15, Section 40, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*. Opt-out affidavit requirements can be found in the *Medicare Benefit Policy Manual*, Chapter 15, Section 40.9, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

The OIG exclusion does not prohibit a physician/non-physician practitioner from opting out of the Medicare program. This includes exclusions under the following sections of the Social Security Act:

- Section 1128, Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs, which is available at *http://www.ssa.gov/OP_Home/ssact/title11/1128.htm*
- Section 1156, Obligations of Health Care Practitioners and Providers of Health Care Services, Sanctions, and Penalties, Hearings and Review, which is available at *http://www.ssa.gov/OP_Home/ssact/title11/1156.htm*, or
- Section 1892, Offset of Payments to Individuals to Collect Past Due Obligations Arising from Breach of Scholarship and Loan Contract, which is available at *http://www.ssa.gov/OP_Home/ssact/title18/1892.htm*.

However, if the opt-out physician/non-physician practitioner elects to order and refer services, then 42 CFR 405.425(j) would be applicable. It states that:

> *The physician or practitioner who is excluded under sections 1128, 1156, or 1892 of the Social Security Act may not order, prescribe, or certify the need for Medicare-covered items and services except as provided in §1001.1901 of this title, and must otherwise comply with the terms of the exclusion in accordance with §1001.1901 effective with the date of the exclusion.*

This article informs opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the OIG that they should file an appeal for any claim denials to their carriers and/or A/B MACs. That is, if they believe it meets one of the exceptions described at 42 CFR 1001.1901(c).

- 42 CFR 1001.1901(c) is available at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr1001_main_02.tpl*.
- The claims appeal should follow the guidelines found in the *Medicare Claims Processing Manual*, Chapter 29, Section 290. It should also include documentation that proves one of the exceptions described at 42 CFR

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Appealing *(continued)*

1001.1901(c) has been met. The *Medicare Claims Processing Manual*, Chapter 29, Section 290, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

Additional information

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Were you sent a request to revalidate your Medicare enrollment?

At this time, the quickest way to see if a revalidation letter was mailed to you is to check the "Downloads" on the Centers for Medicare & Medicaid Services' (CMS) *Revalidation page*. You will find mailing lists beginning with September 2011 when the first letters were sent. Information is now available for Medicare Part A/B revalidation letters mailed in April and May. Updated listings are also available for A/B revalidation letters mailed in February/March and for revalidation letters mailed by the national supplier clearinghouse (NSC). When information has been updated, the link will be revised to show the date the file was updated.

- *Medicare Part A/B revalidations mailed April-May 2012 [ZIP, 253KB]*
- *Medicare Part A/B revalidations mailed February-March 2012 (UPDATE 06/04/2012) [ZIP, 528KB]*
- *NSC revalidation letters mailed (UPDATE 06/03/2012) [ZIP, 429KB]*

You may also use the search option featured on First Coast Service Options' popular *enrollment status lookup*; simply enter your NPI or your PTAN.

Source: CMS PERL 201206-05

Incentive Programs

Help ensure your success in the EHR incentive programs by registering early

The Centers for Medicare & Medicaid Services (CMS) recommends that all eligible professionals (EPs) *register* as early as possible for Medicare and Medicaid's electronic health record (EHR) incentive programs.

If you register early, you can verify that your information is current in all of CMS' systems and resolve any issues, so you may participate in the EHR incentive programs. If you do not resolve registration problems in time, you will not be able to attest and could potentially miss out on a payment year. Registering does not mean you are required to participate – so register today.

Register today to receive maximum incentives

This is the last year for Medicare eligible professionals (EPs) to start participating in the EHR incentive programs in order to receive their full Medicare incentive payments. For more information on registration in the EHR incentive programs, visit the *Registration section* of the EHR Web page.

Want more information about the EHR incentive programs?

Make sure to visit the *EHR incentive programs Web page* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201205-70

View EHR testimonial videos from the 2012 HIMSS annual conference on CMS' YouTube channel

The Centers for Medicare & Medicaid Services (CMS) has posted a series of new videos to the *CMS YouTube channel* featuring health care professionals' experiences with electronic health records (EHRs) and the Medicare and Medicaid EHR incentive programs.

CMS spoke with 10 conference attendees at the 2012 Health Information and Management Systems Society (HIMSS) annual conference this past February and filmed discussions with health care professionals who are participating in the EHR incentive programs. Provider testimonial videos, like *Dr. John Bender's EHR story from the 2012 HIMSS conference*, highlight the experiences of providers and health care professionals with the EHR incentive programs and how they navigated the different steps of the programs.

CMS previously filmed testimonials of attendees at the American Osteopathic Association (AOA) annual medical conference and exposition and of the experiences of providers who have received their incentive payments for 2011. *Watch the videos* to listen to their stories and learn how their experiences may be similar to your own.

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 201206-24

CMS and ONC surpass 2012 goals for EHR adoption and use

More than 100,000 health care providers are using electronic health records that meet federal standards and have benefitted from the Medicare and Medicaid electronic health record (EHR) incentive programs, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced on June 19.

Only three months ago, CMS Acting Administrator Marilyn Tavenner and National Coordinator for Health Information Technology Farzad Mostashari, M.D., Sc.M., declared an ambitious goal of getting 100,000 health care providers to adopt or meaningfully use EHRs by the end of 2012. Today, that goal has already been met and surpassed.

Acting Administrator Tavenner first proposed the 100,000 provider goal in a *blog* in March with Dr. Mostashari that declared 2012 the "Year of Meaningful Use."

The EHR incentive programs, which began in 2011, provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade, or meaningfully use certified EHR technology in ways that improve care. Eligible professionals include physicians, nurse practitioners, certified nurse midwives, and some physician assistants. The program was established by the Health Information for Clinical and Economic Health Act of 2009 (HITECH), one of President Obama's first priorities enacted upon taking office.

As of the end of May 2012:

- More than 110,000 eligible professionals and over 2,400 eligible hospitals have been paid by the Medicare and Medicaid EHR incentive programs.
- Approximately 48 percent of all eligible hospitals and critical access hospitals in the U.S. have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- One out of every five Medicare and Medicaid eligible professionals in the U.S. has received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- Over $5.7 billion in EHR incentive program payments were made.

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ONC *(continued)*

- More than $3 billion in Medicare EHR incentive program payments were made between May 2011 (when the first payments were released) and the end of May 2012.
- More than $2.6 billion in Medicaid EHR incentive program payments were made between January 2011 (when the first states launched their programs) and the end of May 2012.

Through the end of May 2012, over 133,000 primary care providers and 10,000 specialists were partnering with regional extension centers (RECs) to overcome common EHR adoption barriers. Of these providers, 70 percent of small practice providers in rural areas as well as 74 percent of critical access hospitals are working with RECs. These regional organizations work to ensure these clinicians meet meaningful use and receive incentive payments through the Medicare and Medicaid EHR incentive programs. Over 12,000 providers working with RECS have already received their incentive payments.

The Medicare and Medicaid EHR incentive programs provide incentive payments for using EHR technology in "meaningful" ways that lead to higher quality care, improved patient safety, and shared decision making by patients and physicians. Under both the Medicare and Medicaid EHR incentive programs, eligible hospitals and critical access hospitals can receive support and financial incentives for implementing and meaningfully using certified EHR technology.

Forty-four states are participating in the Medicaid EHR incentive program as of May 2012. For more information on which states are participating, please visit the *EHR Incentive Programs* website. CMS expects the remaining states to launch their Medicaid EHR incentive programs by the end of 2012.

Full text of this excerpted *CMS press release* (issued June 19).

Source: CMS PERL 201206-39

FAQs section to include information for EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has upgraded its *frequently-asked question (FAQ) section*. The electronic health records (EHR) incentive programs' FAQs have now been added to the same page as other CMS program FAQs.

New and old FAQ numbers

CMS has tagged FAQs in the new system with two sets of FAQ numbers. You can now identify an FAQ by its old FAQ number (listed after the word "Keywords" below the answer of the FAQ) or its new FAQ number (at the very bottom of the FAQ in parentheses).

Finding FAQs

There are a few different ways to find EHR incentive programs FAQs:

1. Click on the topic "Electronic Health Records Incentive Programs" in the blue navigation panel on the left side of the *FAQ page*:
   - Click on the subtopic of your choice, such as "Getting Started" or "Registration and Attestation," to see the FAQs related to that area of the programs
2. Search for your FAQ in the system:
   - Enter a search term such as "EHR" in the search box on the top, left side of the *FAQ page*.
   - Use the new FAQ numbers:
     - Enter the new FAQ number in the "FAQ #" search box found at the top, left side of the *FAQ page*. Choose the "FAQ #" option.
     - If you have already read an FAQ and noted the new number (in parentheses at the bottom of the FAQ), use that number as a reference to quickly find it again
   - Use the old FAQ numbers
     - Enter the old FAQ number (listed after "Keywords" below the FAQ answer) in the search box found at the top, left side of the *FAQ page*. Choose the "Text" option.

Note: You cannot search by old FAQ number in the "FAQ #" search box. However, you can search by old FAQ numbers in the "Text" search box.

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EHR *(continued)*

You can also download a PDF of all the FAQs for the EHR incentive program. Go to the *FAQ page* on the EHR incentive programs website and click the *link* under the *Downloads* section at the bottom of the page.

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 201206-07

Recording and transcript from June 7 EHR incentive programs registration and attestation call now available

The audio recording and written transcript from the June 7 Medicare and Medicaid electronic health record (EHR) incentive programs registration and attestation for eligible professionals national provider call are now available on the *June 7 EHR* call page in the "Presentation" section.

Source: CMS PERL 201206-38

Revised fact sheet covering HPSA, HSIP, and PCIP programs

The *"Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs"* fact sheet (ICN 903196) (previously titled health professional shortage area) has been revised and is now available in downloadable and hard copy format. This fact sheet is designed to provide education on three Medicare programs. It includes an overview of the health professional shortage area (HPSA) physician bonus, HPSA surgical incentive payment (HSIP), and primary care incentive payment (PCIP) programs. To access a new or revised product available for order in hard copy format, go to *MLN Products* and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the Web page.

Source: CMS PERL 201206-44

General Information

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2012, must be paid before the end of business on March 31, 2012.

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

The new rate of 1.75 percent is in effect through December 31, 2012.

Interest is not paid on:

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

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

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

Health care law saved people with Medicare over $3.5 billion on prescription drugs

In the first four months of 2012, more than 416,000 people with Medicare saved an average of $724 on prescription drugs and 12.1 million used a free preventive service

Under the new health care law – the Affordable Care Act – seniors and people with disabilities in Medicare have saved a total of $3.5 billion on prescription drugs in the Medicare drug benefit coverage gap or "donut hole" from the enactment of the law in March 2010 through April of 2012. The Centers for Medicare & Medicaid Services (CMS) released data on May 24 showing that, in the first four months of 2012 alone, more than 416,000 people saved an average of $724 on the prescription drugs they purchased after they hit the prescription drug coverage gap or "donut hole," for a total of $301.5 million in savings. These savings build on the law's success in 2010 and 2011, when more than 5.1 million people with Medicare saved over $3.2 billion on prescription drugs.

In addition, CMS announced that this year, from January through April, 12.1 million people in traditional Medicare received at least one preventive service at no cost to them – including over 856,000 who have taken advantage of the annual wellness visit provided in the Affordable Care Act. In 2011, over 26 million people in traditional Medicare received one or more preventive benefits free of charge.

People with Medicare who hit the coverage gap "donut hole" in 2010 received a one-time $250 rebate. In 2011, people with Medicare began receiving a 50 percent discount on covered brand name drugs and 7 percent coverage of generic drugs in the "donut hole." This year, Medicare coverage for generic drugs in the coverage gap has risen to 14 percent. Coverage for both brand name and generic drugs in the gap will continue to increase over time until 2020, when the coverage gap will no longer exist. For more information on how the Affordable Care Act closes the Medicare drug benefit coverage gap "donut hole," please visit the *Medicare Drug Discounts Web page*.

Prior to 2011, people with Medicare faced cost-sharing for many preventive benefits like cancer screenings and smoking cessation counseling. Now, many of these benefits are offered free of charge to beneficiaries, with no deductible or copay, so that cost is no longer a barrier for seniors who want to find and treat problems early.

For more information on Medicare-covered preventive services, many of which are now provided without charge to beneficiaries thanks to the Affordable Care Act, please visit the *Medicare Preventive Services Web page*. To learn what screenings, vaccinations and other preventive services doctors recommend for you and those you care about, please visit the *myhealthfinder tool*.

Full text of this excerpted *CMS press release* (issued May 24).

Source: CMS PERL 201205-68

HHS announces 81 health care innovation awards

Providers, tech companies, and local organizations expected to lower costs and improve quality

On June 15, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced the recipients of 81 new health care innovation awards made possible by the health care law, the Affordable Care Act. The awards will support innovative projects nationwide designed to deliver high-quality medical care, enhance the health care workforce, and save money. Combined with the awards announced last month, HHS has awarded 107 projects that, according to awardees, intend to save the health care system an estimated $1.9 billion over the next three years.

The awards are notable for their geographic diversity; projects will be located in urban and rural areas, all 50 states, the District of Columbia and Puerto Rico. The following is one of the award-winning projects:

- "Sepsis early recognition and response initiative" in Texas, a project of the Methodist Hospital Research Institute in Houston, is a novel approach to identify and treat sepsis before it progresses. Sepsis is the sixth most common reason for hospitalization and typically requires double the average time in the hospital. It leads to complications such as renal failure and cognitive decline; one out of 20 patients with sepsis die within 30 days. Methodist Hospital's novel initiative will lead to fewer cases of organ failure, improved patient outcomes, shorter stays in the hospital, and lower costs.

Awardees were chosen for their innovative solutions to the health care challenges facing their communities and for their focus on creating a well-trained health care workforce that is equipped to meet the need for new jobs in the 21st century health system. CMS at HHS contracted with an external organization with extensive experience in managing independent grant review processes to administer the award review process to ensure an objective review of each application.

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HHS harnesses the power of health data to improve the quality of health care

The Department of Health and Human Services (HHS), along with the Institute of Medicine (IoM) and other members of the Health Data Consortium, co-hosted the third annual "Datapalooza" focusing on innovative applications and services that harness the power of open data from HHS and other sources to help improve health and health care.

Announcements made at the forum June 5 include:

The Centers for Medicare & Medicaid Services (CMS) launched an initiative to transform the agency's approach to data and analytics. The initiative will help guide the agency's evolution from a fee-for-service based payer to a "value-based purchaser of care" that links payments to quality and efficiency of care, rather than sheer volume of services. To lead the initiative, CMS created a new Office of Information Products and Data Analysis, which will strive to make development, management, use, and dissemination of data and information resources a core function of CMS. The announcement builds upon many of the recent advances in data transparency and accessibility achieved by CMS in the past 12 months.

Over time, the initiative will modernize CMS' intricate data systems and policies, and it will help the agency achieve greater improvements in health care delivery. Data and information resources available under CMS' initiative include:

- **Medicare geographic variation trend data**: A unique data set that leverages nearly 5 billion Medicare claims in an easy-to-use data format that provides key metrics at the state and hospital referral region levels.
- **Medicare enrollment dashboard**: An online dashboard that provides a single location with comprehensive statistics on Medicare enrollment (Parts A, B, and D and Medicare Advantage).
- **Medicare and Medicaid research review**: A peer-reviewed online journal on current and future directions of the Medicare, Medicaid and Children's Health Insurance.
- **CMS data navigator**: A Web-based search tool that rapidly connects researchers, policy makers, and the general public to the CMS data resources they need.

For more information, view the *CMS fact sheet*.

HHS *(continued)*

The Center for Medicare and Medicaid Innovation within CMS will administer the awards through cooperative agreements over three years.

For more information on the awards announced, go to the *Health Care Innovation Awards: Project Profiles* Web page. To learn more about other innovative models being tested by the Innovation Center, please visit: *innovations.cms.gov*.

Full text of this excerpted *HHS press release* (issued June 15).

Source: CMS PERL 201206-40

The Office for the National Coordinator for Health IT has led national competitions toward the creation of easy to use, Web-based tools that help patients schedule follow-up appointments after being discharged from a hospital stay. In collaboration with the Partnership for Patients, the "Discharge Follow-Up Appointment Challenge" winners were announced:

- **First place**: *MyHealthDIRECT* – a Web-based solution that enables patients and caregivers to search for, book, and confirm appointments and includes reminder and transportation reservation functionality.
- **Second place**: *HePak* – a tool that integrates appointment-making and reminder functions into its hospital, provider, and patient portals.
- **Third place**: *mHealthCoach* – a tool that provides calendar syncing and incorporates educational content and HHS data feeds.

Also announced was the "Blue Button Mash-Up Challenge" (submission period ends September 5, 2012). The Department of Veterans Affairs (VA), in conjunction with the HHS Office of the National Coordinator, announced the challenge that builds on the VA's existing "Blue Button" feature to allow patients to download their health information and share it with health care providers, caregivers, and others. The challenge requires the development of a tool that will help individuals to use their health information, combined with other types of information, such as cost data or comparative health data, to better understand their own health status and make more informed decisions regarding their health care.

View the complete *press release* issued June 5.

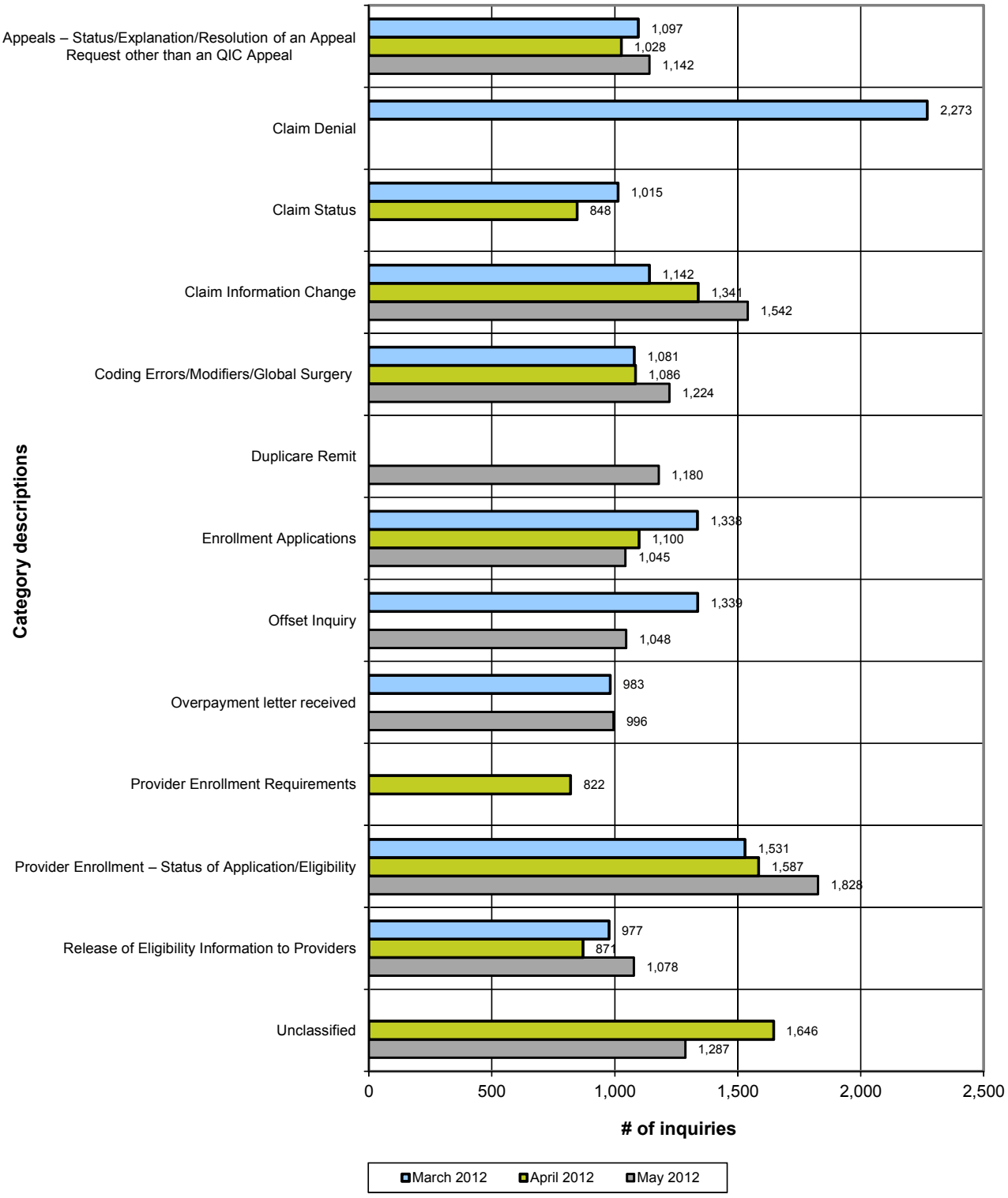
Source: CMS PERL 201206-10

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during March-May 2012.

For tips and resources to help providers 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*.

Part B top inquiries for March-May 2012



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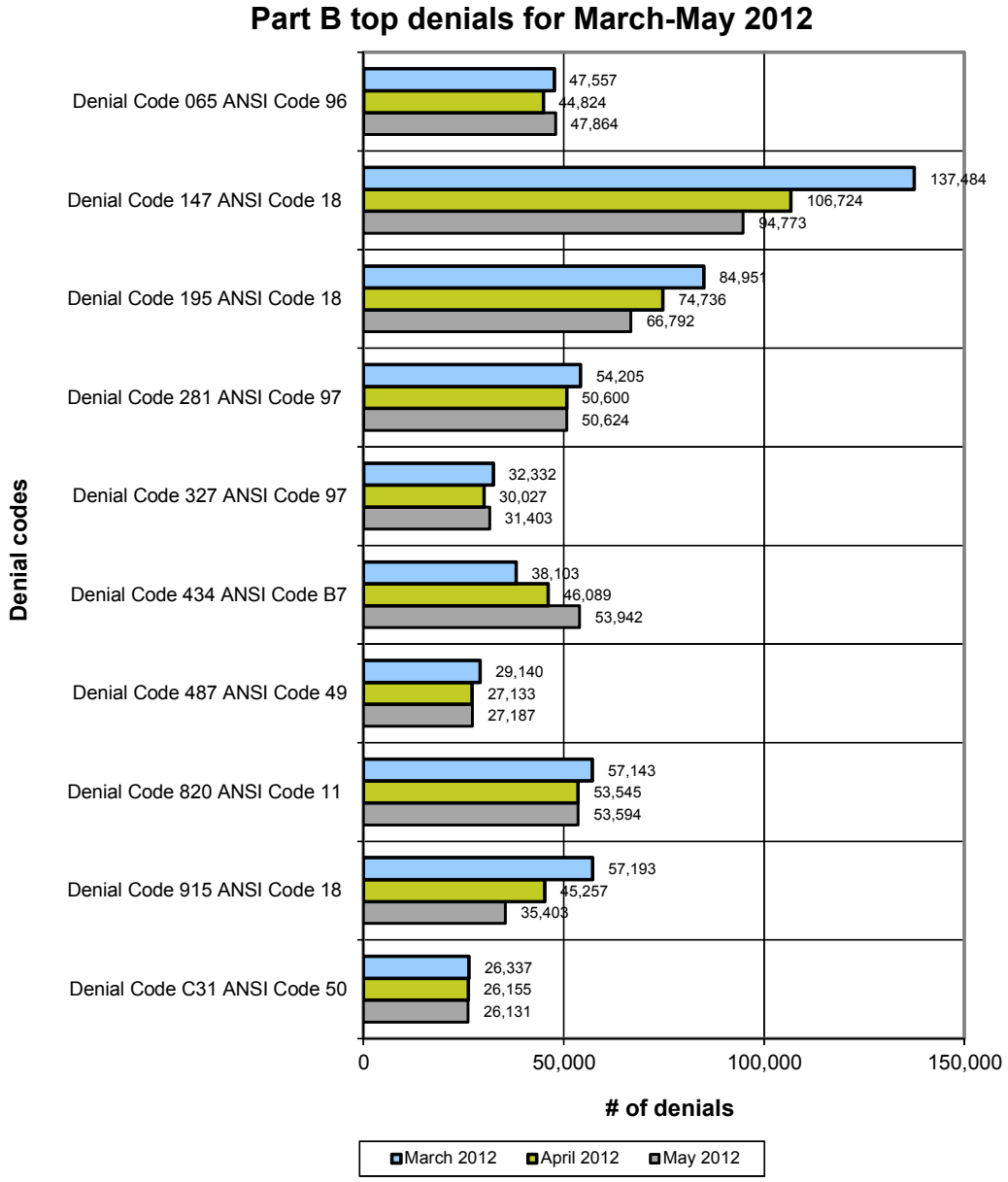


What to do when your claim is denied

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

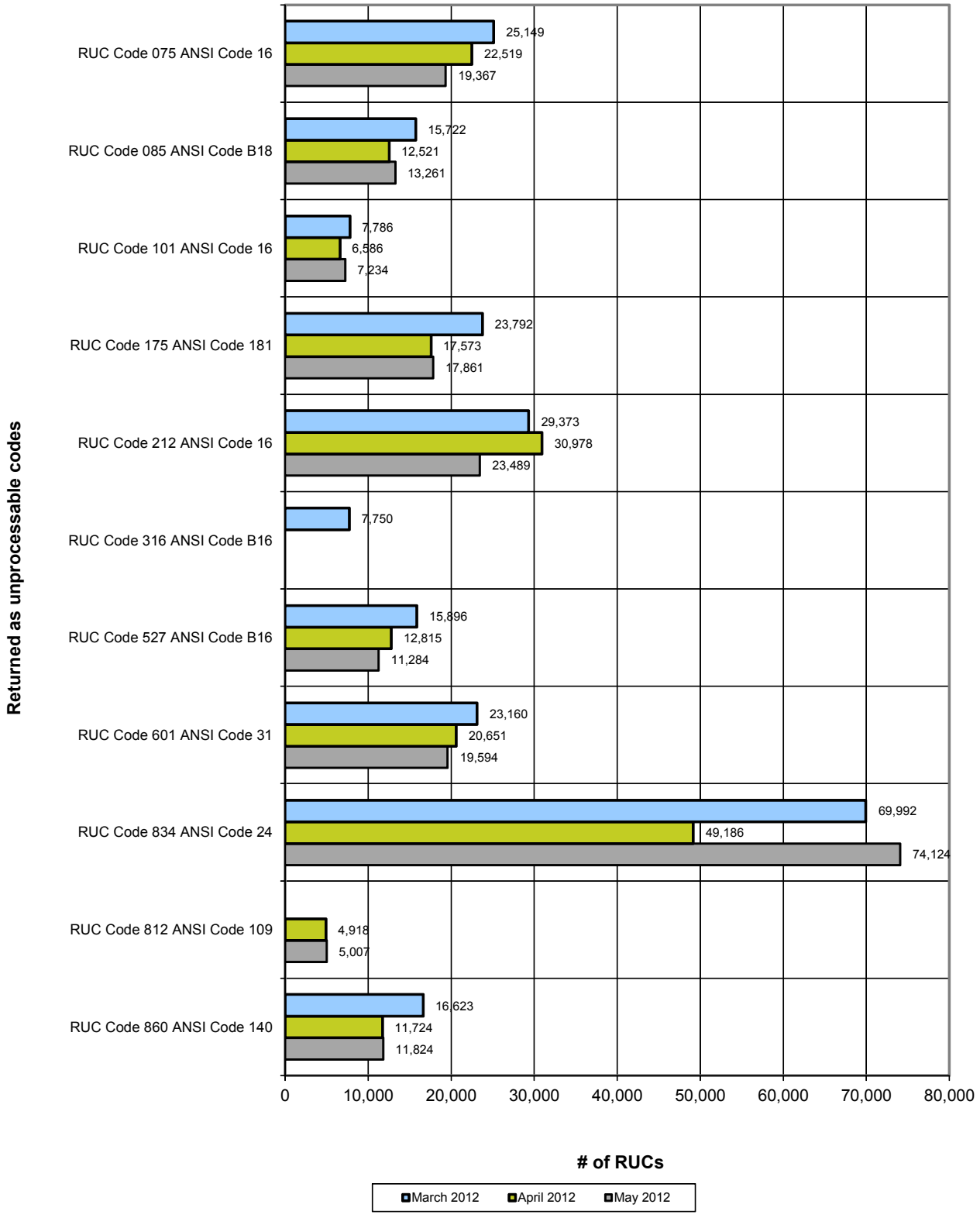
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top *(continued)*

Part B top return as unprocessable claims for March-May 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.

Revisions to LCDs

IDTF: Independent diagnostic testing facility (IDTF) – revision to the LCD

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

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised February 23, 2012. Since that time, the "Coding Guidelines" attachment has been revised in the "Credentialing Matrix" table.

Revisions include the following:

- The "Supervising Physician and Interpreting Physician Qualification Requirements" have been revised for *CPT*® codes *95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95885, 95886*, and *95887* to read: Board Certified (ABMS) Neurologist or Board Certified (ABMS) Physical Medicine and Rehabilitation (PMR) specialist with additional certification by: a) American Board of Electrodiagnostic Medicine, b) Clinical Neurophysiology, or c) American Board of Neurophysiology or a Physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the service under state law.
- The "Technician Qualification Requirements" have been revised for *CPT*® codes *95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95885, 95886*, and *95887* to read: Must be performed by the qualified interpreting physician.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for services rendered **on or after May 29, 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*.

J0881: Erythropoiesis stimulating agents – revision to the LCD

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

The local coverage determination (LCD) for erythropoiesis stimulating agents was most recently revised August 23, 2011. Since that time, based on change requests 7831 and 7844, the LCD was revised to add HCPCS code Q2047 [Injection, peginesatide, 0.1 mg (for ESRD on dialysis)] to the "*CPT*/HCPCS Codes" section of the LCD. The "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 codes that Support Medical Necessity" and "Utilization Guidelines" sections of the LCD were also updated per the Food and Drug Administration (FDA) label. In addition, the "Sources of Information and Basis for Decision" section of the LCD and the LCD "Coding Guidelines" attachment were updated.

Effective date

This LCD revision is effective for services rendered **on or after July 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*.

J9001: Doxorubicin, liposomal (Doxil®) – revision to the LCD

LCD ID number: L29157 (Florida)
LCD ID number: L29419 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil®) was most recently revised April 24, 2012. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" and "*CPT*/HCPCS Codes" sections of the LCD were revised based on change requests 7831, 7844, and 7854. The LCD was revised to remove HCPCS code J9001 and replace it with new HCPCS code Q2048 (Injection, doxorubicin hydrochloride, liposomal, doxil, 10 MG). In addition, HCPCS code J9999 and C9399 were removed and replaced with new HCPCS code Q2049 (Injection, doxorubicin hydrochloride, liposomal, imported lipodox 10mg). Also, the "Contractor's Determination Number" J9001 was changed to Q2048 and the "LCD Title" was changed to Doxorubicin, Liposomal (Doxil/Lipodox).

Effective date

This LCD revision is effective for services rendered **on or after July 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*.

J9310: Rituximab (Rituxan®) – revision to the LCD

LCD ID number: L29271 (Florida)
LCD ID number: L29472 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised April 19, 2011. Since that time, revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. Under this section, the following indication was added to the off-labeled indications: "Second-line or salvage therapy with or without radiation therapy (RT) prior to autologous stem cell rescue for progressive disease or for relapsed disease in patients initially treated with chemotherapy with or without RT in combination with bendamustine." Also, a new "Limitations" subheading was added referencing individual consideration for multiple sclerosis (ICD-9-CM code 340). Under this new "Limitations" section of the LCD, language was given indicating medical records may be requested for prepayment review when diagnosis code 340 is billed for rituximab (Rituxan®). In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add diagnosis code range 201.40-201.48 (Hodgkin disease, lymphocytic-histiocytic predominance), and the "Sources of Information and Basis for Decision" section of the LCD was also updated.

Effective date

This LCD revision is effective for services rendered **on or after June 8, 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*.

NCSVCS: Noncovered services – revision to delete HCPCS code C9732 and replace with *CPT*® code *0308T*, and remove *CPT*® code *66999*

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

The local coverage determination (LCD) for noncovered services was most recently revised on June 12, 2012. Since that time, the LCD was revised to delete HCPCS code C9732 and replace it with *CPT*® code *0308T* under the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Procedures" section of the LCD. This change is based on the Centers for Medicare & Medicaid Services (CMS) transmittal 2481, **change request (CR) 7844**, dated June 1, 2012, (July Update to the CY 2012 Medicare Physician Fee Schedule Database [MPFSDB]) and CMS transmittal 2479, **CR 7854**, dated May 25, 2012, (July 2012 Update of the Ambulatory Surgical Center [ASC] Payment System).

In addition, *CPT*® code *66999* (when billed for the lens, intraocular (telescopic)/implantable miniature telescope [IMT]) (physician's services only) under the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-**Devices**" section of the LCD and *CPT*® code *66999* (when billed for the insertion of ocular telescope prosthesis including removal of crystalline lens) (physician's services only) under the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-**Procedures**" section of the LCD were both removed.

Effective date

This LCD revision is effective for claims processed **on or after July 2, 2012**, for services rendered **on or after July 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*.

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 June 12, 2012. In a previous publication (March 2012 Connection), First Coast Service Options Inc. published the following verbiage based on the Centers for Medicare & Medicaid Services (CMS) transmittal 2402, change request (CR) 7610, dated January 26, 2012.

"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*."

Since that time it has been determined that diagnosis V73.89 is not an applicable diagnosis for *CPT*® codes *87270* and *87320*. Therefore, diagnosis V73.89 has been removed from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions – Laboratory Procedures" section of LCD for *CPT*® codes *87270* and *87320*.

Effective date

This LCD revision is effective for claims processed **on or after July 2, 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*.

SKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L29279 (Florida)
LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised January 1, 2012. Since that time, a revision was made to the LCD based on change request 7854, transmittal 2479, (July 2012 Update of the Ambulatory Surgical Center [ASC] Payment System), dated May 25, 2012, issued by the Centers for Medicare & Medicaid Services (CMS).

After further evaluation of HCPCS codes C9368 (Grafix core, per square centimeter) and C9369 (Grafix prime, per square centimeter), a decision was made to add HCPCS codes C9368 and C9369 to the "*CPT*/HCPCS Codes" section of the LCD under the subsection "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products."

Effective date

This LCD revision is effective for services rendered **on or after July 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*.

VISCO: Viscosupplementation therapy for knee – revision to the LCD

LCD ID number: L29307 (Florida)
LCD ID number: L29408 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was most recently revised January 1, 2010. Since that time, the LCD was revised to add HCPCS code J7326 (Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose) to the "*CPT*/HCPCS Codes" and the "Utilization Guidelines" sections of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

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

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, timing is everything. Don't worry – you won't need your desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our *Appeals of claim decisions page* . Each calculator will automatically calculate when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Additional Information

Self-administered drug (SAD) list – Part B: J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after August 6, 2012**, the following drug has been added to the MAC J9 Part B SAD list.

- C9399/J3490/J3590 – Injection, Exenatide extended release for injectable suspension [Bydureon™]

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

First Coast Service Options Inc. (FCSO) SAD lists are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our *Website highlights page*. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with FCSO's Web team.

Educational Events

Upcoming provider outreach and educational events
August 2012

Medifest 2012 Miami

When: Tuesday, August 14 – Wednesday, August 15
Time: 8:00 a.m.-5:00 p.m. ET
Type of event: Face-to-face

Internet-based PECOS class

When: Tuesday, August 21
Time: 8:00 a.m.-noon
Type of event: Face-to-face

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

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

'National Men's Health Week'

Each year, the week leading up to and including Father's Day, is "National Men's Health Week." "Men's Health Week" is a great time to focus on keeping our fathers, brothers, uncles, and sons healthy – by educating them on health issues that disproportionately affect men, raising awareness of preventable health problems, and encouraging early detection and treatment of disease.

Did you know?

- Heart disease is the leading cause of death for U.S. men
- More U.S. men die from lung cancer than any other type of cancer
- Prostate cancer and colorectal cancer are the second and third most common causes of cancer death in U.S. men, respectively
- 34 percent of U.S. adult men are obese, and 32 percent have hypertension
- Men aged 60 and over are more likely to be obese than younger men

Medicare provides coverage of a wide range of preventive services for certain beneficiaries that meet eligibility and coverage requirements that are especially meaningful to men in helping them prevent and detect disease, including but not limited to:

- Annual wellness visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Colorectal and prostate cancer screenings
- Cardiovascular disease screenings
- Depression screening
- Diabetes screening
- HIV screening
- Immunizations
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Initial preventive physical exam (also commonly referred to as the "Welcome to Medicare" preventive visit)
- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent STIs
- Tobacco use cessation counseling

Encourage men with Medicare to make the most of their benefits by taking advantage of the preventive services that are most appropriate for them.

***Medicare Learning Network*® (*MLN*) resources:**

- *"Quick Reference Information: Medicare Preventive Services "*
- *MLN® Matters Article MM7079, "Annual Wellness Visit, Including Personalized Prevention Plan"*
- *"Quick Reference Information: The ABCs of Providing the Annual Wellness Visit"*
- *MLN® preventive services educational products*

More Information for health care providers:

- *CDC Men's Health Statistics Web page*
- *Men's Health Week*

Source: CMS PERL 201206-09

New delivery reform CME module posted on Medscape

On May 30, Medscape posted a new continuing medical education (CME) module titled, *"CMS Value-based Purchasing Targets Complications, Readmissions,"* highlighting the delivery system reforms created by the Affordable Care Act, specifically value-based purchasing.

Source: CMS PERL 201206-08

Other Educational Resources

Medifest 2012 Miami

Tuesday, August 14 – Wednesday, August 15

Shula's Hotel and Golf Resort

Miami, Florida

Providers will have the opportunity to engage with their peers and Medicare experts from FCSO's Provider Outreach and Education, Customer Service, Electronic Data Interchange, Provider Audit and Reimbursement (PARD), and Provider Enrollment.

This includes the chance to talk with vendors and preview their products and services designed especially for Medicare providers. Here's a sneak preview of Medifest 2012 Miami:

- Planned events with CMS contractors committed to increasing patient care with proactive data tools, reducing fraud and abuse, and assisting providers with electronic health records technology.
- Data-driven and provider recommended topics on top claim submission errors and inquiries related to appeals, evaluation and management, global surgery, cost outlier coding, medical documentation, Medicare secondary payer, "incident to" billing, and much more.
- Workshops on the latest CMS initiatives such as ICD-10, provider incentive programs, and provider enrollment revalidation.
- Technical training classes on direct data entry and PC-ACE Pro32™, as well as updates to Provider Statistics & Reimbursement reports.

Make sure to review our course offerings and agenda in this brochure to learn what Medifest 2012 has to offer.

Or visit our Medifest 2012 page on FCSO's Medicare provider website for more detailed information about the workshops, schedule of events, and registration process.

Go to *http://medicare.fcso.com* and select "*Education*." Whether you come for one or both days, we look forward to building a stronger Medicare community with you through education.

For complete information, including the class schedule, registration instructions, and costs visit *http://medicare.fcso.com/Medifest_Miami/235747.pdf*.

New fast fact available 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. A list of previous fast facts is available on the *MLN® Provider Compliance Fast Fact Archive* page. Please bookmark this page and check back often as a new fast fact is added each month.

Source: CMS PERL 201206-26

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