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Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2009 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
Eculizumab update

Effective March 1, 2012, ICD.9 code 283.11 has been added as a covered indication for this drug in CMS Jurisdiction J15 A/B MAC.

To view the Chemotherapy and Biological policy (L31836)


Chiropractic Services

The J15 LCD for Chiropractic Services (L31862) has been revised for both Part A and Part B in the states of KY and OH to clarify the use of modifiers when billing these services.

Please refer to the ‘Indications and Limitations of Coverage’ section of the LCD for these updates.

Use of Modifiers

Services rendered for covered acute conditions shall be billed with the -AT modifier.

The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an Advance Beneficiary Notice shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1 and include a GA modifier on the claim indicating that they have properly executed an ABN or in rare instances a GZ modifier on the claim indicating no ABN was issued.

For services other than manual manipulation that are statutorily excluded add the modifier GY. It is not required that you bill these excluded services to Medicare but beneficiaries often request this in order to provide a secondary insurer with a denial notice.

For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Please refer to the CGS web site at http://www.cgsmedicare.com to view the policy.

MM7631 - Revised and Clarified Place of Service (POS) Coding Instructions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means.

As part of Medicare’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network’s Special Edition Article #SE1126, titled “Further Details on the Revalidation of Provider Enrollment Information.”

Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare Administrative Contractors (A/B MACs)) for services paid for under the Medicare Physician Fee Schedule (MPFS). This article also applies to certain services provided by independent laboratories.

What You Need to Know

This article is based on Change Request (CR) 7631. It revises and clarifies national policy for POS code assignment. Instructions are provided in CR7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or Professional Component (PC) and the Technical Component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their
implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper CMS 1500 Claim Form (or its electronic equivalent). While CMS currently maintains the National POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from Calendar Year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in Ambulatory Surgical Centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate – rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of correctly coding the POS. Consequently, CR7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS 1500 Claim Form Items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS.

CR7631 establishes that for all services -- with two (2) exceptions -- paid under the MFPS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the TC of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her office location – POS code 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). “The Medicare Claims
Facility and Non-Facility Payment Assignments

The list of settings where a physician’s services are paid at the facility rate include:
- Inpatient Hospital (POS code 21);
- Outpatient Hospital (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Medicare-participating Ambulatory Surgical Center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS code 24);
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24);
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).

Physicians’ services are paid at non-facility rates for procedures furnished in the following settings:
- Pharmacy (POS code 01);
- School (POS code 03);
- Homeless Shelter (POS code 04);
- Prison/Correctional Facility (POS code 09);
- Office (POS code 11);
- Home or Private Residence of Patient (POS code 12);
- Assisted Living Facility (POS code 13);
- Group Home (POS code 14);
- Mobile Unit (POS code 15);
- Temporary Lodging (POS code 16);
- Walk-in Retail Health Clinic (POS code 17);
- Urgent Care Facility (POS code 20);
- Birthing Center (POS code 25);
- Nursing Facility and Skilled Nursing Facilities (SNFs) to Part B residents - (POS code 32);
- Custodial Care Facility (POS code 33);
- Independent Clinic (POS code 49);
- Federally Qualified Health Center (POS code 50);
- Intermediate Health Care Facility/Mentally Retarded (POS code 54);
- Residential Substance Abuse Treatment Facility (POS code 55);
- Non-Residential Substance Abuse Treatment Facility (POS code 57);
- Mass Immunization Center (POS code 60);
- Comprehensive Outpatient Rehabilitation Facility (POS code 62);
- End-Stage Renal Disease Treatment Facility (POS code 65);
- State or Local Health Clinic (POS code 71);
- Rural Health Clinic (POS code 72);
- Independent Laboratory (POS code 81); and
- Other Place of Service (POS code 99).

Special Guidance for Selected POS Codes
CR7631 adds clarifying or special consideration provisions for other settings as well. Those provisions are as follows:

Special Considerations for Mobile Unit Settings (Code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician’s office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner’s office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health Professional Shortage Area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in Section1886(d)(2)(D) of the Social Security Act, the originating physician’s office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

Special Considerations for Walk-In Retail Health Clinic (Code 17) (Effective no later than May 1, 2010)

It should be noted that, while some entities in the industry may elect to use code 17 to track the

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at www.cgsmedicare.com.
setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter 18, Section 10 of the "Medicare Claims Processing Manual" found at http://www.cms.gov/manuals/downloads/clm104c18.pdf on the CMS website. Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special Considerations for Inpatient Hospital (Code 21)
In the case of a physician/practitioner/supplier who provides services to a patient who is an inpatient of a hospital, the inpatient hospital POS code 21 will be used irrespective of the setting where the patient actually receives the face-to-face encounter.

Special Considerations for Outpatient Hospital (Code 22)
Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital will use POS code 22.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department will use POS code 22 (Outpatient Hospital) unless the physician maintains separate office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42 C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42 C.F.R. 413.6. Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special Consideration for Ambulatory Surgical Centers (Code 24)
When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

NOTE: Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the “distinct entity” criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time – and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at http://www.cms.gov/manuals/Downloads/som107ap_I_ambulatory.pdf on the CMS website.

Special Considerations for Hospice (Code 34)
When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an “inpatient” respite or general “inpatient” care stay, the POS code 34 (hospice) will be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) will be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner’s office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient’s physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient’s “home,” where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating “houses” or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient’s independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Additional Information
The official instruction, CR7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2407CP.pdf on the CMS website.

If you have any questions about the correct POS code to use, please contact your carrier or A/B.
MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

News Flash: It’s Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

LCD for Scanning Computerized Ophthalmic Revised

Effective March 1, 2012 the CGS Scanning Computerized Ophthalmic LCD for KY and OH (L31897) has been revised to include ICD.9 code 379.27 as a covered diagnosis.

Please refer to the CGS Web site at: http://www.cgsmedicare.com to view the policy.

Denosumab (Prolia, Xgeva) Update

Correction to previous article, effective January 01, 2012, ICD.9 code 733.09 has been added as a primary code and ICD.9 codes 174.0-174.9, 175.0-175.9, and 185 have been added as secondary codes when billing Denosumab J0897

To view the Chemotherapy and Biological policy (L31836) and the article for Iron Sucrose (A50747).

Please refer to the CGS Web site at: http://www.cgsmedicare.com

1st Quarter 2012 Medical Review FAQs

The following items represent a variety of questions the Medical Review department has received. At least quarterly, CGS will address “Frequently Asked Questions” related to coverage and local medical review policy issues. Providers may submit questions to CGS through the Part B Online Help Center

Radiology and Imaging Services

▪ When submitting documentation please remember to include:
▪ Order (while a physician’s order is not required to be signed, he/she must clearly document in the medical record his/her intent that the test be performed
▪ Properly SIGNED interpretation of the service
▪ Medical Necessity of Services
  o No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
  o Medical necessity is evidenced not only by correct ICD-9 coding but also by clinical documentation in the patient’s medical record supporting the diagnosis and the need for the test.
▪ If subsequent or repeat testing is required, documentation must support the reasons why the initial tests were insufficient or why the serial progression of the test was required (i.e. CT first then MRI or HRCT then PET scan for SPN).

REMEMBER: As the interpreting or intervening radiologist and the party billing Medicare, it is part of your physician’s participation agreement with Medicare to provide sufficient documentation to determine medical necessity for all billed claims. This requirement is no different for radiologists than any other specialty or provider.

Does CGS allow the status of 3 or more chronic conditions as an extended HPI with the 1995 exam guidelines?

The CMS 1995 E/M documentation guidelines list: “An extended HPI consists of four or more elements of the HPI. The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.”

CGS uses the CMS guidelines when determining a correct code.
The following questions concern the use of a past office note for an admission.

1. Can a previous office note be used for a current admission to hospital when the patient is being admitted for planned drug initiation (for example - amio bx)?
2. The office note may be recent or w/in last month.
3. How much needs to be updated/documented on this past note to be able to use it as a current admit note.


Question regarding incident to requirements in the office.
An established patient is seen by the nurse practitioner for an established problem where the plan of care has been documented in the chart by the physician on a prior visit. The established problem requires a medication change during his follow-up visit with the NPP. Can this still be billed as incident to since the NPP is changing the treatment plan by making a medication change?

Yes, since the MD established the POC and the NP is managing it for an established visit but the patient complains if a new symptom requiring new work up—even if it ends up being the same issue (like severe migraines that after work up are found to be related to hypertension that was already being treated) then this is a new POC and not incident to...changing the meds for a known issue under a known plan of care is acceptable for billing incident to.

Signature requirements – Does the physician have to sign off on the NPP note if billed incident to and billed under the physician?
If it is within the scope of practice for an NP or a PA to write med orders then an MD does not need to sign off.

Proper Billing of E&M Codes for Doctors of Chiropractic Medicine
One question that arose during the ACT call led was not clearly and properly addressed. The issue regarding the billing of E&M codes took some research and CGS would like to resolve any confusion on this matter.

The CPT® Manipulation codes have a built in pre-service that includes the following: “A brief evaluation of the patient, including a review of symptoms and a focused examination of the problem and related areas”. Therein it is not proper to bill an E&M code when the intent to service is for Chiropractic manipulation only.

If a Doctor of Chiropractic Medicine wishes to provide an E&M visit for the purpose of considering other treatment modalities which Medicare statutorily does not allow for reimbursement to Chiropractors, then an added E&M may be billed to the beneficiary.

If an E&M visit is billed to the patient an ABN is not required as this is a statutorily excluded service for DC’s. Nonetheless it would be prudent to advise the patient that Medicare does NOT require an E&M visit prior to chiropractic manipulation and that the E&M charge is for the purpose of consideration of other therapy. If a patient demands that the E&M visit be billed to Medicare make sure the modifier –GX is appended if an ABN is signed or –GY if no ABN is signed.

What is a Pre-Pay Review?
Any provider who bills the Medicare Trust fund may be selected for a pre-pay review when certain screening criteria are met (e.g. atypical billing patterns are identified) or when a particular kind of problem is identified (i.e. errors in billing a specific type of service, errors on post payment review).

Prior to turning on a widespread prepay edit an article will be published on the CGS website and listserv, alerting providers what CGS will be looking at and why.

A widespread pre-pay review then begins with the creation of a claims system stop edit that encompasses a range of CPT codes with a specific date range. Affected providers are notified that their claims have been suspended and are requested to submit clinical notes/documentation to support the medical necessity and reasonableness of the claim. The medical records requests are sent through the standard Automated Documentation Request (ADR) system.

CGS may use pre-pay review on an individual basis when a provider meets certain criteria that indicate a risk to the Trust fund. A similar process occurs in this setting.

Your role as a Medicare provider is to submit ALL necessary documentation (to include Medicare approved signatures) to support ALL services billed for those claims that have been suspended.

Furnishing Documentation to Support Medicare Services
For any item to be covered by Medicare, the patient’s medical record must contain sufficient information about the patient’s medical condition to substantiate the necessity and reasonableness of consideration for payment.
for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information, as applicable, such as duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature, and results, past experience with related items, etc. For selected claims, the MAC Contractor may request this information from you in order to verify that Medicare coverage criteria have been met.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule permits disclosure of protected health information without beneficiary authorization when necessary to carry out treatment, payment, or health care operations. The CERT and MAC Contractors perform health care operations as agents of the Centers for Medicare and Medicaid Services (CMS). Providing the requested documentation is in keeping with the HIPAA Privacy Rule. PLEASE NOTE: PHI should never be sent by email unless encrypted as prescribed by the CMS security requirements.

Finally, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act mandates that:

[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

MM7688 - Immediate Recoupment for Fee for Service Claims Overpayments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means.

As part of Medicare’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network’s Special Edition Article #SE1126, titled “Further Details on the Revalidation of Provider Enrollment Information.”

Note: This article was revised on February 10, 2012, to reflect the revised CR7688 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7688 were revised. All other information is the same.

Provider Types Affected
This MLN Matters® article is intended for all Part A, and all Part B Providers, Physicians, and Suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) Durable Medical Equipment (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7688 is policy that implements a standard “immediate recoupment” process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the Key Points section of this article for specifics.

Background
Currently, Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key Points
The “immediate recoupment” process implemented in CR7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.
Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment. Also, note the following:
1. Providers who choose immediate recoupment must do so in writing to the contractors.
2. The request may be for:
   a. a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
   b. a permanent request for the specific demanded overpayment and all future overpayments.
3. The request may be submitted via regular mail, facsimile, or e-mail and the request must include the Provider’s name, contact phone number, Medicare number and/or National Provider Identifier (NPI), Provider or Chief Financial Officer’s signature, demand letter number and what option the provider is requesting.
4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.
5. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after Qualified Independent Contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision.

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

SE1205 - Updating Beneficiary Information with the Coordination of Benefits Contractor

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found here. Alternatively, these FAQ items can be found by visiting http://questions.CMS.hhs.gov/ and searching for “PCIP” or “Primary Care Incentive Payment.”

Provider Types Affected
This MLN Matters® Special Edition Article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

Provider Action Needed

STOP – Impact to You
A new Medicare Secondary Payer (MSP) initiative will affect how you may update beneficiary information to the Coordination of Benefits Contractor (COBC).

CAUTION – What You Need to Know
This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the COBC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare’s Common Working File (CWF).

GO – What You Need to Do
You should make sure that your appropriate staffs are aware of these options for updating a beneficiary’s MSP information.

Background
There has been considerable discussion about
the accuracy of beneficiary Medicare Secondary Payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the COBC by phone.

Therefore (as noted below), CMS and the COBC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

**CMS Initiatives**

In compliance with Section 111 of the Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both Group Health Plans (GHP) and Non Group Health Plans (NGHP)) submit coverage information to the COBC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a Responsible Reporting Entity (RRE), and the COBC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records.

This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the COBC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the COBC. To reduce such conflicts in the future, CMS has developed and implemented a data management “Reporting Hierarchy” process, which the COBC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found at http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf on the CMS website.

**COBC Initiatives**

The COBC works closely with GHP RREs and other reporters in order to reduce “hierarchy” conflicts in future reporting. The following steps are in place to help providers update MSP records:

- **Provider attempting update with the beneficiary in the office:**
  The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are available: 1) Proof of information can be faxed or mailed on the insurer or employer’s company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.

- **Provider attempting update when the beneficiary is not in the office:**
  No update will be made from a telephone call. The provider has 3 options to have the record updated:
  1) Have the Beneficiary contact COBC;
  2) Contact the Beneficiary’s insurer to resolve the issue; or
  3) Fax or mail proof of information on the insurer or employer’s company letterhead and the update will be made in 10-15 business days.

- **Provider with new information:**
  The COBC will take new information for a Beneficiary, but if the new information requires changes to an existing record, two options are available:
  1) The Beneficiary will need to call to close out the record; or
  2) Fax or mail proof of information on the insurer or employer’s company letterhead and the update will be made in 10-15 business days.

- **Provider update for deceased beneficiary:**
  A SINGLE update can be made by ONE provider for a Deceased Beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

**Additional Information**

An explanation of the GHP RRE Hierarchy rules can be found at http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf on the CMS website.

General information about Mandatory Insurer Reporting is available at http://www.cms.gov/mandatoryinsrep on the CMS website.

The COBC’s contact information is:

**Telephone:**
1-800-999-1118 (8 AM to 8 PM Eastern Time)

**Fax:**
1-734-957-9598 (address the fax to Medicare Coordination of Benefits)

**Mailing address:**
Medicare –Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232
ANSI 5010 Payment Alert

Payment Alert! 5010 is Here. Are you ready? You must comply with this important deadline to avoid delays in payments for Medicare Fee-For-Service (FFS) claims after March 31, 2012. You and your billing and software vendors must be ready to begin processing the Health Insurance Portability and Accountability Act (HIPAA) Versions 5010 & D.0 production transactions by March 31, 2012. Beginning April 1, 2012, all electronic claims, eligibility, and claim status inquiries MUST use Versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version. Paper submissions are not an option!


Contacting a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions is another option. For Part B you can also download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at http://www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Prepare now and be ready for the April 1st, 2012 deadline.

MM7610 - Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services

News Flash – REVISED products from the Medicare Learning Network® (MLN)-

- “Medicare Preventive Services Series: Part 2.” Web-Based-Training Course

Provider Types Affected=
This MLN Matters® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for Medicare beneficiaries.

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

In addition, Medicare will cover High Intensity Behavioral Counseling (HIBC) to prevent STIs. Ensure that your billing staffs are aware of these changes.

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

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

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

A new Healthcare Common Procedure Coding System (HCPCS) code, G0445 (high-intensity...
behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually,

30 minutes), has been created for use when reporting HIBC to prevent STIs, effective November 8, 2011. This code is included in the January 2012 Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE) updates.

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

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

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

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

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

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

Further Details
CMS will cover screening for Chlamydia (86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 (used for combined Chlamydia and gonorrhea testing), gonorrhea (87590, 87591, 87850, 87800 (used for combined Chlamydia and gonorrhea testing), syphilis (86592, 86593, 86780), and hepatitis B (hepatitis B surface antigen) 87340, 87341) with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the CLIA regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. As per the requirements, the presence of V74.5 or V73.89 and V69.8, denoting STI screening and high-risk behavior, respectively, and/or V22.0, V22.1, or V23.9, denoting pregnancy as appropriate, must also be present on the claim for STI services along with one of the procedure codes above.

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

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

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

Coverage for HIBC
CMS will also cover up to two, individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs (G0445) for all sexually active adolescents and for adults at increased risk
High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient’s sexual history which is part of any complete medical history, typically part of an AWV or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

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

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

- 1833(u) (6) Physician Defined.—For purposes of this paragraph, the term “physician” means a physician described in **Section 1861(r)(1)** and the term “primary care physician” means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

- 1833(x)(2)(A)(i) (I) is a physician (as described in Section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

- (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in Section 1861(aa)(5)).

**Billing Reminders**

- Institutional providers should note that coverage requires services be performed in a primary care setting. Consequently, if STI services are billed on Types of Bill (TOB) other than 13X, 14X and 85X (when the revenue code is not 096X, 097X, or 098X), or, if G0445 is submitted on a TOB other than 13X, 71X, 77X, or 85X, payment for the services will be denied using the following:
  - Claim Adjustment Reason Code (CARC) 170 – “Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
  - Remittance Advice Remark Code (RARC) N428 – “This service was denied because Medicare only covers this service in certain settings.”

- When applying frequency limitations to HIBC services, contractors will allow both a claim for the professional service and a claim for the facility fee. Institutional claims may be identified as facility fee claims for screening services if they contain G0445, and TOB 13X or TOB 85X (when the revenue code is not 096X, 097X, or 098X). All other claims should be identified as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71X or 77X, or 85X when the revenue code is 096X, 097X, or 098X).

- Contractors will allow institutional claims, TOBs 71X and 77X, to submit additional revenue lines on claims with G0445. Also, HCPCS G0445 will not pay separately with another
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Medicare Bulletin – GR 2012-04

April 2012

encounter/visit on the same day for TOBs 71X and 77X with the exception of: initial preventive physical claims, claims containing modifier 59, and 77X claims containing diabetes self-management training and medical nutrition therapy services. If HCPCS G0445 is present on revenue lines along with an encounter/visit with the same line-item date of service, contractors will assign group code CO and reason code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Services Payment Information REF), if present.”

• G0445 on institutional claims in hospital outpatient departments (TOB 13X) are paid based on OPPS, in critical access hospitals (TOB 85X, not equal to 096X, 097X, or 098X) based on reasonable cost. HCPCS G0445 with revenue codes 096X, 097X, or 098X, when billed on TOB 85X Method II is paid based on 115 percent of the lesser of the MPFS amount or submitted charge.

• Medicare will enforce the frequency requirement for STI services, as mentioned above. Medicare will deny line items that exceed the coverage frequency requirements using the following:
  o CARC 119 – “Benefit maximum for this period or occurrence has been reached.”
  o RARC N362 – “The number of days or units of service exceeds our acceptable maximum.”

• Medicare will deny line items on claims submitted for screening for STIs if the claim lacks the appropriate ICD-9-CM code as mentioned earlier. Such services will be denied payment using:
  o CARC 50 – “These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
  o RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a specific item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

• The presence of ICD-9 code V74.5 or V73.89 identifies STI laboratory tests as screening lab tests payable under CR7610 rather than as diagnostic tests.

• Screening for STIs must be ordered by a primary care provider, and HIBC services, G0445, must be performed by a primary care provider in a primary care setting, with one of the following specialty codes:
  o 01 – General Practice
  o 08 – Family Practice
  o 11 – Internal Medicine
  o 16 – Obstetrics/Gynecology
  o 37 – Pediatric Medicine
  o 38 – Geriatric Medicine
  o 42 – Certified Nurse Midwife
  o 50 – Nurse Practitioner
  o 89 – Certified Clinical Nurse Specialist
  o 97 – Physician Assistant

• STI screenings ordered by other than the above types of providers will be denied payment when submitted on professional claims using:
  o CARC 184 – “The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
  o RARC N95 – “This provider type/provider specialty may not bill this service.”

• Claims for G0445 must be for services performed in the following Places of Service (POS):
  o 11 – Physician Office;
  o 22 – Outpatient Hospital;
  o 49 – Independent Clinic; or
  o 71 – State or local public health clinic.

• Medicare will deny line items for G0445 if performed by other than the above types of providers when submitted on professional claims using:
  o CARC 185 – “The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
  o RARC N95 – “This provider type/provider specialty may not bill this service.”

• Upon full implementation in Medicare systems on July 2, 2012, providers may submit eligibility inquiries in order to identify the next
eligible date that beneficiaries may receive these services.

- Until systems are implemented, contractors will hold institutional claims received before July 2, 2012, with TOBs 13X, 71X, 77X, and 85X reporting HCPCS G0445, or TOBs 13X, 14X, and 85X, when the revenue code is not 096X, 097X, or 098X, for STI services.
- Effective for dates of service on or after November 8, 2011, contractors will not apply deductible or coinsurance to claim lines containing HCPCS G0445, HIBC services.
- Contractors will load HCPCS G0445 to their HCPCS file with an effective date of November 8, 2011.

Additional Information
The official instruction, CR7610, was issued to your FI, carrier and A/B MAC regarding this change via two transmittals. The first updates the “Medicare Claims Processing Manual” and it is at http://www.cms.gov/Transmittals/downloads/R2402CP.pdf on the CMS website. The second transmittal conveys the NCD and it is at http://www.cms.gov/Transmittals/downloads/R141NCD.pdf on the same site.

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

News Flash - It’s Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Revised: MM7641 - Intensive Behavioral Therapy (IBT) for Obesity

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash:
• REVISED products from the Medicare Learning Network® (MLN)

“Medicare Physician Fee Schedule,” Fact Sheet, ICN 006814, Downloadable

Note: This article was revised on March 9, 2012 to reflect the revised CR7641 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR7641 were revised. All other information is unchanged.

Provider Types Affected
This MLN Matters® article is intended for primary care physicians and other primary care practitioners billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in a primary care setting.

Provider Action Needed
STOP – Impact to You
This article is based on Change Request (CR) 7641, which informs Medicare contractors about implementing coverage of Intensive Behavioral Therapy (IBT) for obesity.

CAUTION – What You Need to Know
Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as Body Mass Index (BMI) equal to or greater than 30 kg/m2, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, are eligible for:
• One face-to-face visit every week for the first month;
• One face-to-face visit every other week for months 2-6; and
• One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months.
Medicare coinsurance and Part B deductible are waived for this service.

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

This code was effective November 29, 2011, and will appear in the January 2012 quarterly update of the Medicare Physician Fee Schedule Database (MPFSDB) and the Integrated Outpatient Code Editor (IOCE).

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

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

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

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

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.), over the course of the first 6 months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs.) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

IBT for obesity consists of the following:

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

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

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

Billing Requirements

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

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

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

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

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

Specialty Codes

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

• 01 - General Practice
• 08 - Family Practice
• 11 - Internal Medicine

• 16 - Obstetrics/Gynecology
• 37 - Pediatric Medicine
• 38 - Geriatric Medicine
• 50 - Nurse Practitioner
• 89 - Certified Clinical Nurse Specialist
• 97 - Physician Assistant

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

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

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

Place of Service (POS) Codes

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

• 11 - Physician’s Office
• 22 - Outpatient Hospital
• 49 - Independent Clinic
• 71 - State or local public health clinic.

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

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

**Frequency Limitation**
Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22 limit will be denied using the following codes: (Note: When applying this frequency limitation, a claim for the professional service and a claim for a facility fee will be allowed.)
- CARC 119 – “Benefit maximum for this time period or occurrence has been reached.”
- RARC N362 - “The number of days or units of service exceeds our acceptable maximum.”
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

**Institution Claims Notes**
Claims submitted with either a Type of Bill (TOB) 13X or TOB 85X (where the revenue code is not 096X, 097X, or 098X) will be identified as facility fee service claims.

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

Medicare will pay for G0447 on institutional claims in hospital outpatient departments TOB 13X based on OPPS and in Critical Access Hospitals TOB 85X based on reasonable cost.

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

Medicare will line-item deny any claim submitted with G0447 when the TOB is not 13X, 71X, 77X, or 85X with the following:
- CARC 5 - “The procedure code/bill type is inconsistent with the Place of Service.”
- Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC M77 - “Missing/incomplete/invalid place of service.”
- Group Code PR (Patient Responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file) and
- Group Code CO (Contractual Obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

**Rural Health Clinics and Federally Qualified Health Centers Claims Notes**
Rural Health Clinics, using TOB 71X, and Federally Qualified Health Centers, using TOB 77X, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not applied to this service. Such claims will be paid based on the all-inclusive payment rate.

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 2010 American Medical Association.

For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item DOS, the service line with HCPCS G0447 will be denied with the following messages:
- Claim Adjustment Reason Code (CARC) 97 – “The benefit for this service is included in the payment/allowance for another service/
procedure that has already been adjudicated.

Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present and

• Group Code CO (Contractual Obligation)

Note: Obesity counseling is not separately payable with another encounter/visit on the same day. This does not apply for Initial Preventive Physical Examination (IPPE) claims, claims containing modifier 59, and 77X claims containing Diabetes Self-Management Training and Medical Nutrition Therapy services.

Additional Information


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

News Flash: It’s Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

MM7681 - Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures. (Change Request (CR) 7681 Fully Rescinds and Replaces CR 7177)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found here. Alternatively, these FAQ items can be found by visiting http://questions.CMS.hhs.gov/ and searching for “PCIP” or “Primary Care Incentive Payment.”

Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures. (Change Request (CR) 7681 Fully Rescinds and Replaces CR 7177)

Note: This article was revised on February 10, 2012, to reflect the revised CR7681 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7681 were revised. All other information is the same.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs)) for Advanced Diagnostic Imaging (ADI) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 7681 which fully rescinds and replaces CR7177.

CAUTION – What You Need to Know
CR7177 established that ADI providers/suppliers would need to provide their ADI accreditation information by completing an Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) application
GO – What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

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

MIPPA specifically defines Advanced Diagnostic Imaging (ADI) procedures as including diagnostic Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Nuclear Medicine Imaging (NMI) such as Positron Emission Tomography (PET). The law also authorizes the HHS Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

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

The Centers for Medicare & Medicaid Services (CMS) implemented (effective January 1, 2012) the requirement that ADI providers and/or suppliers must be accredited for ADI services specific to each modality for which they will submit claims. Originally, CMS required the providers/suppliers to provide their accreditation information on their respective CMS-855 form, or through the internet-based PECOS. Change Request (CR) 7681 establishes a new process that allows for ADI providers and/or suppliers to bypass ADI information collection on the appropriate CMS 855 form or in the internet-based PECOS web application. CR7681 instructs that Medicare contractors will:
- Not require documentation from the ADI provider/supplier for proof of their accreditation; and
- Not require providers/suppliers to complete the ADI section in the internet-based PECOS application nor in the appropriate CMS-855 form.

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

Additional Information
The official instruction, CR7681, issued to your carriers and A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R407P1.pdf on the CMS website.

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

News Flash - Flu Season is Here! While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high risk patients, should get vaccinated too. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDDrugAvgSalesPrice/10_VaccinesPricing.asp.

SE1204 - The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services

News Flash – The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved,
providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that the majority of providers respond to the initial demand letter and pay the debt. Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged. If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

Note: This article was revised on February 29, 2012, to add Hawaii and several territories to ZPIC Zone 1 and to add Puerto Rico and the Virgin Islands to ZPIC Zone 7 of the table on page 2. All other information is the same.

Provider Types Affected

This Special Edition MLN Matters® Article is intended for all physicians, providers, and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice (HH+H) MACs for services and supplies provided to Medicare beneficiaries.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services’ (CMS’) ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, Program Safeguard Contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare Fee-For-Service Contracting Reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs). As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare Drug Integrity Contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity (CPI) in CMS.

The following table lists all of the ZPICs and their zones:

<table>
<thead>
<tr>
<th>ZPIC</th>
<th>Zone</th>
<th>States in Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguard Services (SGS)</td>
<td>1</td>
<td>California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>2</td>
<td>Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska</td>
</tr>
<tr>
<td>Cahaba</td>
<td>3</td>
<td>Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky</td>
</tr>
<tr>
<td>Health Integrity</td>
<td>4</td>
<td>Colorado, New Mexico, Texas, and Oklahoma</td>
</tr>
<tr>
<td>AdvanceMed</td>
<td>5</td>
<td>Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia</td>
</tr>
<tr>
<td>Under Protest</td>
<td>6</td>
<td>Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut</td>
</tr>
</tbody>
</table>
Medicare Fraud
Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare Program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare Program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

Contacts for Reporting Potential Fraud
Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800- HHS-TIPS (1-800-447-8477). Providers may report fraud by calling 1-800- HHS-TIPS (1-800-447-8477).

ZPIC Functions
The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:

• Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
• Conducting investigations in accordance with the priorities established by CPI’s Fraud Prevention System;
• Performing medical review, as appropriate;
• Performing data analysis in coordination with CPI’s Fraud Prevention System;
• Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
• Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:
• Request medical records and documentation;
• Conduct an interview;
• Conduct an onsite visit;
• Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
• Withhold payments; and,
• Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf on the CMS website.

Non-ZPIC Functions
The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

• Claims processing, including paying providers/suppliers;
• Provider outreach and education;
• Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
• Medical review not for benefit integrity purposes;
• Complaint screening;
• Claims appeals of ZPIC decisions;
• Claim payment determination;
• Claims pricing; and
• Auditing provider cost reports.

Additional Information

The Medicare Learning Network® (MLN) brochure titled “The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers,”

Florida, Puerto Rico, Virgin Islands
which is designed to provide education on
the Medicare Part A and B administrative
appeals process, is available at http://
www.cms.gov/MLNProducts/downloads/
MedicareAppealsprocess.pdf on the CMS website.

The MLN fact sheet titled “Medicare Fraud &
Abuse: Prevention, Detection, and Reporting,”
which is designed to provide education on
preventing, detecting and reporting Medicare fraud
and abuse, is available at http://www.cms.gov/
MLNProducts/downloads/Fraud_and_Abuse.pdf
on the CMS website.

For the latest educational products designed
to help Medicare Fee-For-Service providers
understand – and avoid – common billing errors
and other improper activities, please visit the MLN
gov/MLNProducts/45_ProviderCompliance.asp
on the CMS website.

News Flash - It’s Not too Late to Give and Get
the Flu Vaccine. Take advantage of each office
visit and protect your patients against the seasonal
flu. Medicare will continue to pay for the seasonal
flu vaccine and its administration for all Medicare
beneficiaries through the entire flu season. The
Centers for Disease Control and Prevention
(CDC) also recommends that patients, healthcare
workers and caregivers be vaccinated against the
seasonal flu. Protect your patients. Protect your
family. Protect yourself. Get the Flu Vaccine—
Not the Flu. Remember: The flu vaccine plus
its administration are covered Part B benefits.
The flu vaccine is NOT a Part D-covered
drug. For more information on coverage and
billing of the flu vaccine and its administration,
and related provider resources, visit 2011-
2012 Provider Seasonal Flu Resources and
Immunizations. For the 2011-2012 seasonal flu
vaccine payment limits, visit http://www.CMS.gov/
McrPartBDrugAvgSalesPrice/10_VaccinesPricing.
asp on the Centers for Medicare & Medicaid
Services (CMS) website.

“Medicare Claim Review Programs: MR, NCCI
Edits, MUEs, CERT, and RAC,” Booklet, ICN
006973, Downloadable

Provider Types Affected
This article is intended for physicians and other
providers who qualify as eligible professionals to
participate in the Centers for Medicare & Medicaid
Services (CMS) Physician Quality Reporting
System reporting and incentive program.

What Providers Need to Know
This article describes claims-based coding
and reporting, and outlines steps that eligible
professionals or practices should take prior to
participating in 2012 Physician Quality Reporting.

For guidance on reporting the electronic
prescribing (eRx) measure, please reference the
Claims- Based Reporting Principles for 2012
Electronic Prescribing Incentive Program at http://
www.cms.gov/ERxIncentive.asp, under the eRx
“Downloads” section of the CMS website.

Background
The Physician Quality Reporting System (Physician
Quality Reporting) is a voluntary reporting program.
The program provides an incentive payment to
practices with eligible professionals (identified on
claims by their individual National Provider Identifier
(NPI) and Tax Identification Number (TIN) who
satisfactorily report data on quality measures for
covered Medicare Physician Fee Schedule (MPFS)
services furnished to Medicare Part B Fee-For-
Service (FFS) beneficiaries (including Railroad
Retirement Board and Medicare Secondary Payer).

Key Points

How to Get Started

STEP 1: Fill Out Claim(s) with Codes for
Reimbursement

STEP 2: Reference Measure Specifications
To ensure accurate application of Physician
Quality Reporting denominator and numerator
codes, reference the 2012 Physician Quality
Reporting System Measure Specifications
available as a download at http://www.cms.gov/
PQRS/15_MeasuresCodes.asp on the CMS
website.

STEP 3: Do a Double Check
CMS encourages eligible professionals to review
their claims for accuracy prior to submission for
reimbursement and reporting purposes.
**STEP 4: Review your Remittance Advice (RA)/Explanation of Benefits (EOB)**
Review your RA/EOB for denial code N365. This code indicates that the Physician Quality Reporting codes were received into the National Claims History.

**Coding and Reporting Principles—tips when reporting via claims**

**Claims-Based Reporting Principles**

Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim.
- Only one diagnosis can be linked to each line item.
- Physician Quality Reporting analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual eligible professional (identified by individual NPI).
- Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient’s care.

All diagnoses reported on the base claim will be included in Physician Quality Reporting analysis, as some measures require reporting more than one diagnosis on a claim.
- For line items containing a Quality-Data Code (QDC), only one diagnosis from the base claim should be referenced in the diagnosis pointer field.
- To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure’s diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in the Physician Quality Reporting analysis.

If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny.
- Physician Quality Reporting analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same Taxpayer Identification Number/National Provider Identifier (TIN/NPI), and analyze as one claim.

- Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.


**Submitting Quality-Data Codes (QDCs)**

QDCs are specified Current Procedural Terminology II (CPT-II) codes (with or without modifiers) and G-codes used for submission of Physician Quality Reporting data. QDCs can be submitted to carriers or A/B Medicare Administrative Coordinators (MACs) either through:

1. **Electronic-based submission** (using the ASC X 12N Health Care Claim Transaction [version 5010]); OR,

2. **Paper-based submission** using the CMS-1500 claim form (version 08-05).

**Principles for Reporting QDCs**

The following principles apply for claims-based reporting of Physician Quality Reporting measures:

1. QDCs must be reported:
   - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B MPFS encounter;
   - For the same beneficiary;
   - For the same date of service (DOS); and
   - By the same eligible professional (individual NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure’s denominator.

2. QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed.
   - The submitted charge field cannot be blank.
   - The line item charge should be $0.00.
   - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount.
   - Entire claims with a zero ($0.00) charge will be rejected.
   - Whether a $0.00 charge or a nominal
This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at www.cgsmedicare.com.

2012 Physician Quality Reporting System

3. When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician’s NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field (#33a on the CMS-1500 form or the electronic equivalent).

Note: Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

Remittance Advice/Explanation of Benefits

The RA/EOB denial code N365 is your indication that the Physician Quality Reporting codes were received into the National Claims History.

- N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.”
- The N365 denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that incentive quotas were met. However, when a QDC is reported satisfactorily (by the individual eligible provider), the N365 can indicate that the claim will be used for calculating incentive eligibility.
- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the carrier or A/B MAC. Each QDC line-item will be listed with the N365 denial remark code.

Timeliness of Quality Data Submission

Claims processed by the carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 22, 2013, to be included in analysis. Claims for services furnished toward the end of the reporting period should be filed promptly.

Additional Information

For more information on reporting measures groups via claims, please see the following resources available as downloads on the Physician Quality Reporting website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.

- 2012 Physician Quality Reporting System Measures Groups Specifications Manual;
- Getting Started with 2012 Physician Quality Reporting of Measures Groups; and

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MM7363 - Additional Provider and Supplier Enrollment Requirements for Fixed Wing and Helicopter Air Ambulance Operators

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – REVISED product(s) from the Medicare Learning Network® (MLN)

- “Medicare Ambulance Services”, Booklet.
In pertinent part Attachment 1 specifies the following additional information is to be submitted with the application:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility; and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner’s name on the FAA 135 Certificate must be the same as the enrolling ambulance company’s name (or the ambulance company owner as reported in Sections 5 or 6) on the application.

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

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

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

Additional Information

The official instruction, CR7363 issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R400PI.pdf on the CMS website.

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

Provider Types Affected

Ambulance suppliers submitting claims for air ambulance services to Medicare Carriers and A/B Medicare Administrative Contractors (A/B MACs) are affected by this article.

Provider Action Needed

This article, based on Change Request (CR) 7363, informs you that, on November 29, 2010, the Centers for Medicare & Medicaid Services (CMS) published a final rule that clarified the reporting requirements for air ambulance suppliers. The rule states that within 30 days of any revocation or suspension of a Federal or State license or certification including Federal Aviation Administration (FAA) certification, an air ambulance supplier must report the revocation or suspension of its license or certification to the applicable Medicare contractor.

Air ambulance suppliers must maintain either directly or through appropriate arrangements, compliance with all applicable Federal and State licenses, and certifications and report the following FAA certifications: Specific pilot certification, instrument and medical certifications, and air worthiness certification.

Background

Medicare contractors must ensure that the air ambulance suppliers remain in compliance with all licensure, and other pertinent Federal and State requirements. The Medicare contractor evaluation process will include an evaluation of all documentation submitted with the CMS 855 B Provider Enrollment Application, and as appropriate, verification with the FAA website.

Attachment 1 to the CMS 855 B Medicare Enrollment Application (Clinics/Group Practices and Certain other Suppliers (07/11) outlines the information that should be submitted with the initial or revalidation air ambulance application. (The 855B application is available at http://www.cms.gov/CMSForms/downloads/cms855b.pdf on the CMS website.)
MM7670 - Claim Status Category and Claim Status Codes Update

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Podcasts from the Thursday, July 21 National Provider Call "The ABCs of the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)" are now available. Short on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smart phone. Two podcasts are now available at http://www.CMS.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1249934 on our website. The 2 audio podcasts for the IPPE and AWV with corresponding written transcripts, as well as the full audio and written transcript of the call can be accessed by scrolling to the "Downloads" section at the bottom of the page.

Note: This article was revised on January 30, 2012, to correct the Web address in the beginning of page 2. All other information is the same.

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

What Providers Need to Know
This article, based on Change Request (CR) 7670, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 were updated during the February 2012 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 2, 2012. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information
If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction, CR7670, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at http://www.cms.gov/transmittals/downloads/R2371CP.pdf on the CMS website.

MM7703 - Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – On November 17, 2011, the Centers for Medicare & Medicaid Services’ Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any Health Insurance Portability and Accountability Act (HIPAA) covered entity that is not in compliance on January 1, 2012, with the ASC X12 Version 5010 (Version 5010), National Council for Prescription Drug Programs (NCPDP) Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS’ discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012. (Small health plans have until January 1, 2013, to comply with NCPDP 3.0.

Provider Types Affected
Physicians, providers, and suppliers submitting professional claims to Medicare contractors
(carriers and/or A/B Medicare Administrative Contractors (A/B MACs)) for providing diagnostic imaging services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 7703 which announces that, effective January 1, 2012, the Centers for Medicare & Medicaid Services (CMS) is discontinuing the use of the “global cap” amount in calculating global payments of certain diagnostic imaging procedures. Medicare implemented the Multiple Procedure Payment Reduction (MPPR) rule on the TC of certain diagnostic imaging procedures effective January 1, 2006, and CR7703 is a reminder that effective January 1, 2012, the MPPR will also be applied to the Professional Component (PC) of such services.

CAUTION – What You Need to Know
The MPPR rule applies to PC-only services, to TC-only services, and to PC and TC portions of global services. Full payment is made for the PC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

GO – What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
The Deficit Reduction Act of 2005 (Section 5102(b); see http://www.govtrack.us/congress/billtext.xpd?bill=s109-1932 on the Internet) provided for capping the payment for the TC of certain diagnostic imaging procedures based on the Outpatient Prospective Payment System (OPPS) payment.

The MPPR rule on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day, and it is applied prior to the application of the OPPS cap. Medicare implemented the MPPR on the TC of certain diagnostic imaging procedures effective January 1, 2006, and effective January 1, 2012, the MPPR is also applied to the PC of such services.

Currently, global services are compared against a “global cap” derived from adding the TC capped amount to the PC. However, with the implementation of the MPPR on the PC, this could result in a situation where, although the global payment amount is lower than the “global cap” amount, the TC is higher than the TC cap amount and is not appropriately being reduced. Therefore, CR7703 announces that CMS is discontinuing calculation and use of the “global cap” amount.

The TC of global services, and TC-only services, will be compared to the OPPS cap amount on the TC to determine the lower of the two.

Full payment is made for the PC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

Additional Information
The official instruction, CR7703, issued to your carriers and A/B MACs, regarding this change, may be viewed at http://www.cms.gov/transmittals/downloads/R1040OTN.pdf on the CMS website.

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

News Flash: It’s Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration
SE1138 - Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates immediately!

Note: This article was revised on January 13, 2012, to correct the last part of the Background Section. That section incorrectly stated that “simply using Not Otherwise Classified as the description does not pass editing and the claim will be rejected”. The claim will not be rejected if “Not Otherwise Classified” is submitted as the description. All other information is unchanged.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

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

The 5010 versions of the institutional and professional claim implementation description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

Background
The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: “Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

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

Additional Information

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1131_pdf on the CMS website.

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

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at www.cgsmedicare.com.
News Flash – The Centers for Medicare & Medicaid Services (CMS) has reevaluated the revalidation requirement in the Affordable Care Act, and believe it affords the flexibility to extend the revalidation period for another 2 years. Revalidation notices will now be sent through March 2015. IMPORTANT: This does not affect providers who have already received a revalidation notice. If you received a revalidation notice from your contractor, respond to that request. Remember, institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) must submit the application fee with their revalidation. CMS will post a list of providers who were sent requests to revalidate on the Medicare Provider-Supplier Enrollment web page. Notification will be sent via a CMS electronic mailing list when this information is posted. If you are signed up for your Medicare contractor’s listserv you will get a notice that way. You may also sign up for a national Fee-For-Service electronic mailing list.

Provider Types Affected
This article is for physicians submitting claims to Medicare Carriers and/or A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

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

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

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

- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and by
- Review of current coding practice.

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

- Column I/Column 2 Correct Coding Edits, and
- Mutually Exclusive Code (MEC) Edits.

Additional information about the CCI, including
the current CCI and Mutually Exclusive Code (MEC) edits, is available at http://www.cms.gov/NationalCorrectCodInitEd on the CMS website.

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

The official instruction, CR7726, issued to your carrier or and A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2384CP.pdf on the CMS website.

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

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

SE1137 - Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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

Note: This article was revised on January 17, 2012, to add a section to clarify Medicare’s capability to cross over HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims to the Coordination of Benefits Agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats. All other information remains unchanged.

Provider Types Affected
This MLN Matters® Special Edition (SE) Article is intended to alert physicians, providers, and suppliers who bill Medicare contractors (Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What Providers Need to Know
Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production Version 4010A1, HIPAA 837 claims to HIPAA Versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their “pre-HIPAA 5010” production Version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

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

NOTE: The same premise will hold for inbound Version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, Version 5.2 batch format for receipt of crossover claims.

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the
following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226—“4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims.”
- N222230—“NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims.”

*To review the entire CR6658, visit http://www.cms.gov/transmittals/downloads/R1844CP.pdf on the CMS website.

*To review the entire CR6664, visit http://www.cms.gov/transmittals/downloads/R1841CP.pdf on the CMS website.

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

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

**Key Points**

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

**Additional Clarification of the Crossover Claims Process**

There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats.

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

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

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

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

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

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

Additional Information
If you have any questions, please contact your Medicare contractor at their toll-free number found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

MM7671 - Summary of Policies in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found here. Alternatively, these FAQ items can be found by visiting http://questions.CMS.hhs.gov/ and searching for “PCIP” or “Primary Care Incentive Payment.”

Note: This article was revised on February 2, 2012, to reflect a revised CR7671 issued on January 18, 2012. The CR was revised to amend language in the summary of the multiple procedure payment reduction and revisions to the practice expense geographic adjustment policies described below in the “Background” section of this article. In addition, the article now reflects a new transmittal number, CR release date, and a revised Web address for accessing the CR. All other information remains the same.

Provider Types Affected
Physicians and non-physician practitioners who submit claims to Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs) are affected by this article.

What You Need to Know
This article is based on Change Request (CR) 7671, which summarizes the policies in the CY 2012 Medicare Physician Fee Schedule Final Rule and announces the Telehealth Originating Site Facility Fee payment amount for CY 2012. Please be sure that your staffs are aware of these changes.

Background
The purpose of this article is to inform you about the CR7671, which summarizes the policies in the CY 2012 Medicare Physician Fee Schedule (MPFS) and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians’ services for the subsequent year.

• The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2012.
The final rule (published in the “Federal Register” on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate notices earlier this year:

- The Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule (published in the “Federal Register” on June 6, 2011), and

The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the “Federal Register” on November 29, 2010).

Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

Updated Policies

Summary of Policies in the CY 2012 Medicare Physician Fee Schedule (MPFS)

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

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

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

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

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

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

Implementation of the 3-day Payment Window Policy in Wholly Owned or Wholly Operated Entities
On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) was enacted. Section 102 of this Act, entitled “Clarification of 3-Day Payment Window,” clarified when certain non-diagnostic services furnished to Medicare beneficiaries in the three days (or, in the case of a hospital that is not a subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the one day) preceding an inpatient admission should be considered “operating costs of inpatient hospital services” and therefore included in the hospital’s payment under the Hospital Inpatient Prospective Payment System (IPPS). This policy is generally known as the “3-day payment window,” and a hospital must include on the inpatient claim for a Medicare beneficiary’s inpatient stay, the technical portion of all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

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

Annual Wellness Visit Providing a Personalized Prevention Plan
The Affordable Care Act provided for Medicare coverage for an Annual Wellness Visits (AWV) providing personalized prevention plan services. The statute required that a Health Risk Assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published “A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries.” This framework includes sections on:
- History of health risk assessments,
- Defining the HRA framework and rationale for its use,
- Use of HRAs and follow-up interventions that evidence suggests can influence health...
As discussed in the preamble to the CY 2012 Physician Fee Schedule Final Rule, we believe it is important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

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

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

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

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

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

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

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

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

**Additional Information**

For more information and access to the CY 2012 Final Rule, go to the “Physician Fee Schedule” available at http://www.cms.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage on the CMS website. The official instruction, CR7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2379CP.pdf on the CMS website.

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

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**MM7701 - Allowing Physician Assistants to Perform Skilled Nursing Facility (SNF) Level of Care Certifications and Recertifications**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – REVISED product from the Medicare Learning Network® (MLN)

“Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants,” Booklet, ICN 901623, Downloadable

Provider Types Affected
SNFs and swing-bed hospitals that bill Medicare contractors (Fiscal Intermediaries (FIs) or A/B Medicare Administrative Contractors (A/B MACs)) for providing Part A SNF services to Medicare beneficiaries are affected.

What Providers Need to Know
This article is based on Change Request (CR) CR7701, which implements Section 3108 of the Affordable Care Act. This section adds physician assistants to the list of practitioners who can perform SNF level of care certifications and recertifications. Performing this function is a requirement for Medicare coverage of SNF services under Part A.

CR7701 directs Medicare contractors to recognize that, effective with services furnished on or after January 1, 2011, physician assistants can perform the required initial certification and periodic recertifications of a beneficiary’s need for a SNF level of care.

Note: Contractors will reopen and reprocess any claims brought to their attention for Part A SNF services that were mistakenly denied (prior to this update) based on having a physician assistant complete the required SNF level of care certification or recertification. However, contractors will not search claims history to identify these claims.

**Additional Information**

The official instruction, CR7701, was issued to your FI or A/B MAC regarding this change via two transmittals. The first modifies the “Medicare General Information, Eligibility, and Entitlement” manual and it may be viewed at http://www.cms.gov/transmittals/downloads/R76GI.pdf on the CMS website. The second updates the “Medicare Benefit Policy” manual, which is available at http://www.cms.gov/Transmittals/downloads/R153BP.pdf on the same site.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.
SE1206 - 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – NEW products from the Medicare Learning Network® (MLN)

“Medicare Coverage of Radiology and Other Diagnostic Services,” Fact Sheet, ICN 907164, Downloadable

Provider Types Affected
This article is intended for physicians and other providers who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing (eRx) Incentive Program.

What Providers Need to Know
This article provides guidance on avoiding future Electronic Prescribing (eRx) Incentive Program payment adjustments for individual eligible professionals and selected group practices participating in the 2012 eRx Group Practice Reporting Option (GPRO).

Background
Under Section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Medicare Physician Fee Schedule (MPFS) payment adjustment applies to eligible professionals who are not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the MPFS amount for covered professional services during the year shall be a percentage less than the MPFS amount that would otherwise apply.

The applicable electronic prescribing percent for payment adjustments under the eRx Incentive Program are as follows:
• 1.0% adjustment in 2012 (eligible professional will receive 99% of their Medicare Part B PFS amount that would otherwise apply to such services);
• 1.5% adjustment in 2013 (eligible professional will receive 98.5% of their Medicare Part B PFS amount for covered professional services); and
• 2.0% adjustment in 2014 (eligible professional will receive 98% of their Medicare Part B PFS amount for covered professional services).

Key Points
Exclusion Criteria for Individual Eligible Professionals is as follows:
• An individual eligible professional (regardless of participation in other CMS incentive programs) will not be included in analysis for the payment adjustment if one of the payment adjustment exclusion criteria (listed in Table 1) applies.
• CMS will determine whether an individual eligible professional (defined by individual rendering National Provider Identifier, or NPI) is subject to future payment adjustments for each Tax Identification Number (TIN).

Table 1: Payment Adjustment Exclusion Criteria for Individual Eligible Professionals

<table>
<thead>
<tr>
<th>2013 Payment Adjustment Exclusion Criteria</th>
<th>2014 Payment Adjustment Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>The eligible professional is a successful electronic prescriber during the 2011 eRx 12-month reporting period (1/1/11-12/31/11).</td>
<td>The eligible professional is a successful electronic prescriber during the 2012 eRx 12-month reporting period (1/1/12-12/31/12).</td>
</tr>
</tbody>
</table>
The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).

The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2013, based on primary taxonomy code in the NPPES.

The eligible professional does not have at least 100 MPFS cases containing an encounter code in the measure’s denominator for dates of service from 1/1/12-6/30/12.

The eligible professional does not have at least 100 MPFS cases containing an encounter code in the measure’s denominator for dates of service from 1/1/13-6/30/13.

The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure’s denominator for dates of service from 1/1/12-6/30/12.

The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure’s denominator for dates of service from 1/1/13-6/30/13.

The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between 1/1/12-6/30/12.

The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between 1/1/13-6/30/13.

**Avoiding the 2013 eRx Payment Adjustment**

Individual eligible professionals and group practices participating in the eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx Incentive Program payment adjustment by meeting the specified reporting requirements during the appropriate reporting period. Please refer to the tables in Appendix 1 for reporting options and criteria. (Appendices are part of the Additional Information section of this article.)

**Avoiding the 2014 eRx Payment Adjustment**

Individual eligible professionals and group practices participating in the eRx GPRO can avoid the 2014 eRx payment adjustment by meeting the specified reporting requirements during the appropriate reporting period. Please refer to the tables in Appendix 2 for reporting options and criteria.

**2013 Hardship Codes and Hardship Exemption Requests**

CMS may exempt individual eligible professionals and group practices participating in the eRx GPRO from the 2013 payment adjustment if it is determined that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

**Hardship Exemption Circumstances and Codes:**

- Inability to electronically prescribe due to state, or federal law, or local law or regulation;
- The eligible professional prescribes fewer than 100 prescriptions during a 6–month payment adjustment reporting period;
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642); and
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643).

**Submitting a Hardship Request**

- CMS established the Quality Reporting Communication Support Page at [http://www.qualitynet.org/pqrs](http://www.qualitynet.org/pqrs) for eligible professionals to submit hardship requests, including those associated with a G-code. For more information detailing how to navigate the Quality Reporting Communication Support Page, please reference the following documents:
  - “Quality Reporting Communication Support Page User Guide” posted on the QualityNet website at [https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234](https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234) on the Internet; and

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Newsletters issued after January 1997 are available at no cost from our website at [www.cgsmedicare.com](http://www.cgsmedicare.com).
ERx Incentive/20_Payment_Adjustment_Information.asp on the CMS website.

- A hardship G-code may also be submitted at least once on a claim during the 6-month 2013 eRx payment adjustment reporting period, if applicable.
- The hardship G-code must be submitted on a claim with a billable Medicare Part B service.
- The hardship G-code does not need to be submitted on a claim that contains eRx measure denominator codes.

**eRx Participation Feedback**

Refer to the Remittance Advice (RA) to determine whether or not eRx quality-data codes submitted to the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) are processed into the National Claims History database (NCH). CMS uses the NCH data for eRx program analysis. Take the following steps to ensure the eRx Quality-Data Codes (QDCs) are processed into the NCH:

- The eRx line items will be denied for payment, but are passed through the claims processing system to the NCH used for eRx claims analysis.
- The RA will include a standard remark code (N365). N365 reads: “This procedure code is not payable.
- It is for reporting/information purposes only.” The N365 remark code does NOT indicate whether the eRx G-code is accurate for that claim or for the reported measure. **N365 only indicates that the eRx G-code passed into the NCH.**
- If the entire claim is rejected, please review claim for errors before re-submitting, since eRx G-codes will NOT be processed or tracked if the claim is rejected.
- Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

Eligible professionals reporting eRx via claims can find additional information about claims submission and claims processing in the “2012 eRx Claims-Based Reporting Principles” document on CMS website at [http://www.cms.gov/ERxIncentive](http://www.cms.gov/ERxIncentive) under the “E-Prescribing Measure” section on the CMS website.

**Additional Information**

For more information on the CMS eRx Incentive Program, go to [http://www.cms.gov/ERxIncentive](http://www.cms.gov/ERxIncentive) on the CMS website.

For more information on future payment adjustments, go to [http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp](http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp) on the CMS website.

CMS has provided the following resource to answer inquiries regarding the Physician Quality Reporting System and eRx Incentive Program, incentive payments, feedback reports, and Individuals Authorized Access to CMS Computer Services (IACS) registration:

**QualityNet Help Desk** – 7:00 AM – 7:00 p.m. CST. This desk can help with:

- General CMS Physician Quality Reporting System and eRx Incentive Program information;
- Portal password issues;
- Feedback report availability and access;
- Physician Quality Reporting-IACS registration questions; and
- Physician Quality Reporting-IACS login issues.

**Phone:** 1-866-288-8912  
**TTY:** 1-877-715-6222  
**Email:** Qnetsupport@sdps.org

**News Flash - It’s Not too Late to Give and Get the Flu Vaccine.** Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-](http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp)

Appendix 1: Reporting Options for Avoiding the 2013 Payment Adjustment

**Individual Eligible Professionals – 12-Month Reporting Period**
(Dates of Service 1/1/2011-12/31/2011)

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Data Processing</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Data must be processed into the NCH no later than <strong>February 24, 2012.</strong></td>
<td>Report G8553 for at least 25 unique denominator eligible eRx events</td>
</tr>
<tr>
<td>Registry</td>
<td>Submit data during the 2012 submission period.</td>
<td></td>
</tr>
<tr>
<td>EHR eRx</td>
<td>Submit data during the 2012 submission period.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Successful submission of the required number of eRx events in the 12-month reporting period will allow for receipt of 2011 eRx incentive payment and allow the eligible professional to avoid the 2013 payment adjustment.

**Individual Eligible Professionals – 6-Month Reporting Period**
(Dates of Service 1/1/2012-6/30/2012)

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Data Processing</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Data must be processed into the NCH no later than <strong>July 27, 2012.</strong></td>
<td>Report G8553 for at least 10 MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.</td>
</tr>
</tbody>
</table>

**eRx GPRO – 6-Month Reporting Option**
(Dates of Service 1/1/2012-6/30/2012)

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Reporting Period</th>
<th>Reporting Mechanism</th>
<th>Criteria for Avoiding the 2013 eRx Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-99 EPs</td>
<td><strong>January 1, 2012 – June 30, 2012</strong></td>
<td>Claims</td>
<td>Report G8553 for at least 625 unique MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.</td>
</tr>
</tbody>
</table>
Appendix 2: Reporting Options for Avoiding the 2014 Payment Adjustment

**Individual Eligible Professionals – 12-Month Reporting Period**
*(Dates of Service 1/1/2012-12/31/2012)*

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Data Processing</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Data must be processed into the NCH no later than <strong>February 22, 2013</strong>.</td>
<td>Report G8553 for <strong>at least 25 unique denominator eligible eRx events.</strong></td>
</tr>
<tr>
<td>Registry</td>
<td>Submit data during the 2013 submission period.</td>
<td></td>
</tr>
<tr>
<td>EHR eRx</td>
<td>Submit data during the 2013 submission period.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Successful submission of the required number of eRx events in the 12-month reporting period will allow for receipt of 2012 eRx incentive payment and allow the eligible professional to avoid the 2014 payment adjustment.

**Individual Eligible Professionals – 6-Month Reporting Period**
*(Dates of Service 1/1/2013-6/30/2013)*

<table>
<thead>
<tr>
<th>Reporting Method</th>
<th>Data Processing</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Data must be processed into the NCH no later than <strong>July 26, 2013</strong>.</td>
<td>Report G8553 for <strong>at least 10 MPFS encounters.</strong> The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, <strong>regardless</strong> of whether the claim contains coding in the eRx measure’s denominator.</td>
</tr>
</tbody>
</table>

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Newsletters issued after January 1997 are available at no cost from our website at [www.cgsmedicare.com](http://www.cgsmedicare.com).
MM7694 - New Waived Tests

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – REVISED product from the Medicare Learning Network® (MLN)

“Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements,”
Fact Sheet, ICN 905063, Downloadable

Provider Types Affected
This MLN Matters® Article is intended for clinical laboratories and providers who submit claims to Medicare contractors (carriers and Medicare Administrative Contractors (MACs)) for laboratory test services provided to Medicare beneficiaries are affected.

Provider Action Needed
STOP – Impact to You
There are eleven newly waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

CAUTION – What You Need to Know
Change Request (CR) 7694 from which this article is taken announces that (effective April 2, 2012,) the Food and Drug Administration (FDA) has approved new waived tests under CLIA. The codes for these tests are in a table in the Background section.

GO – What You Need to Do
You should ensure that your billing staffs are aware of these new waived tests.

Background
CLIA regulations require a facility to be appropriately certified for each test that it performs. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CR7694, from which this article is taken, announces the latest 11 tests approved by the FDA as waived tests under CLIA (effective April 2, 2012). The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW, defined as CLIA waived test, to be recognized as a waived test. However, the tests displayed at the beginning of the following table (i.e., CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

TESTS GRANTED WAIVED STATUS UNDER CLIA

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82274QW</td>
<td>September 8, 2004</td>
<td>Hemosure One-Step Fecal Occult Blood Test</td>
</tr>
<tr>
<td>G0328QW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81003QW</td>
<td>October 28, 2009</td>
<td>Acon Mission U120 Urine Analyzer</td>
</tr>
<tr>
<td>G0434QW</td>
<td>May 5, 2011</td>
<td>Premier Integrity Solutions P/Tox Drug Screen Cup {OTC}</td>
</tr>
<tr>
<td>81003QW</td>
<td>June 2, 2011</td>
<td>BTNX Rapid Response U120 Urine Analyzer</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 7, 2011</td>
<td>Instant Technologies, Inc. iCassette DX Drug Screen Test</td>
</tr>
</tbody>
</table>

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Newsletters issued after January 1997 are available at no cost from our website at www.cgsmedicare.com.
For 2012, the new CPT code **86386** was developed for the Nuclear Matrix Protein 22 (NMP22), qualitative test. Therefore, the CPT code assigned to the Matritech, Inc. NMP22® BladderCheck™ Test for Professional and Prescription Home Use is changed to 86386QW with an effective date of January 1, 2012.

Please note that your carrier or A/B MAC will not search their files to either retract payment or retroactively pay claims; however, should adjust claims you bring to their attention.

**Additional Information**

The official instruction, CR7694, issued to your carrier and A/B MAC regarding this change may be viewed [here](http://www.cms.gov/transmittals/downloads/R2408CP.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at [here](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

News Flash: It’s Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit **2011-2012 Provider Seasonal Flu Resources and Immunizations**. For the 2011-2012 seasonal flu vaccine payment limits, visit [here](http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp) on the Centers for [here](http://www.CMS.gov/McrPartBDrugAvgSale) Medicare & Medicaid Services (CMS) website.

<table>
<thead>
<tr>
<th>Code</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0434QW</td>
<td>July 19, 2011</td>
<td>Express Diagnostic Int'l Inc DrugCheck Waive RT (Model 9308z)</td>
</tr>
<tr>
<td>80061QW, 82465QW, 82947QW, 82950QW, 82951QW, 82952QW, 83718QW, 84450QW, 84460QW, 84478QW</td>
<td>August 16, 2011</td>
<td>Alere Cholestech LDX {Whole Blood}</td>
</tr>
<tr>
<td>82055QW</td>
<td>September 13, 2011</td>
<td>Acon Laboratories Inc. Mission Saliva Alcohol Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>September 13, 2011</td>
<td>Amedica Biotech Instant Test Cup</td>
</tr>
<tr>
<td>81003QW</td>
<td>September 26, 2011</td>
<td>Immunostics Inc., Detector Uristrip+ Analyzer</td>
</tr>
<tr>
<td>82055QW</td>
<td>October 4, 2011</td>
<td>Teco Diagnostics Saliva Alcohol Test</td>
</tr>
<tr>
<td>86386QW</td>
<td>January 1, 2012</td>
<td>Alere NMP22 BladderChek Test (Prescription Home Use)</td>
</tr>
<tr>
<td>86386QW</td>
<td>January 1, 2012</td>
<td>Alere NMP22 BladderChek Test (Professional Use)</td>
</tr>
</tbody>
</table>
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found here. Alternatively, these FAQ items can be found by visiting http://questions.CMS.hhs.gov/ and searching for “PCIP” or “Primary Care Incentive Payment.”

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
Medicare will use the April 2012 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2012, with dates of service April 1, 2012, through June 30, 2012.

CAUTION – What You Need to Know
Change Request (CR) 7734, from which this article is taken, instructs your Medicare contractors to download and implement the April 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2012, October 2011, July 2011, and April 2011 files.

GO – What You Need to Do
You should make sure that your billing staffs are aware of the release of these April 2012 ASP Medicare Part B drug files.

Background
The Medicare Modernization Act of 2003 (MMA; Section 303(c); (see http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf on the Centers for Medicare & Medicaid Services (CMS) website) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/manuals/downloads/clin104c04.pdf on the CMS website.)

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2012 ASP and ASP NOC</td>
<td>April 1, 2012, through June 30, 2012</td>
</tr>
</tbody>
</table>
Additional Information

You can find the official instruction, Change Request (CR) 7344, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting [http://www.cms.gov/Transmittals/downloads/R2396CP.pdf](http://www.cms.gov/Transmittals/downloads/R2396CP.pdf) on the CMS website. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at [http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

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**MM7737 - Emergency Update to the CY 2012 Medicare Physician Fee Schedule Database (MPFSDB)**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

**News Flash** – A new fast fact is now available on [MLN Provider Compliance](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip). This web page provides the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

**Provider Types Affected**

Physicians, non-physician practitioners, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

**What You Need to Know**

This article is based on Change Request (CR) 7737, which informs you that new Medicare Physician Fee Schedule (MPFS) payment files have been created and are available to Medicare contractors.

- Payment files were issued to Medicare contractors based upon the CY 2012 Medicare Physician Fee Schedule (MPFS) Final Rule, issued on November 1, 2011, and published in the “Federal Register” on November 28, 2011.
- CR7737 amends those payment files to include corrections described in the CY 2012 MPFS Final Rule Correction Notice, as well as relevant statutory changes applicable January 1, 2012.

**Background**

**Medicare Physician Fee Schedule Revisions and Updates**

Some physician work, practice expense, and malpractice Relative Value Units (RVUs) published in the CY 2012 MPFS Final Rule have been revised to align their values with the CY 2012 MPFS Final Rule policies. These changes are discussed in the CY 2012 MPFS Final Rule Correction Notice and revised RVU values are found in Addendum B and Addendum C of the CY 2012 MPFS Final Rule Correction Notice.

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

Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2012 MPFS Final Rule Correction Notice public use data files, which are located at: [http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.aspx#TopOfPage](http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.aspx#TopOfPage) on the CMS website.

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This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at [www.cgsmedicare.com](http://www.cgsmedicare.com).
Changes to the physician work RVUs and payment indicators can be found in the attachment associated with CR7737, which is cited in the Additional Information section below. Changes to practice expense RVUs are reflected in Addendum B and Addendum C of the CY 2012 MPFS Final Rule Correction Notice.

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

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$33.9764</td>
<td>0.0 percent (1.000)</td>
<td>0.2 percent (1.0018)</td>
<td>$34.0376</td>
</tr>
</tbody>
</table>

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

Extension of Medicare Physician Work Geographic Adjustment Floor
Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense (PE), and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index through February 29, 2012. This change is included in the revised CY 2012 MPFS payment files. Updated CY 2012 geographic practice cost indices (GPCI) are included in the attachment to CR7737. See the “Additional Information” section below for information on accessing CR7737.

Extension of MPFS Mental Health Add-On
For calendar year 2011, certain mental health services’ payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services through February 29, 2012. This five percent increase is reflected in the revised CY 2012 MPFS payment files. The lists of Psychiatry Current Procedural Terminology (CPT) codes that represent
the specified services subject to this payment policy are included in the attachment to CR7737.

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

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

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

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

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Work RVU</th>
<th>Fully Implemented Non-Facility PE RVU</th>
<th>Transitional Non-facility PE RVU</th>
<th>Fully Implemented Facility PE RVU</th>
<th>Transitional Facility PE RVU</th>
<th>Malpractice RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>77080</td>
<td>0.23</td>
<td>2.50</td>
<td>2.50</td>
<td>N/A</td>
<td>N/A</td>
<td>0.14</td>
<td></td>
</tr>
</tbody>
</table>

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our website at www.cgsmedicare.com.
Additional Information
The official instruction, CR 7737, issued to your FI, RHHI, carrier and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R1015OTN.pdf on the CMS website.

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

MM7672 – January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

News Flash – Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates immediately!

Note: This article was revised on February 23, 2012, to reflect a revised CR7672, issued on January 13, 2012. CR7672 was revised to correct the fixed dollar threshold amount in Section 17.d of the CR and this article was revised accordingly. Also, the CR was revised to change HCPCS code Q1079 in Table 5 to show the correct code of Q0179. The CR release date, transmittal number, and the Web address for accessing the CR have also been changed. All other information is the same.

Provider Types Affected
This MLN Matters® article is intended for providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services subject to the Outpatient Prospective Payment System (OPPS) that are provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on change request (CR) 7672 which describes changes to the OPPS to be implemented in the January 2012 OPPS update.

CAUTION – What You Need to Know
CR7672, from which this article is taken:
1. Describes changes to, and billing instructions for, various payment policies implemented in the January 2012 OPPS update; and
2. Implements several changes and clarifications in the manual requirements for the provision of hospital outpatient therapeutic services, finalized in the Calendar Year (CY) 2012 OPPS/Ambulatory Surgical Center (ASC) Final Rule.
GO – What You Need to Do
You should make sure your billing staffs are aware of these changes.

Background
CR7672 describes changes to and billing instructions for various payment policies implemented in the January 2012 OPPS update. The January 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR.

The January 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR7668, “January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0.” (You can find the associated MLN Matters® article at http://www.cms.gov/MLNMattersArticles/downloads/MM7668.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

Key changes to and billing instructions for various payment policies implemented in the October 2010 OPPS update are as follows:

Physician Supervision
In the “Medicare Benefit Policy Manual,” Chapter 6 (Hospital Services Covered Under Part B), Section 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010), CMS is making several revisions to the standards governing the supervision of hospital or Critical Access Hospital (CAH) outpatient therapeutic services.

Currently, CMS requires the direct supervision of outpatient therapeutic services except for nonsurgical extended duration therapeutic services, for which CMS allows general supervision during a portion of the service at the discretion of the supervising practitioner.

CR7672 provides that (effective January 1, 2012) CMS may assign general or personal supervision for the duration of the service to certain hospital outpatient therapeutic services. To enable such assignment, CMS is defining those levels of supervision using the definitions that are used in the Medicare Physician Fee Schedule.

CR7672 also provides (as specified in CMS regulations), that in addition to providing direct supervision certain non-physician practitioners may also furnish the required general or personal supervision.

New Device Pass-Through Categories
The Social Security Act (the Act) (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2012. Table 1, below, provides a listing of new coding, Status Indicator (SI), Ambulatory Payment Classification (APC), and payment information concerning the new device category for transitional pass-through payment.

Table 1
New Device Pass-Through Code

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC for Device Offset from Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1886</td>
<td>01-01-12</td>
<td>H</td>
<td>1886</td>
<td>Catheter, ablation</td>
<td>Catheter, extravascular tissue ablation, any modality (insertable)</td>
<td>0415</td>
</tr>
</tbody>
</table>
Device Offset from Payment for C1886
Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct, from pass-through payments for devices, an amount that reflects the portion of the APC payment amount determined to be associated with the cost of the device. (Please see 2005 Federal Register, Vol. 70, page 68627-8 at http://www.gpoaccess.gov/fr/retrieve.html on the Internet).

CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), in APC 0415, Level II, Endoscopy, lower airway. The device offset from payment represents this deduction from pass-through payments for category C1886, when it is billed with a service included in APC 0415.

The device offset amount for APC 0415, along with the device offsets for other APCs, is available under “Annual Policy Files” at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS website.

Revised Device Offset from Payment for Category C1840
Effective January 1, 2012, device pass-through category C1840 must be billed with procedure code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens), (see New Procedure Code section below) to receive pass-through payment. C9732 is assigned to APC 0234, Level IV Anterior Segment Eye Procedures. Therefore, as of January 1, 2012, device C1840 will be used with an APC 0234 service. The new device offset for CY 2012 for APC 0234, is available under “Annual Policy Files” at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS website.

New Procedure Code
CMS is establishing one new procedure code, effective January 1, 2012. Table 2 provides a listing of the descriptor and payment information for this new code.

Table 2
New Procedure Code

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9732</td>
<td>01-01-12</td>
<td>T</td>
<td>0234</td>
<td>Insert ocular</td>
<td>Insertion of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>telescope pros</td>
<td>ocular telescope</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>prosthesis</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>including</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>removal of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>crystalline lens</td>
</tr>
</tbody>
</table>

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

Note: These billing instructions supersede prior billing instructions for C1830 provided in the October 2011 update of the OPPS, Transmittal 2296, CR7545.

Billing for Thermal Anal Lesions by Radiofrequency Energy
For CY 2012, the CPT Editorial Panel created new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence)) to describe the procedure associated with radiofrequency energy creation of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by CPT code 0288T, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT code 0288T effective January 1, 2012. In addition, CPT code 0288T is being reassigned from APC 0148 to APC 0150 effective January 1, 2012. This change will be reflected in the January 2012 OPPS I/OCE and OPPS Pricer. Table 3 below lists the final OPPS status indicator and APC assignment for HCPCS codes C9716 and 0288T.
Table 3 – CY 2012 OPPS Status Indicator and APC Assignment for HCPCS Codes C9716 and 0288T

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>CY 2012 SI</th>
<th>CY 2012 APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9716</td>
<td>Radiofrequency energy to anu</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0288T</td>
<td>Anoscopy w/rf delivery</td>
<td>T</td>
<td>0150</td>
</tr>
</tbody>
</table>

**Cardiac Resynchronization Therapy Payment for CY 2012**

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures and pacing electrode insertion procedures when performed on the same date of service.

CMS also is implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)) is billed without one of the primary CPT codes for insertion of an implantable cardioverter defibrillator or pacemaker as specified in the 2012 CPT code book. CMS is adding new Section 10.2.2 to the “Medicare Claims Processing Manual”, Chapter 4, to reflect the implementation of this new composite service policy and claims processing edits for CPT code 33225.

**Billing for Drugs, Biologicals, and Radiopharmaceuticals**

**Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals** Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is CMS’ standard rate-setting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a “new” drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.
Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

**New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals**

For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4.

**Table 4**

New CY 2012 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A9585</td>
<td>Injection gadobutrol, 0.1 ml</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>C9287</td>
<td>Injection, brentuximab vedotin, 1 mg</td>
<td>G</td>
<td>9287</td>
</tr>
<tr>
<td>C9366</td>
<td>EpiFix, per square centimeter</td>
<td>G</td>
<td>9366</td>
</tr>
<tr>
<td>J0257</td>
<td>Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg</td>
<td>K</td>
<td>1415</td>
</tr>
<tr>
<td>J7180</td>
<td>Injection, factor xiii (antihemophilic factor, human), 1 i.u.</td>
<td>G</td>
<td>1416</td>
</tr>
<tr>
<td>J7326</td>
<td>Hyaluronan or derivative, gel-one, for intra-articular injection, per dose</td>
<td>K</td>
<td>1417</td>
</tr>
<tr>
<td>J8561</td>
<td>Everolimus, oral, 0.25 mg</td>
<td>K</td>
<td>1418</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell, per square centimeter</td>
<td>K</td>
<td>1419</td>
</tr>
</tbody>
</table>

**Other Changes to CY 2012 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

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

Table 5 displays those drugs, biologicals, and radiopharmaceuticals that have undergone changes in either their HCPCS/CPT codes, their long descriptors, or both. Each product’s CY 2011 HCPCS/CPT code and CY 2011 long descriptor are noted in the two left hand columns, with the CY 2012 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

**Table 5**

Other CY 2012 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C9270</td>
<td>Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
<td>J1557</td>
<td>Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
</tr>
<tr>
<td>C9272</td>
<td>Injection, denosumab, 1 mg</td>
<td>J0897</td>
<td>Injection, denosumab, 1 mg</td>
</tr>
<tr>
<td>C9273***</td>
<td>Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion</td>
<td>Q2043</td>
<td>Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion</td>
</tr>
<tr>
<td>C9274</td>
<td>Crotalidae Polyvalent Immune Fab (Ovine), 1 vial</td>
<td>J0840</td>
<td>Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram</td>
</tr>
<tr>
<td>C9276</td>
<td>Injection, cabazitaxel, 1 mg</td>
<td>J9043</td>
<td>Injection, cabazitaxel, 1 mg</td>
</tr>
<tr>
<td>C9277</td>
<td>Injection, alglucosidase alfa (Lumizyme), 1 mg</td>
<td>J0221</td>
<td>Injection, alglucosidase alfa, (lumizyme), 10 mg</td>
</tr>
<tr>
<td>C9278*</td>
<td>Injection, incobotulinumtoxin A, 1 unit</td>
<td>J0588</td>
<td>Injection, incobotulinumtoxin A, 1 unit</td>
</tr>
<tr>
<td>Q2040*</td>
<td>Injection, incobotulinumtoxin A, 1 unit</td>
<td>J0588</td>
<td>Injection, incobotulinumtoxin A, 1 unit</td>
</tr>
<tr>
<td>C9280</td>
<td>Injection, eribulin mesylate, 1 mg</td>
<td>J9179</td>
<td>Injection, eribulin mesylate, 0.1 mg</td>
</tr>
<tr>
<td>C9281</td>
<td>Injection, pegloticase, 1 mg</td>
<td>J2507</td>
<td>Injection, pegloticase, 1 mg</td>
</tr>
<tr>
<td>C9282</td>
<td>Injection, ceftaroline fosamil, 10 mg</td>
<td>J0712</td>
<td>Injection, ceftaroline fosamil, 10 mg</td>
</tr>
<tr>
<td>C9283</td>
<td>Injection, acetaminophen, 10 mg</td>
<td>J0131</td>
<td>Injection, acetaminophen, 10 mg</td>
</tr>
<tr>
<td>C9284</td>
<td>Injection, ipilimumab, 1 mg</td>
<td>J9228</td>
<td>Injection, ipilimumab, 1 mg</td>
</tr>
<tr>
<td>C9365</td>
<td>Oasis Ultra Tri-Layer matrix, per square centimeter</td>
<td>Q4124</td>
<td>Oasis ultra tri-layer wound matrix, per square centimeter</td>
</tr>
<tr>
<td>C9406</td>
<td>Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries</td>
<td>A9584</td>
<td>Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries</td>
</tr>
<tr>
<td>J0220</td>
<td>Injection, alglucosidase alfa, 10 mg</td>
<td>J0220</td>
<td>Injection, alglucosidase alfa, 10 mg, not otherwise classified</td>
</tr>
<tr>
<td>J0256</td>
<td>Injection, alpha 1 - proteinase inhibitor - human, 10 mg</td>
<td>J0256</td>
<td>Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg</td>
</tr>
<tr>
<td>J1561**</td>
<td>‘Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
<td>J1561</td>
<td>Injection, immune globulin, (Gamunex/Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg</td>
</tr>
<tr>
<td>Q2044</td>
<td>Injection, belimumab, 10 mg</td>
<td>J0490</td>
<td>Injection, belimumab, 10 mg</td>
</tr>
<tr>
<td>Q2042</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
<td>J1725</td>
<td>Injection, hydroxyprogesterone caproate, 1 mg</td>
</tr>
</tbody>
</table>
### Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2012

For CY 2012, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, a single payment of ASP + 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payment for drugs and biologicals with pass-through status for the first quarter of CY 2012 is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was postponed beginning January 1, 2009.

Should the Part B Drug CAP program be reinstated sometime during CY 2012, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2012 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2012, payment rates for many drugs and biologicals have changed from the values published in the CY 2012 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2011.

In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2012 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this instruction implementing the January 2012 update of the OPPS. However, the updated payment rates effective January 1, 2012 can be found in the January 2012 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp](http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp) on the CMS website.

### Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011, through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 6 and have been installed in the January 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. Your Medicare contractor will adjust any claims related to the changes shown in Table 6, provided you make the contractor aware of such claims.
Table 6
Updated payment Rates for Certain HCPCS Codes Effective October 1, 2011, through December 31, 2011

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9600</td>
<td>K</td>
<td>0856</td>
<td>Porfimer sodium injection</td>
<td>$19,143.46</td>
<td>$3,828.69</td>
</tr>
<tr>
<td>Q4121</td>
<td>K</td>
<td>1345</td>
<td>Theraskin</td>
<td>$20.77</td>
<td>$4.15</td>
</tr>
</tbody>
</table>

Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is only surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status as a device, separate payment for the device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the implanted biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

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

Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, non-pass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2012, the status indicator for separately payable therapeutic radiopharmaceuticals is “K” to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for non-pass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.
Table 7 - Non-Pass-Through Separately Payable Therapeutic Radiopharmaceuticals for January 1, 2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A9517</td>
<td>Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie</td>
<td>1064</td>
<td>K</td>
</tr>
<tr>
<td>A9530</td>
<td>Iodine I-131 sodium iodide solution, therapeutic, per millicurie</td>
<td>1150</td>
<td>K</td>
</tr>
<tr>
<td>A9543</td>
<td>Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries</td>
<td>1643</td>
<td>K</td>
</tr>
<tr>
<td>A9545</td>
<td>Iodine I-131 tositumomab, therapeutic, per treatment dose</td>
<td>1645</td>
<td>K</td>
</tr>
<tr>
<td>A9563</td>
<td>Sodium phosphate P-32, therapeutic, per millicurie</td>
<td>1675</td>
<td>K</td>
</tr>
<tr>
<td>A9564</td>
<td>Chromic phosphate P-32 suspension, therapeutic, per millicurie</td>
<td>1676</td>
<td>K</td>
</tr>
<tr>
<td>A9600</td>
<td>Strontium Sr-89 chloride, therapeutic, per millicurie</td>
<td>0701</td>
<td>K</td>
</tr>
<tr>
<td>A9604</td>
<td>Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries</td>
<td>1295</td>
<td>K</td>
</tr>
</tbody>
</table>

Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals
Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR6416, pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. (You can find the associated MLN Matters® article at http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf on the CMS website).

Effective July 1, 2011, the diagnostic radiopharmaceutical reported with HCPCS code A9584 (Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries) was granted pass-through status under the OPPS and assigned status indicator “G.” HCPCS code A9584 will continue on pass-through status for CY 2012 and therefore, when HCPCS code A9584 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9584 by the corresponding nuclear medicine procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The “policy-packaged” portions of the CY 2012 APC payments for nuclear medicine procedures may be found on the CMS website at http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2012 OPPS Offset Amounts by APC.

CY 2012 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table:
Table 8
APCs to Which Nuclear Medicine Procedures are Assigned for CY 2012

<table>
<thead>
<tr>
<th>CY 2012 APC</th>
<th>CY 2012 APC Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>0308</td>
<td>Positron Emission Tomography (PET) Imaging</td>
</tr>
<tr>
<td>0377</td>
<td>Level II Cardiac Imaging</td>
</tr>
<tr>
<td>0378</td>
<td>Level II Pulmonary Imaging</td>
</tr>
<tr>
<td>0389</td>
<td>Level I Non-imaging Nuclear Medicine</td>
</tr>
<tr>
<td>0390</td>
<td>Level I Endocrine Imaging</td>
</tr>
<tr>
<td>0391</td>
<td>Level II Endocrine Imaging</td>
</tr>
<tr>
<td>0392</td>
<td>Level II Non-imaging Nuclear Medicine</td>
</tr>
<tr>
<td>0393</td>
<td>Hematologic Processing &amp; Studies</td>
</tr>
<tr>
<td>0394</td>
<td>Hepatobiliary Imaging</td>
</tr>
<tr>
<td>0395</td>
<td>GI Tract Imaging</td>
</tr>
<tr>
<td>0396</td>
<td>Bone Imaging</td>
</tr>
<tr>
<td>0397</td>
<td>Vascular Imaging</td>
</tr>
<tr>
<td>0398</td>
<td>Level I Cardiac Imaging</td>
</tr>
<tr>
<td>0400</td>
<td>Hematopoietic Imaging</td>
</tr>
<tr>
<td>0401</td>
<td>Level I Pulmonary Imaging</td>
</tr>
<tr>
<td>0402</td>
<td>Level II Nervous System Imaging</td>
</tr>
<tr>
<td>0403</td>
<td>Level I Nervous System Imaging</td>
</tr>
<tr>
<td>0404</td>
<td>Renal and Genitourinary Studies</td>
</tr>
<tr>
<td>0406</td>
<td>Level I Tumor/Infection Imaging</td>
</tr>
<tr>
<td>0408</td>
<td>Level III Tumor/Infection Imaging</td>
</tr>
<tr>
<td>0414</td>
<td>Level II Tumor/Infection Imaging</td>
</tr>
</tbody>
</table>

Payment Offset for Pass-Through Contrast Agents
Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a “policy-packaged” drug amount greater than $20.00 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR6751, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount) so no duplicate contrast agent payment is made. You can find the MLN Matters® article associated with this CR at [http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM6416.pdf) on the CMS website.

CY 2012 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 9. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used.

For CY 2012, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in the table on the same date of service, a specific
pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2012, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. HCPCS code C9275 is assigned a status indicator of “G”. Therefore, in CY 2012, CMS will reduce the payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast enhanced procedure reported on the same claim on the same date as HCPCS code C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table.

The “policy-packaged” portions of the CY 2012 APC payments that are the offset amounts may be found on the CMS website at: http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp in the download file labeled 2012 OPPS Offset Amounts by APC.

Table 9
APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2011

<table>
<thead>
<tr>
<th>CY 2012 APC</th>
<th>CY 2012 APC Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>0080</td>
<td>Diagnostic Cardiac Catheterization</td>
</tr>
<tr>
<td>0082</td>
<td>Coronary or Non-Coronary Atherectomy</td>
</tr>
<tr>
<td>0083</td>
<td>Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization</td>
</tr>
<tr>
<td>0093</td>
<td>Vascular Reconstruction/Fistula Repair without Device</td>
</tr>
<tr>
<td>0104</td>
<td>Transcatheter Placement of Intracoronary Stents</td>
</tr>
<tr>
<td>0128</td>
<td>Echocardiogram with Contrast</td>
</tr>
<tr>
<td>0152</td>
<td>Level I Percutaneous Abdominal and Biliary Procedures</td>
</tr>
<tr>
<td>0229</td>
<td>Level II Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>0278</td>
<td>Diagnostic Urography</td>
</tr>
<tr>
<td>0279</td>
<td>Level II Angiography and Venography</td>
</tr>
<tr>
<td>0280</td>
<td>Level III Angiography and Venography</td>
</tr>
<tr>
<td>0283</td>
<td>Computed Tomography with Contrast</td>
</tr>
<tr>
<td>0284</td>
<td>Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast</td>
</tr>
<tr>
<td>0333</td>
<td>Computed Tomography without Contrast followed by Contrast</td>
</tr>
<tr>
<td>0334</td>
<td>Combined Abdomen and Pelvis CT with Contrast</td>
</tr>
<tr>
<td>0337</td>
<td>Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast</td>
</tr>
<tr>
<td>0375</td>
<td>Ancillary Outpatient Services When Patient Expires</td>
</tr>
<tr>
<td>0383</td>
<td>Cardiac Computed Tomographic Imaging</td>
</tr>
<tr>
<td>0388</td>
<td>Discography</td>
</tr>
<tr>
<td>0442</td>
<td>Dosimetric Drug Administration</td>
</tr>
<tr>
<td>0653</td>
<td>Vascular Reconstruction/Fistula Repair with Device</td>
</tr>
<tr>
<td>0656</td>
<td>Transcatheter Placement of Intracoronary Drug-Eluting Stents</td>
</tr>
<tr>
<td>0662</td>
<td>CT Angiography</td>
</tr>
</tbody>
</table>
Clarification of Coding for Drug Administration Services
As noted in CR7271, in 2011 CMS revised the "Medicare Claims Processing Manual," Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 230.2 (Coding and Payment for Drug Administration)), to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, CMS noted that beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. CMS has subsequently become aware of new CPT guidance regarding the reporting of initial drug administration services in the event of a disruption in service; however, Medicare contractors are to continue to follow the guidance given in this manual. (You can find the associated MLN Matters® article at http://www.cms.gov/MLNMattersArticles/downloads/MM7271.pdf on the CMS website and this manual reference at http://www.cms.gov/manuals/downloads/clm104c04.pdf on the CMS website).

Provenge Administration
Effective July 1, 2010, the autologous cellular immunotherapy treatment reported with HCPCS code C9273 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) was granted pass-through status under OPPS and assigned status indicator “G.” Effective July 1, 2011, this product was assigned to HCPCS code Q2043 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) with status indicator “G.” HCPCS code Q2043 will continue on pass-through status for CY 2012.

Please note that the HCPCS long descriptor for CY 2012 for HCPCS code Q2043 includes payment for the drug itself, as well “all other preparatory procedures,” referring to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient. Payment for Q2043 does not include OPPS payment for drug administration.

Billing for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – National Coverage Determination (NCD)

Effective for claims with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening, and for those who screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: 1) who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting. In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

To implement this recent coverage determination, CMS created two new G-codes to report annual alcohol screening and brief, face-to-face behavioral counseling interventions. The long descriptors for both G-codes appear in Table 10.
Table 10 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>G0442</td>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
<tr>
<td>G0443</td>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
</tbody>
</table>


**Screening for Depression in Adults – NCD**

Effective for claims with dates of service on and after October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, Ambulatory Surgical Centers (ASCs), independent diagnostic testing facilities, Skilled Nursing Facilities (SNFs), inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the annual depression screening. The long descriptor for the G-code appears in Table 11.

Table 11 – Annual Depression Screening

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>G0444</td>
<td>Annual Depression Screening, 15 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
</tbody>
</table>


**Billing for Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs – NCD**

Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with Dates of Service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for High Intensity Behavioral Counseling (HIBC) to prevent
Sexually Transmitted Infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report HIBC to Prevent STIs. The long descriptor for the G-code appears in Table 12.

Table 12 –STIs Screening and HIBC to Prevent STIs

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>G0445</td>
<td>High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
</tbody>
</table>

HCPCS code G0445 has been assigned to APC 0432 and given a status indicator assignment of “S.” Further reporting guidelines on HIBC to Prevent STIs will be provided in a future CR.

CMS is deleting screening code G0450 (Screening for sexually transmitted infections, includes laboratory tests for Chlamydia, Gonorrhea, Syphilis, and Hepatitis B) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 8, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

Billing for Intensive Behavioral Therapy for Cardiovascular Disease – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit), which consists of the following three components: 1) encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years; 2) screening for high blood pressure in adults age 18 years and older; and 3) intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease. Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. For the purposes of this NCD, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the CVD risk reduction visit. The long descriptor for the G-code appears in Table 13.
Table 13 – Intensive Behavioral Therapy for Cardiovascular Disease

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>G0446</td>
<td>Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
</tbody>
</table>

Further reporting guidelines on intensive behavioral therapy for cardiovascular disease can be found in 100-03, Medicare National Coverage Determinations Manual, Pub. chapter 1, section 210.11 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 160, as well as in Transmittals 137 and 2357, CR 7636 that was published on November 23, 2011. The MLN Matters® article on this NCD is at http://www.cms.gov/MLNMattersArticles/downloads/MM7636.pdf on the CMS site.

**Intensive Behavioral Therapy for Obesity – NCD**

Effective for claims with dates of service on and after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for: 1) One face to face visit every week for the first month; 2) One face to face visit every other week for months 2-6; and 3) One face to face visit every month for months 7-12.

To implement this recent coverage determination, CMS created a new G-code to report counseling for obesity. The long descriptor for the G-code appears in Table 14.

Table 14 – Intensive Behavioral Therapy for Obesity

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>G0447</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>S</td>
<td>0432</td>
</tr>
</tbody>
</table>

Further reporting guidelines on intensive behavioral therapy for obesity will be provided in a future CR.

CMS is deleting screening code G0449 (Annual face to face obesity screening, 15 minutes) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 29, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

**Payment Window for Outpatient Services Treated as Inpatient Services**

CMS is revising its billing instructions to clarify that in situations where there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were. See the “Medicare Claims Processing Manual”, Chapter 4, Section 10.12 and Chapter 1, Section 50.3.2 for the updated billing guidelines.

**Partial Hospitalization APCs**

For CY 2012, CMS is updating the four PHP per diem payment rates based on the median costs calculated using the most recent claims data for each provider type: two for CMHCs (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The
APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a Community Mental Health Center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176. The tables below provide the updated per diem payment rates:

**Table 15**

CY 2011 Median Per Diem Costs for CMHC PHP Services Plus Transition

<table>
<thead>
<tr>
<th>APC</th>
<th>Group Title</th>
<th>Median Per Diem Costs Plus Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0172</td>
<td>Level I Partial Hospitalization (3 services) for CMHCs</td>
<td>$97.64</td>
</tr>
<tr>
<td>0173</td>
<td>Level II Partial Hospitalization (4 or more services) for CMHCs</td>
<td>$113.83</td>
</tr>
</tbody>
</table>

**Table 16**

CY 2011 Median Per Diem Costs for Hospital-Based PHP Services

<table>
<thead>
<tr>
<th>APC</th>
<th>Group Title</th>
<th>Median Per Diem Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0175</td>
<td>Level I Partial Hospitalization (3 services) for hospital- based PHPs</td>
<td>$160.74</td>
</tr>
<tr>
<td>0176</td>
<td>Level II Partial Hospitalization (4 or more services) for hospital-based PHPs</td>
<td>$191.16</td>
</tr>
</tbody>
</table>

**Molecular Pathology Procedure Test Codes**

The American Medical Association’s (AMA) CPT Editorial Panel created 101 new molecular pathology procedure test codes for CY 2012. These new codes are in the following CPT code range: 81200-81299, 81300-81383, and 81400-81408. For payment purposes under the hospital OPPS these test codes will be assigned to status indicator “E” (Not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available) effective January 1, 2012. These new codes will be listed in the January 2012 OPPS Addendum B, which can be downloaded from [http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp on the CMS website.](http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp)

Please note that each of the new molecular pathology procedure test code represents a test that is currently being utilized and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understand that existing CPT test codes are “stacked” to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare in the following manner – 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) – in order to represent the performance of the entire test. If the new CPT test coding structure were active, Laboratory A would bill Medicare the new, single CPT test code that corresponds to the test represented by the “stacked” codes in the example above rather than billing each component of the test separately.

Effective January 1, 2012, under the hospital OPPS, hospitals are advised to report both the existing CPT “stacked” test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active. Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment [i.e.,
Changes to OPPS Pricer Logic
a. Rural sole community hospitals and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2012. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2012. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2012 inpatient deductible.

c. For hospital outpatient payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2012. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. There will be no change in the fixed-dollar threshold in CY 2012. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments.

e. For outliers for CMHCs (bill type 76X), there will be no change in the multiple threshold of 3.4 for 2012. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2012, 4 devices are eligible for pass-through payment in the OPPS Pricer logic. Categories C1749 (Endoscope, retrograde imaging/illumination colonoscopy device (implantable)) and C1830 (Powered bone marrow biopsy needle) have an offset amount of $0 because CMS is not able to identify portions of the APC payment amounts associated with the cost of the devices. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY2012. Pass-through offset amounts are adjusted annually. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g. Effective January 1, 2012, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2012, there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, the Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2012 APC payments for nuclear medicine procedures and may be found on the CMS website.

i. Effective January 1, 2012, there will be 1 contrast agent receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the “policy-packaged” portions of the CY 2012 APC payments for procedures using contrast agents and may be found on the CMS website.

Use of Modifiers for Discontinued Services (Modifiers 52, 53, 73, and 74)
CMS is revising the guidance related to use of modifiers for discontinued services in the “Medicare Claims Processing Manual”, Chapter 4, Section 20.6.4.
j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and
diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on
ASP on a quarterly basis.

k. Effective January 1, 2012, CMS is adopting the FY 2012 IPPS post-reclassification wage index
values with application of out-commuting adjustment authorized by Section 505 of Pub. L. 108-173
to non-IPPS hospitals discussed below.

Coverage Determinations
The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate
under the OPPS does not imply coverage by the Medicare program, but indicates only how the product,
procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare
Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets
all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and
necessary to treat the beneficiary’s condition and whether it is excluded from payment.

Additional Information
You can find the official instruction, CR7672, was issued to your FI, A/B MAC, or RHHI via two
transmittals. The first transmittal revises the “Medicare Benefit Policy Manual” and it is at http://www.
cms.gov/Transmittals/downloads/R152BP.pdf on the CMS website. The second transmittal updates the
the same site.

You will find the revised “Medicare Benefit Policy Manual,” Chapter 6 (Hospital Services Covered Under
Part B), Sections 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January
1, 2010) and 20.5.2 (Coverage of Outpatient Therapeutic Services Incident to a Physicians Service
Furnished on or After January 1, 2010); and the revised “Medicare Claims Processing Manual,” Chapter
1 (General Billing Requirements), Section 50.3.2 (Policy and Billing Instructions for Condition Code 44),
and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Sections 10.2.2 (Cardiac
Resynchronization Therapy), 10.12 (Payment Window for Outpatient Services Treated as Inpatient
Services), 20.6.4 (Use of Modifiers for Discontinued Services), and
10.2.1 (Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes) as an
attachment to that CR.

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

News Flash - Flu Season is Here! While seasonal flu outbreaks can happen as early as October, flu
activity usually peaks in January. Remind your patients that annual vaccination is recommended for
optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and
others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high
risk patients, should get vaccinated too. Protect your patients. Protect your family. Protect yourself.
Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered
Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage
and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012
Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine
payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp
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By joining the CGS electronic mailing list, you can get immediate updates on Medicare information, including:

- Medicare publications
- Important updates
- Workshops
- Medical Review information

To join the ListServ follow this link: https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp
Overpayment Refunds

Personal provider checks sent to us for any reason should be sent to the following address (if you are submitting a refund due to Medicare Secondary Payer, include “MSP” on the envelope or correspondence):

Kentucky and Ohio Providers
CGS – J15 Part B Kentucky and Ohio
PO Box 957065
St. Louis, MO 63195-7065

Personal provider checks should never be sent to our Nashville operations as this will create processing delays. For example, in situations where you have received a letter of notification regarding a Medicare overpayment, these delays can result in payment offset and/or interest accrual.

Checks issued by CGS that need to be returned to us should be sent to the following address:

Kentucky and Ohio Providers
CGS – J15 Part B Kentucky and Ohio
PO Box 957065
St. Louis, MO 63195-7065

Medicare Bulletin

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Nashville, TN 37228

The CGS website (www.cgsmedicare.com) provides formal notification for all notices developed and distributed by CGS, including the Part B Medicare Bulletin. Providers/suppliers are obligated and responsible for remaining updated on current Medicare issues and legislation as it is posted to the website.

Please note that for LCDs listed on the website, the start of the notice period may be different than the date it is posted to the website. Please abide by the notice period dates on the document, not the posting date.

A quarterly CD-ROM, which includes the Medicare Bulletin and other additional resources, is mailed to the same location as Medicare checks. Provider groups will receive one copy of the CD-ROM. Each individual provider in that group will not receive their own copy for his/her individual provider identification number (PIN).
This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after January 1997 are available at no cost from our Web site at www.cgsmedicare.com.