The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC (Cahaba) as their Fiscal Intermediary or Regional Home Health Intermediary. The CPT codes, descriptors and other data only are copyright © 2010 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Important Information from Cahaba Government Benefit Administrators®, LLC (Cahaba)

December 1, 2010 Vol. 17, No. 3

This bulletin should be shared with all health care practitioners and members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com

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Stay Informed! Subscribe to the Cahaba E-mail Notification Service to receive the most current home health and hospice Medicare information. This service is free. When you subscribe, we’ll send you periodic e-mails telling you about new or updated Medicare information.

Key for Icons: Home Health Providers Hospice Providers
Disclaimer
This educational material was prepared as a tool to assist Medicare providers and other interested parties and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within this module, the ultimate responsibility for the correct submission of claims lies with the provider of services. Cahaba employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of these materials. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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News Flash Messages from CMS for Home Health and Hospice Providers

Vaccination is the Best Protection Against the Flu
This year, the Centers for Disease Control and Prevention (CDC) is encouraging everyone 6 months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for health care workers, who may spread the flu to high risk patients. Don’t forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/AdultImmunizations on the CMS Web site.

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Medicare Self-Referral Disclosure Protocol (SRDP)
Section 6409(a) of the Affordable Care Act requires the Secretary of the Department of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, to establish a Medicare self-referral disclosure protocol (“SRDP”) that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act). The SRDP requires health care providers of services or suppliers to submit all information necessary for CMS, on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of
the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located at http://www.cms.gov/PhysicianSelfReferral/ on the CMS Web site.

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The Provider Enrollment, Chain and Ownership System (PECOS) is Now Available for DMEPOS Suppliers

DMEPOS suppliers can use Internet-based PECOS to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare, and check on the status of a Medicare enrollment application via the Internet. For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll and select the “Internet-based PECOS” tab on the left side of screen. The EUS Help Desk provides assistance to providers and suppliers if they encounter an application navigation or systems problem with Internet-based PECOS.

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A New Medicare Learning Network® Publication

A new publication titled “Caregiving Education” (September 2010) is now available in downloadable format from the Medicare Learning Network® at http://www.cms.gov/MLNProducts/downloads/MLN_CaregivingEducation.pdf on the CMS Web site. Medicare will pay for certain types of caregiver education when it is provided as part of a patient’s medically-necessary face-to-face visit. This publication provides information on how to bill for Caregiver Education under Medicare Parts A and B.

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From the Medicare Learning Network: “Hospice Payment System”

The revised Medicare Learning Network® publication titled “Hospice Payment System” (September 2010) is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf. This publication provides information about the coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees.
Partial Code Freeze Prior to ICD-10 Implementation
The Centers for Medicare & Medicaid Services (CMS) has provided the following Special Edition (SE) Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: SE1033  Related Change Request (CR) #: N/A
Related CR Release Date: N/A  Effective Date: N/A
Related CR Transmittal #: N/A  Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know
At the ICD-9-CM Coordination & Maintenance (C&M) Committee Meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting.

The partial freeze will be implemented as follows:
• The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
• On October 1, 2012, there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
• On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9-CM on October 1, 2013, as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to: http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp on the CMS Web site. From there, select the September 15-16, 2010, meeting documents and transcripts from the “Downloads” section, and
then from the ZIP files, select the ‘091510_Morning_Transcript’ file. This section appears on page 4 of the 78-page document.


Additional Information
CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at http://www.cms.gov/ICD10 on the CMS Web site. In addition, the following CMS resources are available to assist in your transition to ICD-10:

• Medicare Fee-for-Service Provider Resources Web Page - This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp and check back regularly for access to ICD-10 implementation information of importance to you. **Note: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.**

• CMS Sponsored National Provider Conference Calls - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS Web site.

• Frequently Asked Questions (FAQs) - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10/ , select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

• Workgroup for Electronic Data Interchange (WEDI) http://www.wedi.org; and

• Health Information and Management Systems Society (HIMSS) http://www.himss.org/icd10 on the Internet.

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.
January 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7188  Related Change Request (CR) #: 7188
Related CR Release Date: October 15, 2010  Effective Date: January 1, 2011
Related CR Transmittal #: R2067CP  Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on CR 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by CMS, also the revised October 2010, July 2010, April 2010, and January 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the “Background” and “Additional Information” sections of this article for further details regarding these changes.

Background
Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2011 ASP and ASP NOC files</td>
<td>January 1, 2011, through March 31, 2011</td>
</tr>
<tr>
<td>October 2010 ASP and ASP NOC files</td>
<td>October 1, 2010, through December 31, 2010</td>
</tr>
<tr>
<td>July 2010 ASP and ASP NOC files</td>
<td>July 1, 2010, through September 30, 2010</td>
</tr>
<tr>
<td>April 2010 ASP and ASP NOC files</td>
<td>April 1, 2010, through June 30, 2010</td>
</tr>
<tr>
<td>January 2010 ASP and ASP NOC files</td>
<td>January 1, 2010, through March 31, 2010</td>
</tr>
</tbody>
</table>

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.
Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

The official instruction (CR 7188) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.gov/Transmittals/downloads/R2067CP.pdf on the CMS Web site.

Counseling to Prevent Tobacco Use
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7133 Related Change Request (CR) #: 7133
Related CR Release Date: September 30, 2010 Effective Date: August 25, 2010
Related CR Transmittal #: R125NCD and R2058CP Implementation Date: January 3, 2011

Provider Types Affected
Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for tobacco cessation counseling services provided to Medicare beneficiaries who are outpatients or are hospitalized are affected.

Provider Action Needed STOP – Impact to You
This article is based on CR 7133 which announces that CMS will cover counseling to prevent tobacco use for outpatient and hospitalized beneficiaries.

CAUTION – What You Need to Know
Effective for dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.  These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.  The ICD-9 diagnosis codes that should be reported for these individuals are 305.1 (non-dependent tobacco use disorder) or V15.82 (history of tobacco use).

GO – What You Need to Do
New G codes and C codes are also created for these services.  See the “Background” and “Additional Information” sections of this article for further details regarding these changes and the use of the new G and C codes.

Background
Medicare Part B (Section 210.4 of the National Coverage Determination (NCD) Manual) already covers cessation counseling for individuals who:
1. Use tobacco and have been diagnosed with a recognized tobacco-related disease, or,
2. Use tobacco and exhibit symptoms consistent with a tobacco-related disease.

In November 2009, based upon authority to cover “additional preventive services” for Medicare beneficiaries if certain statutory requirements are met, the CMS initiated a new national coverage analysis. This analysis was to evaluate whether the existing evidence on counseling to prevent tobacco use is sufficient to extend national coverage for cessation counseling to those individuals who use tobacco (but do not have signs or symptoms of tobacco-related disease).

One of these statutory requirements is that the service be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the US Preventive Services Task Force (USPSTF).

CR 7133 instructs that, effective for claims with dates of service on and after August 25, 2010, CMS will cover counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries:
1. Who use tobacco (regardless of whether they have signs or symptoms of tobacco-related disease);
2. Who are competent and alert at the time that counseling is provided; and
3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

The diagnosis codes that should be reported for these individuals are:
- ICD-9 code 305.1 (non-dependent tobacco use disorder), or
- ICD-9 code V15.82 (history of tobacco use).

The CMS has created two new G codes for billing for tobacco cessation counseling services to prevent tobacco use for dates of service on or after January 1, 2011. These are in addition to the two CPT codes 99406 and 99407 that currently are used for tobacco cessation counseling for symptomatic individuals. Medicare will waive the deductible and coinsurance/copayment for counseling and billing with these two new G codes on or after January 1, 2011. The new G codes for use on claims with dates of service on or after January 1, 2011, are:
- **G0436**: Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes,
  Short Descriptor: Tobacco-use counsel 3-10 min;
- **G0437**: Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes,
  Short Descriptor: Tobacco-use counsel >10 min.

Medicare will pay claims not paid under the Outpatient Prospective Payment System (OPPS) with dates of service on or after August 25, 2010, through December 31, 2010, but received prior to January 1, 2011, when billed with diagnosis code 305.1 (non-dependent tobacco-use disorder) or V15.82 (history of tobacco use) and unlisted HCPCS code 99199 for Counseling to Prevent Tobacco Use Services. Code 99199 is Medicare contractor-priced.

However, two new, temporary C codes have been created for facilities paid under the OPPS when billing for Counseling to Prevent Tobacco Use and Tobacco-Related Disease services during the interim period of
August 25, 2010, through December 31, 2010. (Facilities paid under the OPPS may not bill the unlisted 99199 code.) The two new C codes are:

- **C9801:** Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes,
  Short descriptor: Tobacco-use counsel 3-10 min;
- **C9802:** Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes,
  Short descriptor: Tobacco-use counsel >10 min.

CMS will allow two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to 8 sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than 3 minutes up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

**Note:** Section 4104 of the Affordable Care Act provided for a waiver of the Medicare coinsurance and Part B deductible requirements for counseling to prevent tobacco use services, codes G0436 and G0437, effective on or after January 1, 2011. No other tobacco cessation codes are eligible for waiver of coinsurance/deductible at this time. Prior to January 1, 2011, this service will be subject to the standard Medicare coinsurance and Part B deductible requirements.

The method of payment to institutional providers for outpatient services is as shown in the following table:

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Method of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Centers (RHCs) (Type of Bill (TOB) 71X/Federally Qualified Health Centers (FQHCs) (TOB 77X)</td>
<td>All-inclusive rate (AIR) for the encounter</td>
</tr>
<tr>
<td>Hospitals (TOBs 12X and 13X)</td>
<td>OPPS for hospitals subject to OPPS</td>
</tr>
<tr>
<td></td>
<td>Medicare Physician Fee Schedules (MPFS) for hospitals not subject to OPPS</td>
</tr>
<tr>
<td>Indian Health Services (IHS) (TOB 13X)</td>
<td>AIR for the encounter</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (SNFs) (TOBs 22X and 23X)</td>
<td>MPFS</td>
</tr>
<tr>
<td>Home Health Agencies (HHAs) (TOB 34X)</td>
<td>MPFS</td>
</tr>
<tr>
<td>Critical Access Hospitals (CAHs) (TOB 85X), IHS CAHs (TOB 85X)</td>
<td>Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS</td>
</tr>
<tr>
<td></td>
<td>Based on specific rate</td>
</tr>
<tr>
<td>Maryland Hospitals</td>
<td>Payment is based according to the Health Services Cost Review Commission (HSCRC) that is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.</td>
</tr>
</tbody>
</table>
Note also the following claims processing information from CR 7133:

- Claims submitted with the tobacco cessation counseling codes of G0436 and G0437, but which lack a required diagnosis code (305.1 or V15.82) will be denied with Claim Adjustment reason Code (CARC) 167 (This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Health Care Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), Remittance Advice Remarks Code (RARC) M64 (Missing/incomplete/invalid other diagnosis), and Group Code PR assigning financial liability to the beneficiary if a claim is received with a signed Advance Beneficiary Notice (ABN). If no ABN is on file, Group Code CO is used to assign financial liability to the provider.
- Claims are accepted for G0436 and G0437 with revenue code 0942 on TOB 12X, 13X, 22X, 23X, 34X, and 85X.
- Claims are accepted for G0436 and G0437 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II under the MPFS.
- Claims are accepted for G0436 and G0437 with revenue code 052X when billed on TOBs 71X or 77X.
- Claims are accepted for G0436 and G0437 with revenue code 0510 when billed by IHS facilities.
- Institutional claims billed on TOBs other than 12X, 13X, 22X, 23X, 34X, 71X, 77X, or 85X will be returned to the provider.
- When claims are denied for exceeding a combined total of eight (8) sessions within a 12-month period, the claims will be denied using CARC 119 (Benefit maximum for this time period or occurrence has been reached.), RARC N362 (The number of days or units of service exceeds our acceptable maximum.), and Group code PR if a signed ABN is on file. A Group Code of CO is assigned if no ABN is on file.

**NOTE:** In calculating a 12-month period, 11 months must pass following the month in which the 1st Medicare covered cessation counseling session was performed.

- Medicare will allow payment for a medically necessary Evaluation and Management (E/M) service on the same date as tobacco cessation counseling, provided it is clinically appropriate. Such E/M service should be reported with modifier 25 to indicate it is separately identifiable from the tobacco use service.

**Additional Information**


If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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Annual Clotting Factor Furnishing Fee Update 2011

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7168
Related CR Release Date: October 15, 2010
Related CR Transmittal #: R2068CP
Related Change Request (CR) #: 7168
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

What You Need to Know
CR 7168, from which this article is taken, announces that for calendar year 2011, the clotting factor furnishing fee of $0.176 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the Average Sales Price (ASP) or Not Otherwise Classified (NOC) drug. Please be sure your billing staffs are aware of this fee update.

Additional Information
The official instruction, CR 7168 issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2068CP.pdf on the CMS Web site.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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Implementation of Errata Version 5010 of Health Insurance Portability and Accountability Act (HIPAA) Transactions, and Updates in 837I, 837P, and 835 Flat Files

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/
Provider Types Affected
This article is for physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), and regional home health intermediaries (RHHIs)), for services provided to Medicare beneficiaries.

Provider Action Needed
CMS issued CR 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA Regulations that the Secretary of the Department of Health and Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an Errata version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P and 835 flat files. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Background
The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective date of the regulation: March 17, 2009;
- Level I compliance by December 31, 2010;
- Level II compliance by December 31, 2011; and
- All covered entities have to be fully compliant on January 1, 2012.


Key Points of CR7202
CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011;
- During the transition period January 2011 - March 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version 5010. From April 2011 to December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions; and
- All Medicare claims processing systems will use appropriate X12 based Flat File layouts for transactions 837I, 837P, and 835, as attached to CR7202. (To review the file descriptions, go to [http://www.cms.gov/Transmittals/downloads/R2090CP.pdf](http://www.cms.gov/Transmittals/downloads/R2090CP.pdf) on the CMS Web site.)
• Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the Errata modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.

• The Errata are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
  o 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (A separate CR will be issued for the 270/271);
  o 005010X221A1 835 Health Care Claim Payment/Advice;
  o 005010X222A1 837 Health Care Claim: Professional;
  o 005010X223A2 837 Health Care Claim: Institutional; and
  o 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

Additional Information
The official instruction, CR 7202 issued to your carrier, A/B MAC, and RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2090CP.pdf on the CMS Web site.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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. CPT only copyright 2009 American Medical Association.

January 2011 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7181 Related Change Request (CR) #: 7181
Related CR Release Date: November 5, 2010 Effective Date: January 1, 2011
Related CR Transmittal #: R2088CP Implementation Date: January 3, 2011

Provider Types Affected
This article is for providers and suppliers submitting claims to durable medical equipment (DME) Medicare administrative contractors (DME MACs), or Medicare regional home health intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries.
Provider Action Needed
This article is based on CR 7181, which provides the January 2011 quarterly update for the DMEPOS competitive bidding single payment amounts. CR 7181 also provides necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes and ZIP codes for the competitive bidding program. The single payment rates for the Round One Rebid of the DMEPOS competitive bidding program are implemented through CR 7181 and are effective January 1, 2011. Be sure billing staff are aware of these changes.

Background
The Medicare DMEPOS competitive bidding program was mandated by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The program’s objectives include:

- Assuring beneficiary access to quality DMEPOS items;
- Reducing the amount Medicare pays for DMEPOS items; and
- Reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items.

The Round One Rebid Competitive Bidding Program will be implemented on January 1, 2011, in Competitive Bidding Areas (CBAs) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando-Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor’s (CBIC) Web site at www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

Key Points of 7181

Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA number. The competitive bidding CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
- 28140 - Kansas City, MO-KS (non-mail order and mail order)
• 28141 - Kansas City, MO-KS (mail order only)
• 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
• 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
• 36740 - Orlando- Kissimmee, FL (non-mail order and mail order)
• 36741 - Orlando- Kissimmee, FL (mail order only)
• 38300 - Pittsburgh, PA (non-mail order and mail order)
• 38301 - Pittsburgh, PA (mail order only)
• 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
• 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

Public Use Files
The competitive bidding zip codes and single payment amounts per product category and CBA are also available on the Competitive Bidding Implementation Contract (CBIC) Web site for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The Competitive Bidding Implementation Contractor (CBIC) Web site can be accessed at http://www.dmecompetitivebid.com/palmetto/cbic.nsf or by visiting http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS Web site. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

HCPCS Code Changes
The following HCPCS codes are changing from “K” codes to “E” codes in the HCPCS file, effective January 1, 2011:
• K0734 is crosswalked to E2622
• K0735 is crosswalked to E2623
• K0736 is crosswalked to E2624
• K0737 is crosswalked to E2625

This change to “E” codes for the aforementioned codes will be reflected in the competitive bidding files and public use files as part of this update.

Instructions for Competitive Bidding Modifiers
HCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The HCPCS modifiers used in conjunction with claims for items subject to competitive bidding, along with their corresponding effective dates are:
• KG – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1; effective 7/1/2007
• KK – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2: effective 7/1/2007
• KU – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3; effective 7/1/2007
• KW – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4: effective 1/1/2008
• KY – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5; effective 1/1/2008
• KL – DMEPOS Item Delivered via Mail; effective 7/1/2007
• KV – DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished as part of a Professional Service; effective 1/1/2008
• KT  – Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Areas and Receives a Competitive Bidding Item; effective 4/1/2008
• J4  – DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished by a Hospital upon Discharge; effective 1/1/2010

The KG, KK, KU, KW, and KY modifiers are modifiers that suppliers must use on claims for beneficiaries residing in CBAs to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. All suppliers, including grandfathered suppliers, should submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are treated as pricing modifiers in the Round One Rebid of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.

Suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258, and A4259) furnished on or after July 1, 2007, (See the MLN Matters article related to CR 5641 at http://www.cms.gov/MLNMattersArticles/downloads/MM5641.pdf on the CMS Web site.) Effective January 1, 2009, the KL modifier changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers should use the KL modifiers on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary’s residence and are obtained from local supplier storefronts. Contract suppliers must use the KL modifier on all claims for the diabetic supply codes identified above that are furnished via mail order.

The KV modifier is to be used to identify claims for items subject to the exceptions provided in regulations at 42 CFR 414.404(b) for certain competitive bid items that can be furnished by physicians and other practitioners who are not contract suppliers in a competitive bidding area. Physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries residing in a CBA must submit the informational KV modifier with claims for items/HCPCS codes in competitive bidding product category 9 (Walkers and Related Accessories), that are appropriately furnished in accordance with this exception to receive payment for these items at the applicable single payment amount. Physicians and practitioners located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries residing in a CBA must also affix the KV modifier to claims submitted for these items.

The KV modifier should not be used by contract suppliers for competitive bidding product category 9, Walkers & Related Accessories, when submitting competitive bidding claims for this category.

Suppliers should submit claims with the KT modifier for non-mail order DMEPOS competitive bidding items that are furnished to beneficiaries that have traveled outside of the CBA in which they reside. This travel modifier must be affixed to competitive bidding claims submitted by non-contract suppliers for traveling beneficiaries residing in CBAs and by contract suppliers in CBAs that are different from the CBA where the traveling beneficiary resides.

Physicians and treating practitioners that are located outside a CBA who furnish walkers and/or related accessories in competitive bidding product category 9 as part of a professional service to traveling beneficiaries must affix the KT modifier, in addition to the KV modifier, to claims submitted for these items.

Non-contract Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that are not located in a CBA should also use the KT modifier on claims for residents with a permanent home address in a CBA. SNF or NF claims that meet the above requirement and are submitted without the KT modifier will be denied.
Claims for mail order competitive bidding diabetic supplies submitted with the KT modifier will be denied. Contract suppliers should submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary’s permanent home address.

**The J4 modifier** is used under the DMEPOS Competitive Bidding Program to denote certain competitively bid items that a hospital can furnish to their patients on the date of discharge without submitting a bid and being awarded a competitive bidding contract. The DME items that a hospital may furnish as part of this exception are limited to: crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. For the Competitive Bidding Program Round One Rebid, the DME competitive bid items that a hospital may furnish as part of this exception are limited to walkers and related accessories. For additional information on this exception, please see (See the MLN Matters® article related to CR 6677 at http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf on the CMS Web site). Hospitals located outside a CBA, who provide walkers and/or related accessories on the date of discharge to traveling beneficiaries residing in a CBA, must also affix the J4 modifier to claims submitted for these items. The J4 modifier should not be used by contract suppliers for the Walkers and Related Accessories competitive bidding product category when submitting competitive bidding claims for this category.

**The KE modifier** (Bid Under Round One of the DMEPOS Competitive Bidding Program for Use With Non-Competitive Bid Base Equipment) was added to the HCPCS file effective January 1, 2009, as a pricing modifier that suppliers must use on all Part B Fee-For-Service claims to identify when the same accessory item can be furnished in multiple DMEPOS Competitive Bidding Program and non-Competitive Bidding Program product categories. For additional information on the use of the KE modifier, please refer to the instructions contained in the MLN Matters® article related to CR 6270 at http://www.cms.gov/MLNMattersArticles/downloads/MM6270.pdf on the CMS Web site. For beneficiaries residing in competitive bid areas, suppliers should not use the KE modifier to identify competitively bid accessories used with competitively bid base equipment. Rather, such claims should be submitted using the appropriate KG or KK modifier.

The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers are denoted in the single payment amount public use charts found under the supplier page on the CBIC Web site: www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Internet.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

**Reminders Regarding the Single Payment Amount**

Under the competitive bidding program, single payment amounts replace the current DMEPOS fee schedule payment amounts for competitive bidding items in CBAs. Medicare will pay contract suppliers 80 percent of the single payment amount for each competitively bid item. The beneficiaries will be responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months.
The changes to the power wheelchair payment rules made by section 3136 of the Affordable Care Act do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the single payment amount for the first three months and 75 percent of the single payment amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount. For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with section 40.3 of Chapter 20 of the Medicare Claims Processing Manual (Pub. 100-04). That manual information is available at http://www.cms.gov/Manuals/downloads/clm104c20.pdf on the CMS Web site. The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Additional Information
The official instruction, CR 7181 issued to your RHHI and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/r2088cp.pdf on the CMS Web site.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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Implementation of the PWK (Paperwork) Segment for X12N Version 5010—Revised
The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Medicare Learning Network (MLN) Matters article, “Implementation of the PWK (Paperwork) Segment for X12N Version 5010,” which was published in the October 1, 2010, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/
Provider Types Affected
This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Provider Action Needed
This article is based on CR 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background
Since 2003, CMS has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the “linkage” between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers:
• Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS Web site.
• Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
• Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
• Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
• Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
• Medicare contractors will allow seven calendar “waiting” days (from the date of receipt) for additional
information to be faxed or ten calendar “waiting” days for additional information to be mailed.
• Submitters must send ALL relevant PWK data at the same time for the same claim.
• If the additional documentation is not received within the seven calendar waiting days (fax) or ten
calendar waiting days for mailed submissions, your contractor will begin normal processing procedures
on your claim.
• Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information
If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone
Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at

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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.

2010 - 2011 Seasonal Influenza (Flu) Resources for Health Care Professionals—Revised
The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Medicare Learning
Network (MLN) Matters article, “2010 - 2011 Seasonal Influenza (Flu) Resources for Health Care Professionals,” which was published in the November 1, 2010, Home Health & Hospice Medicare A Newsline. This MLN Matters article and other CMS articles can be found on the CMS Web site at:
http://www.cms.gov/MLNMattersArticles/

MLN Matters Number: SE1031 Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was revised on October 26, 2010, to include references to MLN Matters® article
#MM7120 (Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season) and to a
new Web-Based Training Module available on Medicare preventive services. All other information is
the same.

Provider Types Affected
All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other
health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration
provided to Medicare beneficiaries
Provider Action Needed
• Keep this Special Edition MLN Matters article and refer to it throughout the 2010 - 2011 flu season.
• Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
• Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
• Don’t forget to immunize yourself and your staff.

Introduction
Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, 5 to 20 percent of Americans catch the seasonal flu, with about 36,000 people dying from flu-related causes. Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

CMS reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu vaccine. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Get the Flu Vaccine, Not the Flu!

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don’t forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don’t forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational Products for Health Care Professionals
CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

1. MLN Matters Seasonal Influenza Articles
• MM7120: Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season at [link]
• SE1026: Important News About Flu Shot Frequency for Medicare Beneficiaries at [link]


2. **MLN Seasonal Influenza Related Products for Health Care Professionals**


• **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at [http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf](http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf) on the CMS Web site.
• **MLN Preventive Services Educational Products Web Page** - This Medicare Learning Network (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page ([http://www.cms.gov/MLNProducts/35_PreventiveServices.asp](http://www.cms.gov/MLNProducts/35_PreventiveServices.asp)) for easy access.

3. **Other CMS Resources**

4. **Other Resources**
The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009 – 2010 flu season:
   • Advisory Committee on Immunization Practices are at [http://www.cdc.gov/vaccines/recs/acip/default.htm](http://www.cdc.gov/vaccines/recs/acip/default.htm) on the Internet.
   • American Lung Association’s Influenza (Flu) Center is at [http://www.lungusa.org](http://www.lungusa.org). This website provides a flu clinic locator at [http://www.flucliniclocator.org](http://www.flucliniclocator.org) on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
   • Other sites with helpful information include:
     - Centers for Disease Control and Prevention - [http://www.cdc.gov/flu](http://www.cdc.gov/flu);
     - Flu.gov - [http://www.flu.gov](http://www.flu.gov);
     - Food and Drug Administration - [http://www.fda.gov](http://www.fda.gov);
     - Immunization Action Coalition - [http://www.immunize.org](http://www.immunize.org);
     - Indian Health Services - [http://www.ihs.gov](http://www.ihs.gov);
     - National Alliance for Hispanic Health - [http://www.hispanichealth.org](http://www.hispanichealth.org);
     - National Vaccine Program - [http://www.hhs.gov/nvpo](http://www.hhs.gov/nvpo);
     - Office of Disease Prevention and Promotion - [http://odphp.osophs.dhhs.gov](http://odphp.osophs.dhhs.gov);
     - Partnership for Prevention - [http://www.prevent.org](http://www.prevent.org); and
Medicare Remit Easy Print (MREP) Enhancement

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7178 Related Change Request (CR) #: 7178
Related CR Release Date: October 8, 2010 Effective Date: January 1, 2011
Related CR Transmittal #: R2064CP Implementation Date: January 3, 2011

Note from Cahaba: This MLN Matters® article applies only to providers using the MREP Software.

Provider Types Affected
This article is for physicians, providers, and suppliers using the MREP Software supplied through Medicare contractors (carriers, fiscal intermediaries (FIs), DME Medicare administrative contractors (DME MACs) and/or Part A/B Medicare administrative contractors (MACs)).

What You Need to Know
CMS announces in CR 7178, the following list of enhancements to the MREP:
- The MREP Demo function has been updated to reflect current functionalities; and
- A report can be run now for Medicare Secondary Payer (MSP) Claims to distinguish the Medicare secondary payments from the primary payments.

If you use the MREP software, be sure to obtain the new version in January and install it to begin benefiting from these enhancements.

Background
CMS developed the free MREP software to enable providers/suppliers to read and print the HIPAA-compliant Electronic Remittance Advice (ERA), also known as Transaction 835. MREP was first implemented in October 2005, and MREP has been enhanced continuously based on requests/comments received from users. These enhancements are based on requests received either through the carriers, MACs, DME MACs or through the CMS MREP Web site.

Additional Information
The official instruction, CR 7178 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2064CP.pdf on the CMS Web site.
If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Web site.

Disclaimer
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News from CMS for Home Health Providers

Outpatient Therapy Cap Values for CY 2011
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: http://www.cms.gov/MLNMattersArticles/

MLN Matters® Number: MM7107 Related Change Request (CR) #: 7107
Related CR Release Date: October 22, 2010 Effective Date: January 1, 2011
Related CR Transmittal #: R2073CP Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on CR 7107, which describes the CMS policy for outpatient therapy caps for Calendar Year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background
The Balanced Budget Act of 1997 set therapy caps, which change annually, for Part B Medicare patients. The Deficit Reduction Act of 2005 allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be $1870. The exceptions process will continue unchanged for the time frame directed by the Congress.

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

**Additional Information**

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

Additional information concerning outpatient therapy services may be found at [http://www.cms.gov/therapyservices](http://www.cms.gov/therapyservices) on the CMS Web site.

**Disclaimer**
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**Reporting of Modifiers and Revenue Codes on Claims for Therapy Services**
The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: [http://www.cms.gov/MLNMattersArticles/](http://www.cms.gov/MLNMattersArticles/)

- **MLN Matters® Number:** MM7170
- **Related Change Request (CR) #:** 7170
- **Related CR Release Date:** November 12, 2010
- **Effective Date:** April 1, 2011
- **Related CR Transmittal #:** R2091CP
- **Implementation Date:** April 4, 2011

**Provider Types Affected**
Institutions that provide outpatient rehabilitation services to Medicare beneficiaries and bill Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs).

**Provider Action Needed STOP – Impact to You**
This CR 7170 creates new edits in Medicare claims processing systems to ensure correct billing of therapy-related codes on institutional claims.

**CAUTION – What You Need to Know**
Claims that report conflicting combinations of these codes will be returned to the provider for correction.

**GO – What You Need to Do**
See the “Background” and “Key Points” sections below for specifics.
**Background**

On Medicare institutional claims, outpatient rehabilitation services are identified by the provider reporting revenue code 042x (physical therapy), 043x (occupational therapy) or 044x (speech-language pathology). Individual procedures are also identified as being provided under an outpatient rehabilitation plan of care by the provider reporting modifier GN (speech-language pathology), GO (occupational therapy) or GP (physical therapy).

During analysis of Medicare claims data for outpatient rehabilitation services, CMS has found that these codes are not always used in a correct and consistent manner. For example, CMS has found outpatient rehabilitation claims that report both a GO and GP modifier for the same service.

These claims represent non-compliant billing by outpatient rehabilitation providers. They also complicate CMS ability to analyze claims data for purposes of Medicare program improvements.

**New Edit in CR 7170**

Medicare contractors will edit to make certain that only one occurrence of modifiers GN, GO or GP are reported on the same service line on all institutional claims.

Any claim that reports more than one of these modifiers on the same line will be returned to the provider for correction.

**Additional Information**


If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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**Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services**

The Centers for Medicare & Medicaid Services (CMS) has provided the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS Web site at: [http://www.cms.gov/MLNMattersArticles/](http://www.cms.gov/MLNMattersArticles/)

- **MLN Matters® Number:** MM7050
- **Related CR Release Date:** November 3, 2010
- **Related CR Transmittal #:** R800OTN
- **Effective Date:** January 1, 2011
- **Implementation Date:** January 3, 2011
**Provider Types Affected**
Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs) for therapy services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

**Provider Action Needed**
This article is based on CR 7050, which announces that Medicare is applying a new Multiple Procedure Payment Reduction (MPPR) to the Practice Expense (PE) component of payment of select therapy services paid under the MPFS. Make sure your billing staff is aware of these payment reductions.

**Background**
Section 3134 of The Affordable Care Act added section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. CMS is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 75 percent payment for the PE.

For therapy services furnished by a group practice or “incident to” a physician’s service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

The reduction applies to the HCPCS codes contained on the list of “always therapy” services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR 7050 as Attachment 1. CR 7050 is available at [http://www.cms.gov/Transmittals/downloads/R800OTN.pdf](http://www.cms.gov/Transmittals/downloads/R800OTN.pdf) on the CMS Web site. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example:

<table>
<thead>
<tr>
<th>Procedure 1 Unit 1</th>
<th>Procedure 1 Unit 2</th>
<th>Procedure 2</th>
<th>Current Total Payment</th>
<th>Proposed Total Payment</th>
<th>Proposed Payment Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work $7.00</td>
<td>$7.00</td>
<td>$11.00</td>
<td>$25.00</td>
<td>$25.00</td>
<td>no reduction</td>
</tr>
<tr>
<td>PE $10.00</td>
<td>$10.00</td>
<td>$8.00</td>
<td>$28.00</td>
<td>$23.50</td>
<td>$10 + (.75 x $10) + (.75 x $8)</td>
</tr>
<tr>
<td>Malpractice $1.00</td>
<td>$1.00</td>
<td>$1.00</td>
<td>$3.00</td>
<td>$3.00</td>
<td>no reduction</td>
</tr>
<tr>
<td>Total $18.00</td>
<td>$18.00</td>
<td>$20.00</td>
<td>$56.00</td>
<td>$51.50</td>
<td>$18 + ($18-$10) + ($20-$8) + (.75 x $8)</td>
</tr>
</tbody>
</table>
Where claims are impacted by the MPPR, Medicare will return a Claim Adjustment Reason Code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a Group Code of Contractual Obligation (CO).

Additional Information
The official instruction, CR 7050, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R800OTN.pdf](http://www.cms.gov/Transmittals/downloads/R800OTN.pdf) on the CMS Web site.

If you have questions regarding this issue, refer to the “Contact Us” page of our Web site and select “Phone Us” under the “Home Health & Hospice (HH+H)” heading to call the Provider Contact Center.

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**News from Cahaba for Home Health and Hospice Providers**

**Important Reminder: Timely Claim Filing Requirements**

Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements for submission of all home health and hospice billing transactions, (Requests for Anticipated Payments (RAPs), claims, and adjustments) to one calendar year after the date of service. In addition, all billing transactions for services furnished prior to January 1, 2010, must be filed no later than December 31, 2010.

Providers need to take steps to ensure that their billing transactions with dates of service from October 1, 2008, through December 31, 2009, are submitted and received by Cahaba by December 31, 2010.

Billing transactions with dates of service on or after January 1, 2010, must be submitted and received by Cahaba within one calendar year after the date of service.

- Example: Date of service 1/15/2010; claim must be received by 1/15/2011. Date of service 3/25/2010; claim must be received by 3/25/2011.

**NOTE:** As indicated in the Medicare Learning Network (MLN) Matters® article, MM7080, the “Through” date of the home health and hospice claim will be used to determine whether the timely filing requirements have been met.

- Example: A claim submitted with a “From” date of 10/01/10, and a “Through” date of 10/31/10, must be received by 10/31/11 to meet timely filing.

For hospice providers, add-on bills (type of bill 815 or 825) are also subject to the timely filing requirements. However, notices of election (NOEs) are not subject to timely filing.
As a reminder, a new receipt date is assigned to RAPs, claims and adjustments that are corrected (F9d) from the Return to Provider (RTP) file. Therefore, it is important to ensure that your billing transactions are corrected from RTP (T B9997 status/location) prior to the timely filing deadline.

Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for “error or misrepresentation” of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.

Resources:
- Change Request 6960: Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months
- Change Request 7080: Timely Claims Filing: Additional Instructions
- Section 6404 of the Patient Protection and Affordable Care Act

For a summary of Medicare timely filing guidelines, and how this change impacts your home health or hospice agency, Cahaba will be offering a Webinar “Timely Filing in 30 Minutes” on Tuesday, December 7, 2010. To register for this event, go to: https://www.cahabagba.com/apps/course_registration/ia/course_summary.jsp?EID=514

CMS Clarification: Physicians Must Date Signatures

We have recently received clarification from the Centers for Medicare & Medicaid Services (CMS) about physician signature dates. CMS has clarified that physicians must sign and date hospice certifications and home health Plan of Cares, verbal orders, and certifications. This changes Cahaba’s long standing policy of accepting a date stamp as proof of timeliness in lieu of a physician dating his/her signature. This change is effective for all claims submitted on or after January 1, 2011, and is based on the following CMS references.

Home Health
- Medicare General Information, Eligibility and Entitlement Manual (Pub. 100-01), Chapter 4, section 30.1 states: “The attending physician signs and dates the POC/certification prior to the claim being submitted for payment.”
- This manual requirement is also addressed in 42CFR 424.22 (D)2 effective 1/1/11, and states: “The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.” The instructions for recertifications are found in this same Part and restates that it “must be signed and dated by the physician who reviews the plan of care.”

Hospice
- Medicare General Information, Eligibility and Entitlement Manual (Pub. 100-01), Chapter 4, section 60 states: “Certification statements must be dated and signed by the physician.”
- This manual requirement is also addressed in 42CFR 418.22 (b)(5) effective 1/1/11 and states: “All certifications and recertifications must be signed and dated by the physician(s).
As we work forward to update our Web site with this information, please keep in mind that this information supersedes previously published material.

System and Provider Contact Center Availability for December
Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). Listed below are the training dates and times for our home health and hospice PCC Customer Service Representatives training sessions.

<table>
<thead>
<tr>
<th>CSR Training Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 15, 2010</td>
<td>10:20 a.m.—1:40 p.m. Central Time</td>
</tr>
<tr>
<td>January 11, 2011</td>
<td>8:20 a.m.—10:40 a.m. Central Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) remains available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. You may also refer to the “Resources for the Most Common Home Health and Hospice Medicare Questions” Web page and the HH+H “Frequently Asked Questions” Web page for assistance.

System Availability
While we celebrate the Christmas holiday with our families, our office will be closed on Thursday and Friday, December 23 and 24, 2010. Our data center has informed us that FISS will not be available either day. In addition, FISS will not cycle December 23 and 24, 2010, which means that claims will not be sent to the Common Working File (CWF) during the nightly cycles. Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on December 23 and 24, 2010. However, the Interactive Voice Response (IVR) unit will be available to providers to check beneficiary eligibility or the status of claims.

You Heard It On The IVR! — New Web Page
When you call Cahaba’s Provider Contact Center (PCC) the Interactive Voice Response (IVR) system provides informational messages telling you about educational events, self-service tools, and Medicare resources. These messages often include information that is difficult to remember or to quickly write down. Therefore, we have developed a new Web page that provides you with the current IVR informational message(s) and past messages.
This allows you quick access to the educational events, tools and resources that may be beneficial for your facility. Links to the “You Heard It On The IVR!” Web page can be found in the list of “Popular Links” on the HH+H main Web page at https://www.cahabagba.com/rhhi/ and on the “Contact Us” Web page at https://www.cahabagba.com/contact.htm under the “Home Health & Hospice (HH+H) column.

Check Out the Changes Made to the Educational Materials Web Page!
To improve awareness and access to educational materials, Cahaba has made a few revisions to the Home Health and Hospice (HH+H) “Educational Materials” Web page at https://www.cahabagba.com/rhhi/education/materials/index.htm. The revisions include:

- **Medicare Overview** — A brief summary of what is offered on the “Medicare Overview” Web page has been added. (https://www.cahabagba.com/rhhi/education/materials/overview.htm)

- **FISS Reference Guide** — An introduction to the guide was added. In addition, as you roll your mouse over the titles of each section, a pop-up displays with a brief summary of each section.
In addition to the online courses, refer to the Home Health and Hospice Quick Reference Tools. These self service tools provide a variety of home health and hospice information to help you understand the Medicare benefit and how Cahaba processes your claims.

Cahaba strives to improve ways to communicate with our providers. Therefore, we welcome your comments and suggestions. If you have feedback about our Web site, please go to http://listmgr.cahabagba.com/subscribe/survey?f=354 to complete our online Web site customer survey.

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**Online Courses** — Instead of one link to all of Cahaba’s online courses, you will find the link “Home Health Online Courses” under the Home Health Agency Educational Materials list, and the link “Hospice Online Courses” under the Hospice Educational Materials list.

**Past Educational Event Handouts** — Click on this link to access the handouts that were provided during past Cahaba educational events (Webinars).

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**Home Health Prospective Payment System (HH PPS) Changes for 2011**

The Centers for Medicare & Medicaid Services (CMS) released the final rule for the HH PPS Rate Update for Calendar Year 2011 to the public on Wednesday, November 3, 2010. You should read the final rule (which is accessible at: http://edocket.access.gpo.gov/2010/pdf/2010-27778.pdf) to ensure you understand the upcoming changes, which will impact your agency during the coming year.

In addition to updating the payment rates for episodes, per visit amounts, non-routine supplies (NRS), Low Utilization Payment Amounts (LUPA) add-on payments, and wage index amounts, the final rule also implements regulations mandated by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), such as the HH PPS outlier policy and face-to-face encounters for beneficiaries receiving home health care. The rule also revises capitalization requirements for home health agencies (HHAs) and adds language to clarify “skilled services”.

Below is a summary of changes that will impact Medicare home health coverage and claims processing for all home health providers effective January 1, 2011.
Updated Certification Requirements
The final rule amended the Code of Federal Regulations, 42CFR Part 424.22 as follows:

- The physician responsible for performing the start of care home health certification must document that a face-to-face (FTF) encounter was performed within 90 days prior to the start of care (SOC) or 30 days after the SOC.
- The encounter must be related to the primary reason for admission to homecare. If the FTF encounter occurred within 90 days of the SOC but is not related to the primary reason for home health, the NPP or certifying physician must have a FTF encounter within 30 days after the SOC.
- The FTF encounter may be performed by either the certifying physician or a qualified non-physician practitioner (NPP). An NPP is defined as a nurse practitioner, clinical nurse specialist as defined in the Social Security Act section 1861(aa)(5) who is working in collaboration with the physician as defined by State law, a certified nurse midwife as defined in section 1861(gg) of the Act, or a physician assistant (as defined in the Social Security Act section 1861(aa)(5)) under the supervision of a physician.
- The FTF encounter may not be performed by either a physician or an NPP whom is employed by or has a financial relationship with the home health agency as defined in section 411.354. Additional information regarding this topic is also accessible in section 424.24.
- The NPP performing the FTF encounter must document the clinical findings of the FTF encounter and communicate those findings to the certifying physician. The certifying physician is responsible for documenting the FTF encounter took place.
- The FTF encounter may be performed through telehealth. This must be performed via Medicare eligible telehealth services. For information on what constitutes Medicare eligible telehealth services, see www.cms.gov/Telehealth
- Documentation of the FTF encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated, and signed by the certifying physician. The documentation must include the date of the encounter, that the condition for which the patient was being treated in the encounter is related to the primary reason the patient requires home care services, and why the clinical findings of the encounter support that the patient is homebound and in need of Medicare covered home health services. The home health agency may not formulate standard language on the certification forms related to the encounter.

These regulations take effect for home health start of care certifications occurring on or after January 1, 2011. As a reminder, all certification documentation, including the FTF encounter documentation, must be signed and dated by the physician before the claim is submitted to Medicare.

HCPCS Codes Submitted on Home Health Claims
The final rule added new HCPCS codes submitted on home health claims when reporting physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and skilled nursing (SN) services.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX1</td>
<td>Services performed by qualified physical therapist assistant (PTA) in home health setting, each 15 minutes.</td>
</tr>
<tr>
<td>GXXX2</td>
<td>Services performed by qualified occupational therapist assistant in home health setting, each 15 minutes.</td>
</tr>
<tr>
<td>GXXX3</td>
<td>Services performed by qualified physical therapist, in home health setting, in establishment or delivery of safe &amp; effective therapy maintenance program, each 15 minutes.</td>
</tr>
<tr>
<td>GXXX4</td>
<td>Services performed by qualified occupational therapist, in home health setting, in establishment or delivery of safe &amp; effective therapy maintenance program, each 15 minutes.</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GXXX5</td>
<td>Services performed by qualified speech-language pathologist, in home health setting, in establishment or delivery of safe &amp; effective therapy maintenance program, each 15 minutes.</td>
</tr>
<tr>
<td>GXXX6</td>
<td>Skilled services by licensed nurse, in delivery of management &amp; evaluation of POC, or observation &amp; assessment of patient’s condition while patient’s treatment regime is stabilized, in home health setting, each 15 minutes.</td>
</tr>
<tr>
<td>GXXX7</td>
<td>Skilled services by licensed nurse, in training and/or education of patient or family member, in home health setting, each 15 minutes.</td>
</tr>
</tbody>
</table>

CMS agreed with industry feedback that a G-code for services for the management and evaluation of the plan of care (GXXX6) should be separate from a G-code for the services for the observation and assessment of a patient’s condition while a patient’s treatment is stabilized. Therefore, separate G-codes will be adopted.

A Change Request (CR) detailing the specific new codes for use by HHAs will be issued by CMS.

**Outlier Payments**

The ten percent provider specific cap for home health outlier payments that was implemented in 2010, remains in effect for 2011. For more information about this topic, please see Medicare Learning Network (MLN) article, MM6759. In addition, total outliers paid under HH PPS may not exceed 2.5 percent of total projected/estimated HH PPS payments.

**Therapy Services**

The following clarifications regarding therapy services in the home health setting will go into effect on April 1, 2011. Please note that **these requirements apply separately to each therapy service** for which the beneficiary is receiving home health services.

- A qualified therapist must make an assessment visit every 30 days.
- Unless exceptional circumstances are documented or the beneficiary receiving therapy services in the home health setting is in a rural area, an assessment performed by a qualified therapist must also occur on the 13th and 19th visit.
  - If exception/rural criteria is met, the therapist may visit between the 10th-13th visits and 16th-19th visit.
- Treatment goals must be objective. Re-assessments at each point above must document objective progress towards the treatment goals.
- If the above requirements are not met, **no Medicare payment** can be made for the therapy services.

CMS also clarified that therapy services not requiring a qualified therapist to perform or supervise them are not considered to be reasonable and necessary. If a qualified therapist, who meets the requirements of his or her state practice act, performs wound care that does not require the specialized skills of a therapist, and could be routinely performed by agency nursing staff, these services would not be covered therapy services under the Medicare home health benefit. As part of the overall final rule, this clarification in therapy wound care is effective January 1, 2011.
To further assist HHAs in understanding these changes and their impact on Medicare-covered home health services, Cahaba will be offering a Webinar, “2011 Home Health Prospective Payment System (HH PPS) Medicare Updates” on Friday, December 17, 2010. Administrators, clinicians, and billing staffs of HHAs are encouraged to attend this event by registering at https://www.cahabagba.com/apps/course_registration/ia/course_summary.jsp?EID=516

Recertification of Alzheimer’s Disease Care Problematic in HH Medical Review
Each quarter, Cahaba performs an analysis of the current medical review edits. One current edit, 5THCC, will continue to select non-start of care claims with a primary diagnosis of Alzheimer’s disease, as a result of the continuing errors. The denial rate from July 1, 2010, through September 30, 2010, was over 92 percent based on dollars denied.

Top Denial Reason
The most problematic issue identified was that the documentation for the skilled nurse visits did not support medical necessity. To be covered as skilled nursing services, the services must require the skills of a nurse, and must be reasonable and necessary to the treatment of the patient’s illness or injury. Observation and assessment of the patient’s condition are reasonable and necessary skilled services when the likelihood of change in a patient’s condition requires a skilled nurse to identify and evaluate the patient’s need for possible modification in the patient’s Plan of Care (POC) until the patient’s treatment regimen is essentially stabilized. Indications such as abnormal/fluctuating vital signs, weight changes, or edema and respiratory changes may justify further observation and assessment. Where these indications are such that it is likely that skilled observation and assessment will result in changes to the treatment of the patient, the services would be covered. Observation and assessment by a nurse is not reasonable and necessary where these indications are part of a longstanding pattern of the patient’s condition, and there is no attempt to change the treatment to resolve them.

Supportive Documentation of Medical Necessity
Although the topics of the edits are driven by a diagnosis, the denials were not due to “coding”. The entire medical record is reviewed for qualifying technical components and overall medical necessity. For the skilled service of observation and assessment to be covered by Medicare, there must be clear documentation of the patient condition that warrants this service. Typically, this is clear through documentation of changes in diagnosis, exacerbations, medication or treatment changes that continue to put the beneficiary at risk for further plan of care changes. The Medicare Benefit Policy Manual (CMS Pub 100-02), Ch. 7, §40.1.2.1, states that when observation and assessment are supported, Medicare allows 21 days of covered nursing services. Since these claims are greater than 120 days, there is a higher incidence of error and denial of services. Nursing may continue observation and assessment when there have been continued changes and risks for further need to change the POC, but there is no “21 day window” after start of care. Ongoing assessment is based on the clinician’s judgment and documentation.

The second reason for denial was related to the POC. Please ensure your agency is documenting clearly the complete order, including frequency, duration, discipline and modalities prior to providing services. The POC and all service orders must be signed and dated by the physician before submitting the final claim. For additional references, refer to the Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7 and/or the OASIS C Manual, Chapter 3.
Changes in the Hospice Certification Process Effective January 1, 2011
The Centers for Medicare & Medicaid Services (CMS) released a Final Rule to the public on Wednesday, November 3, 2010, titled “Home Health Prospective Payment System Rate Update for Calendar Year 2011” which also included updated certification requirements for hospice services, effective January 1, 2011. The final rule amended the Code of Federal Regulations, 42CFR Part 418 as follows:

- Hospice certifications may be completed no more than 15 calendar days prior to the effective date of election.
- Hospice recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.
- All hospice certifications must contain the benefit period dates.
- The certifying hospice physician or hospice nurse practitioner (NP) must have a face-to-face (FTF) encounter with each hospice patient no more than 30 calendar days prior to the beginning of the 3rd benefit period and each subsequent recertification thereafter to gather clinical findings to determine continued eligibility for hospice care.
- Hospices that admit a patient who previously received hospice services (from the admitting hospice or from another hospice) must consider the beneficiary’s entire Medicare hospice stay to determine in which benefit period the patient is in, and whether a FTF encounter is required.
- The physician or NP who performs the FTF encounter must attest in writing that he or she had the FTF encounter, including the date of the visit. The attestation of the NP must state that the clinical findings of the visit were provided to the certifying physician.
- The FTF attestation must be signed and dated by the individual who performed the visit and must be a separate distinct section of the certification, or a clearly titled addendum to the certification.
- The certification, physician narrative and attestation, and FTF encounter and attestation must all be completed by the same physician, except in the circumstance where a hospice NP performs the FTF visit. The narrative must include an explanation of why the clinical findings of the FTF encounter support a life expectancy of six months or less.
- The FTF may occur at the patient’s home or the patient may come to the hospice physician/NP. However, if travel to the hospice physician/NP does not optimize patient comfort, and/or meet the goals and needs of the patient and family, the hospice physician/MP must travel to the patient. Ambulance transports to conduct the FTF are not separately reimbursable.

The face-to-face encounter requirements are in effect for beneficiaries who begin their 3rd or subsequent benefit period on or after January 1, 2011. The FTF encounter is considered an administrative function and is not billable unless medically reasonable and necessary care related to the hospice terminal diagnosis was provided during the visit. As a reminder, an NP may only bill covered services when he/she is designated as the patient’s attending physician. Telehealth visits are not allowed as a substitution for an in-person visit with the hospice physician or NP.

To ensure that you have a thorough understanding of this new regulation, please read the instructions provided in the Final Rule, which can be viewed at: [http://edocket.access.gpo.gov/2010/pdf/2010-27778.pdf](http://edocket.access.gpo.gov/2010/pdf/2010-27778.pdf)
Cahaba will be sponsoring a Webinar, titled “Hospice Update for 2011: Face-To-Face Recertifications” to educate hospice providers on this topic. The Webinar will be held December 16, 2010, from 1:00 – 2:00 p.m. Central Time. For more information, or to register for this event, go to the Cahaba ‘Calendar of Events’ Web page. Registration deadline is December 13, 2010.

Hospice Plan of Care—Coverage and Payment Criteria
When performing claims review, Medical Review (MR) staff review the documentation submitted to determine if all coverage and payment requirements are met. MR staff has noticed that frequently, hospice plans of care do not meet the coverage and payment criteria as set forth in the Code of Federal Regulations (CFR) Chapter 42, section 418.56.

For an individual to receive covered hospice services, the hospice must develop an individualized written plan of care (POC) for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs, as such needs relate to the terminal illness and related conditions. The hospice must designate an interdisciplinary group (IDG) of individuals who work together to meet the patient’s and family’s needs. The interdisciplinary group must include, but is not limited to, a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The entire IDG must review, revise and document the individualized plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient’s updated comprehensive assessment and must note the patient’s progress toward outcomes and goals. Payment may not be made unless all these requirements are met and documented clearly.

The most frequent documentation errors found include no IDG meeting notes submitted, no signatures/credentials of staff present at IDG meetings, and no POC updates documented every 15 days, or documentation does not support that all four required disciplines reviewed the POC.

If your claim is developed for additional information (i.e., additional development request [ADR]) for medical review, please review the reason code message carefully to determine what documentation you need to submit. Among other information requested, each reason code will request that you send the plan of care, all plan of care updates, and all IDG meeting notes that cover the entire billing period under review. Please send updates/meeting notes even if the POC update or IDG team meeting occurred before the start of the billing period under review, if the updates/meetings pertained to the dates of service under review. If this information is not sent, your claim may be denied.

For more information on hospice plan of care requirements, see 42CFR 418.56.
Widespread Hospice Edit Continues to Find Errors

Each quarter, the Medical Review department evaluates the current edits to ensure they continue to be effective in selecting the most vulnerable claims. Last quarter, from July 1 - September 30, 2010, one widespread hospice edit reviewed was 5011T, which had a denial rate of nearly 63 percent. This edit selects claims where the length of service is greater than 240 days, and the primary hospice diagnosis is 294.8 - Organic Brain Syndrome (OBS). This edit was initiated in 2007, and remains a problem for providers consistently with the top denial reason of “Six-month terminal prognosis not supported in the documentation.”

Patients with OBS may be appropriate for hospice, but it is the hospice agency’s responsibility to ensure the documentation supports the six month prognosis. Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary’s life expectancy is six months or less. Review the following for guidance to ensure sufficient documentation.

Supporting Documentation

The top denial reason, 5PTER, is related to the common obstacle of documenting a six-month terminal prognosis. The Centers for Medicare & Medicaid Services (CMS) Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, states an individual is eligible for the Medicare hospice benefit when that individual has a terminal illness with a life expectancy of six months or less if the terminal illness runs its normal course. Documentation is essential in “painting the picture,” especially for patients that have remained on the hospice benefit for an extended length of time, or for patients that have chronic illnesses or general decline. These diagnoses alone may not support a six-month or less life expectancy; therefore, documentation is depended upon to show why the patient is hospice appropriate. The local coverage determination (LCD), “Hospice - Determining Terminal Status” L13653, is helpful in identifying guidelines for hospice coverage for patients, and provides some documentation suggestions. Cahaba also provides a “Hospice Documentation Tool” to assist providers in improving their documentation. The patient’s appropriateness for the hospice benefit must be clearly supported in the medical record from admission and throughout the hospice care provided.

For additional information, refer to the Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9. Please review these resources and tools and share with staff in your education of coverage and of documentation.

Hospice Certifications

The second denial reason was 5PCER. Denials received by providers for 5PCER were related to missing, incomplete or untimely certifications. An individual is eligible for the Medicare hospice benefit when the hospice agency obtains a valid physician’s certification stating that the patient has a terminal illness with a life expectancy of six months or less if the terminal illness runs its normal course.

For the first 90-day period of hospice coverage, the hospice must obtain a certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual’s attending physician if the individual has an attending physician.

For subsequent periods, the certification statement must be obtained from the medical director of the hospice or the physician member of the hospice’s interdisciplinary group. If the hospice cannot obtain the written certification within two calendar days of the beginning of the certification period, the hospice must obtain verbal certification within the two days. The certification must be signed and dated by the physician(s) prior to billing of the claim.
Since October 2009, hospices have also had to obtain a narrative statement from the physician upon certification and recertification. This must be completed by the physician, and be narrative in format, avoiding “canned language” or checkboxes. The certification must also contain a statement from the certifying physician attesting that the narrative was composed by him/her.

For information about changes to the hospice certification process, refer to the above article entitled, “Changes in the Hospice Certification Process Effective January 1, 2011”.

Documentation notes from multiple disciplines involved in the care of the client should demonstrate a picture of the beneficiary's terminal progression. Avoid vague statements such as “slow decline” or “disease progressing” that do not clearly support the terminal progression requirements; the more objective the documentation, the better.

Please ensure that all of your hospice staff has a working knowledge of the Hospice LCD and continue to consistently support the need for hospice services in their documentation to avoid this denial reason for the continuing widespread edit. The Hospice LCD “Hospice – Determining Terminal Status” can be accessed from the CMS Web site, via the Cahaba’s “Active Local Coverage Determinations” Web page.
December 2010 Education Events

To register for educational events, go to the “Calendar of Educational Events” page on our Web site. Select the event title for registration instructions.

- **“Timely Filing in 30 Minutes” Webinar**
  - **Date:** December 7, 2010
  - **Time:** 12:00 to 12:30 p.m. Central Time
  - **Registration Deadline:** December 2, 2010
  - **Intended Audience:** Home health and hospice billing and financial staff, and administrators.
  - **Description:** This webinar will provide a summary of the recent changes affecting Medicare timely filing guidelines, and discuss how this change impacts your home health or hospice agency.

- **“Home Health Supplies in 30 Minutes” Webinar**
  - **Date:** December 16, 2010
  - **Time:** 12:00 to 12:30 p.m. Central Time
  - **Registration Deadline:** December 13, 2010
  - **Intended Audience:** Home health agencies, including clinicians, administrators, and billing staff.
  - **Description:** This 30 minute webinar will discuss coverage and billing of supplies provided to Medicare beneficiaries and reimbursed under the Home Health Prospective Payment System (HH PPS).

- **“Hospice Update for 2011: Face-To-Face Recertifications” Webinar**
  - **Date:** December 16, 2010
  - **Time:** 1:00 to 2:00 p.m. Central Time
  - **Registration Deadline:** December 13, 2010
  - **Intended Audience:** Hospice agency physicians, administrators and clinicians.
  - **Description:** This webinar will review the new regulation which mandates a face-to-face encounter occur to determine continued eligibility for the Medicare hospice benefit. This requirement was published in the Home Health Prospective Payment System Rate Update for Calendar Year 2011 Final Rule.
“2011 Home Health Prospective Payment System (HH PPS) Medicare Updates” Webinar
Date: December 17, 2010
Time: 12:00 to 2:00 p.m. Central Time
Registration Deadline: December 14, 2010
Intended Audience: Home health agency staff, including clinicians, administrators, and billing staff.
Description: This webinar will review the coverage, billing, and claims processing changes impacting Medicare home health services as set forth in the Home Health Prospective Payment System Rate Update for Calendar Year 2011 Final Rule, including the revised requirements to home health certifications necessitating a face-to-face encounter, new HCPCS codes submitted on home health claims, and clarifications regarding therapy services provided in the home health setting.

“Hospice Certification in 30 Minutes” Webinar
Date: December 28, 2010
Time: 12:00 to 12:30 p.m. Central Time
Registration Deadline: December 21, 2010
Intended Audience: Hospice agencies, including clinicians, administrators and QI staff.
Description: This 30 minute webinar will discuss the components and timeliness for a compliant certification under the Medicare hospice benefit.

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