

Communiqué A / B MAC

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Key to Indicators in Table of Contents

A	Article Applies to Part A Only
B	Article Applies to Part B Only
A/B	Article Applies to Both Part A and Part B

Items of Importance**ATTENTION OPHTHALMOLOGY PHYSICIANS****~Part B~**

WPS Medicare identified an issue with coding Evaluation and Management (E/M) services within a post-operative period. We identified Ophthalmology providers billing a higher level of service than warranted.

E/M services provided by the surgeon or a member of the same group with the same specialty within a global period of a surgery are part of the surgery and are not separately payable. An exception to this rule is for E/M services not related to the surgery performed as identified by the diagnosis code. Providers can use a modifier 24 to indicate the visit is unrelated to the surgery.

When a visit during the post-operative period of a surgical procedure includes some services related to the surgery and some services that are not, the provider should code a level of service that reflects only those services not related to the surgery. We identified providers billing procedure codes 99213 and 99214 when the work performed for the unrelated diagnosis only supports a procedure code level of 99211 or 99212.

We ask Ophthalmology offices to perform a self-audit and verify they are billing services correctly.

You can find more information on the Global Surgery package pricing and instructions in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Pub. 100-04, Chapter 12, Section 40, available at the following Website address:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Additional global surgery modifier information is also available on the WPS Medicare Website:

http://www.wpsmedicare.com/j5macpartb/education/global_surgery.pdf

<http://www.wpsmedicare.com/j5macpartb/education/24.pdf>

ATTENTION PART B JURISDICTION 5 (J5) MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) PROVIDERS**~Part B~****Multi-Carrier System (MCS) Merge Affects All Part B Providers in J5**

In December 2008, the Centers for Medicare & Medicaid Services (CMS) provided instructions to WPS Medicare outlining a merge of the Multi-Carrier System (MCS) claims processing environments of Iowa and Eastern Missouri with the existing Kansas, Nebraska and Western Missouri MCS claims processing environment. This includes all data values and files, such as procedure code files and claims history. This merge is necessary to maximize efficiency and cost savings for CMS' Medicare Administrative Contracting environment.

This new claim processing environment is scheduled to begin operation on **August 1, 2009**.

WPS Medicare received CMS approval for a "Dark Day" on **Friday, July 31, 2009** to execute the merge. The Dark Day affects all Part B J5 MAC providers.

During the Dark Day, there will be:

- No Provider Call Center activities
- No claims processing
- No EDI claims acceptance
- No payments made to providers or beneficiaries
- No Electronic Admittance Advices (ERAs) produced
- No IVR access

Provider Call Center representatives will not be available on July 31, 2009, as they will not have access to the Medicare claims processing system.

Providers will not be able to access information on July 31, 2009 via the Interactive Voice Response (IVR) unit.

How will this merge affect your payment?

In preparation for these changes, WPS Medicare will implement a payment floor reduction for both paper and Electronic Data Interchange (EDI) affecting those claims approved to pay between July 22 and July 30, 2009. We will reduce the payment floor to zero days over a two-day period beginning with the payment cycle on July 22, 2009.

Schedule for the Payment Floor Reduction:

- 07/22/09 Payment floor of 29 days reduced to 14 days for paper claims and 14 days reduced to 7 days for EDI claims
- 07/23/09 Payment floor to remain at the reduced days of 14 for paper claims and 7 days for EDI claims
- 07/24/09 14 day payment floor for paper reduced to 0 days and 7 day payment floor for EDI claims reduced to 0 days
- 08/03/09 Reset payment floor to 29 days for paper claims and 14 days for EDI claims

This temporary reduction of the payment floor will result in **payments being issued early** (checks and Electronic Funds Transfers (EFTs)). As a result of this payment floor reduction, it may appear to providers that cash revenues increased, when in fact, payments for claims will simply be released at an earlier date.

IOWA & EASTERN MISSOURI ONLY

MCS Merge issues affecting J5 Part B providers in Iowa and Eastern Missouri only

Electronic Prepass Reports and Electronic Remittance Advice (ERA)

If you conduct business in multiple J5 states, starting July 31, 2009, you will receive one combined report and electronic remittance for each day's production. Your prepass report will continue to indicate the billing Provider NPI and batch number (taken from the HL segment). Your ERA will have the pay to provider NPI in the 1000A/NM109 field along with the respective state code in the 1000A/REF02 (TU) field. This may be especially important to providers who have a common NPI in multiple states the NPI may appear in multiple provider "batches" but for different state codes. If you have an NPI in multiple J5 states and the combined report or

remittance is a concern, you may want to request a separate submitter ID for each line of business. To request a separate submitter ID for reports, remittance and claim submission; you will need to complete a self-registration process on our WPS Trading Partner System (WTPS) to prepare for transaction testing and production claim submission. WTPS is located at the following URL:

<https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>

The additional submitter ID would only be necessary if a combined report or remittance is an issue for your practice due to the NPI being multi-J5 states.

What if you receive a claim denial or rejection?

Your remittance advice contains reason and remarks codes that identify the specific reason for the denial or rejection. You can determine your next action by viewing and understanding these codes. These actions include:

- Making changes to your claim and resubmitting,
- Requesting a redetermination, or
- Taking no action because the services are not payable by Medicare

EASTERN MISSOURI ONLY

MCS Merge issues affecting J5 Part B providers in Eastern Missouri only

Providers in Eastern Missouri will experience a change in the contractor number they use when submitting electronic claims. The new contractor number is 05302 and is only for use with claims submitted on July 31, 2009 and later! ***Please DO NOT use the 05302 contractor number for electronic claims submission prior to July 31, 2009.***

Please continue to check the WPS Medicare Website, [eNews](#), and *Communiqué* for information and upcoming educational events concerning this system merge.

CLARIFICATION ON THE USE OF MODIFIER 79

~Part B~

The Office of the Inspector General (OIG) recently issued a Management Implication Report on the misuses of the modifier 79.

The Centers for Medicare & Medicaid Services (CMS) global surgical package was established, in part, to ensure that all of the components of surgery (including pre and post-operative services) are bundled into one payment. CMS established modifier 79 to simplify billing for services provided to a patient during the post-operative period that are unrelated to the original surgical procedure. For example, "Unrelated procedure by the same physician during the post-operative period."

Appropriate use of the 79 modifier includes:

- To describe an unrelated procedure performed during the post-operative period of the original procedure
- The two procedures are performed by the same physician
- All procedure codes except those with XXX in the GLOB (global) field of the MPFSDB

- Used on services during the post-operative period starting the day after the procedure

Inappropriate use of the 79 modifier includes:

- The procedure performed is related to the original procedure or a staged procedure
- If the services performed are related to the original procedure, it is considered part of the global period

The global surgical package components, payment rules, billing procedures, edits, claims review, adjudication, and post-payment instructions can be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 12, Section 40.

You can find additional information on modifier 79, global surgery modifiers, as well as other modifiers by visiting the WPS Medicare Website:

http://www.wpsmedicare.com/j5macpartb/education/b_modifiers.shtml

HOW YOU MAKE A DIFFERENCE

~Part A & Part B~

Have you wondered what WPS Medicare does with your Website Customer Satisfaction ForeSee Results Survey responses? Your feedback is extremely important to WPS Medicare, and your survey responses play a large role in the shaping of the WPS Medicare Website. WPS Medicare staff reviews the results of the survey on a weekly basis, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website.

Over the last several months, WPS Medicare made the following changes to our Website based upon your feedback:

- Splitting of the J5 MAC Website into separate sites for J5 MAC Part A providers and J5 MAC Part B providers
- Redesign of Contact Information
- New and improved home pages
- Creation of comprehensive "Forms" Web pages
- And so much more!

Be sure to continue to regularly complete the Website Customer Satisfaction survey when you visit the WPS Medicare Website and help WPS Medicare continue to provide a Website that meets your needs.

More information on the Website Customer Satisfaction survey is available at

http://www.wpsmedicare.com/sat_survey.pdf.

Claim Submission**BILLING ROUTINE COSTS OF CLINICAL TRIALS**

~ CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM6431
Related CR Release Date: April 10, 2009
Related CR Transmittal #: R1710CP

Related Change Request (CR) #: 6431
Effective Date: July 10, 2009
Implementation Date: July 10, 2009

Provider Types Affected

Physicians and non-physician practitioners submitting claims to Medicare Administrative Contractors (MACs) and carriers for clinical trials

Provider Action Needed

This article is based on Change Request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

Background

CR 6431 revises the Medicare *Claims Processing Manual*, Chapter 32, Section 69.6 (*Requirements for Billing Routine Costs of Clinical Trials*). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the QV or Q1 modifier is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor **will not** consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:
 - Claims adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication; **and**
 - As least one Remark Code, which may be comprised of either:
 - The Remittance Advice Code (M76, Missing/incomplete/invalid diagnosis or condition) **or**
 - National Council for Prescription Drug Programs Reject Reason Code.

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in

the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30;
- Report a secondary diagnosis code of V70.7; and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
 - QA/QR for dates of service before January 1, 2008; or
 - Q0 for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
 - QV for dates of service before January 1, 2008; or
 - Q1 for dates of service on or after January 1, 2008.

Institutional providers should also note that they must not bill outpatient clinical trial services and non-clinical trial services on the same claim for Medicare beneficiaries enrolled in managed care plans.

Additional Information

If you have questions, please contact your Medicare MAC and/or carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

The official instruction (CR6431) issued to your Medicare MAC, or carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1710CP.pdf> on the CMS Website.

MEDICARE CLAIMS PROCESSING MANUAL CLARIFICATIONS FOR SKILLED NURSING FACILITY (SNF) AND THERAPY BILLING

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6407
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R1706CP

Related Change Request (CR) #: 6407
Effective Date: October 1, 2006
Implementation Date: April 27, 2009

Provider Types Affected

Skilled Nursing Facilities and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) 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) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for Skilled Nursing Facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

Change Request (CR) 6407 provides clarifications and updates to the Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS

Coding Requirements). These clarifications indicate that effective January 1, 2009, the new Current Procedural Terminology (CPT) code 95992 (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per Day*) is bundled under the Medicare Physician Fee Schedule (MPFS).

Regardless of whether CPT code 95992 is billed alone or in conjunction with another therapy code, **separate Medicare payment is never made for this code**. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that **both full and partial benefits exhaust claims must be submitted by SNFs monthly**. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1. Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim; and
2. Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types **must be submitted after** the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types **may be submitted prior** to the submission of bill type 210 (SNF no-payment **bill type**).

Additional Information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1706CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

Coverage – Policies**INFORMATION ON WEBSITE****~Part A & Part B~**

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as retired LCDs/Local Medical Review Policies (LMRPs) for Medicare on its Website:

Part A: http://www.wpsmedicare.com/j5macparta/policy/a_mac_lcds.shtml

Part B: http://www.wpsmedicare.com/j5macpartb/policy/b_mac_lcds.shtml

If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LCD/LMRP by writing to our Freedom of Information (FOI) Unit.

Part A	
Iowa Part A	Kansas Part A
WPS Medicare Part A Freedom of Information P.O. Box 7665 Madison, WI 53707-7665	WPS Medicare Part A Freedom of Information P.O. Box 7576 Madison, WI 53707-7576
Missouri Part A	Nebraska Part A
WPS Medicare Part A Freedom of Information P.O. Box 8890 Madison, WI 53707-8890	WPS Medicare Part A Freedom of Information P.O. Box 8799 Madison, WI 53708-8799
Part B	
Iowa, Kansas, Missouri, Nebraska	
WPS Medicare Attn: Freedom of Information Act (FOIA) P.O. Box 8810 Marion, IL 62959	

RETIREMENT OF LCDS NOTIFICATION**~Part A & Part B~****~Part A~****Jurisdiction MAC Part A**

Iowa, Kansas, Missouri, Nebraska

The following WPS Medicare Part A LCD will be retired effective 05/17/2009.

MAC Part A	L26610	Non-Invasive Vascular Studies	Replaced by new policy
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~Part B~

Jurisdiction MAC Part B

Iowa, Kansas, Missouri, Nebraska

The following WPS Medicare Part B LCDs were retired effective 04/30/2009.

MAC Part B	L26637 CV 535	Intravascular Brachytherapy (IVBT)	Not being replaced
MAC Part B	L26627 CV-519	Electrophysiology Studies	Not being replaced
MAC Part B	L26635 CV-532	Insertable Loop recorder	Not being replaced

The following WPS Medicare Part B LCD will be retired effective 05/17/2009.

MAC Part B	L26636 CV-533	Non-invasive Vascular Studies	Replaced by new policy
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Revised Policies for May 2009

Part A/ Part B	Policy #	Title	NCD/ LCD	Web	Communiqué Page
Part A & Part B	HONC-010 (L28576)	<i>Chemotherapy Drugs and their Adjuncts</i>	LCD	Click here to view	12
Part B	INJ-539 (L26657)	<i>Gonadotropin Releasing Hormone Analogs</i>	LCD	Click here to view	12
Part A & Part B	MS-004 (L28527)	<i>Bone Mass Measurement</i>	LCD	Click here to view	13

Coverage – Revised Policies**~Part A & Part B~****Contractor Name**

Wisconsin Physicians Service (WPS)

Contractor TypeCarrier
MAC A
MAC B**LCD Database ID Number**

L28576

LCD Title

Chemotherapy Drugs and their Adjuncts

Contractor's Determination Number

HONC-010

Revision Effective Date

*05/16/09

Indications and Limitations of Coverage and/or Medical Necessity

The following coverage has been added to this document.

- *15. Decitabine (Dacogen) (J0894)
*Acute Myeloid Leukemia 205.00, 205.01, 205.02

**~Part B~****LCD Database ID Number**

L26657

LCD Title

Gonadotropin Releasing Hormone Analogs

Contractor's Determination Number

INJ-539

Primary Geographic Jurisdiction

Iowa, Kansas, Missouri, Nebraska

Revision Effective Date

01/01/2009

CPT Codes

*96372 Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

CPT code 90772 deleted with the 2009 CPT/HCPCS update and replaced with CPT code 96372.

**~Part A & Part B~****Contractor's Policy Number**

MS-004

LCD Database Number

L28527

LCD Title

Bone Mass Measurement

Primary Geographic Jurisdiction

Intermediary: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, District of Columbia, American Samoa, Guam, Northern Mariana Islands, Virgin Islands

Carrier: Wisconsin, Illinois, Michigan, Minnesota

MAC A/B: Iowa, Missouri, Nebraska, Kansas

Revision Effective Date

May 1, 2009

ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

When 77078, 77079, 77081, 77083, 76977, or G0130 is done as an **initial diagnostic test** that determines a diagnosis of 255.0, 733.00, 733.01, 733.02, 733.03, 733.09, or 733.90, code as a secondary diagnosis the reason for the bone mass density test.

For Use with CPT Codes 77078, 77079, 77080, 77081, 77083, 76977, G0130

*820.00-820.9 Fracture of neck of femur

ICD-9-CM codes 820.00 – 820.9 were added as payable diagnoses for use with CPT codes 77078, 77079, 77080, 77081, 77083, 76977, and G0130 as defined in LCD MS-004.

Electronic Data Interchange (EDI)**HEALTH CARE PROVIDER TAXONOMY CODES****~Part B~**

The Health Care Provider Taxonomy codes are updated periodically and the latest version is now available on the Washington Publishing Company's (WPC) Website:

<http://www.wpc-edi.com/codes>

INSTRUCTIONS FOR UTILIZING ANSI X12 837 INSTITUTIONAL CAS SEGMENTS FOR MEDICARE SECONDARY PAYER (MSP) PART A CLAIMS

~Revised CMS MLN Matters~

~Part A~

MLN Matters Number: MM6275 Revised
Related CR Release Date: December 19, 2008
Related CR Transmittal #: R63MSP

Related Change Request (CR) #: 6275
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: On March 27, 2009, the Centers for Medicare & Medicaid Services (CMS) rescinded CR 6275 and replaced it with CR 6426. As a result, this article is replaced by article MM6426, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf> on the CMS Website.

INSTRUCTIONS FOR UTILIZING 837 INSTITUTIONAL CLAIM ADJUSTMENT SEGMENTS (CAS) FOR MEDICARE SECONDARY PAYER (MSP) PART A CLAIMS (THIS CR RESCINDS AND FULLY REPLACES CR 6275)

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6426
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R66MSP

Related Change Request (CR) #: 6426
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

What You Need to Know

CR 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their

use of data reported in ANSI ASC X12N 837 institutional CAS segments for MSP Part A Claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is Obligated to Accept as Payment in Full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements;
- Providers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 Institutional claim.

Adjustments made by the payer are reported in the CAS segment on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as Value Code 44 in the 2300 HI Value Information. This amount is also known as the Obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be

found in the CMS Medicare Secondary Payer Manual and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional Information

You can find the official instruction (CR6426) issued to your FI, RHHI, or MAC by visiting <http://www.cms.hhs.gov/transmittals/downloads/R66MSP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

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

INSTRUCTIONS FOR UTILIZING 837 PROFESSIONAL CLAIM ADJUSTMENT (CAS) SEGMENTS FOR MEDICARE SECONDARY PAYER (MSP) PART B CLAIMS

~ Revised CMS MLN Matters ~

~ Part B ~

MLN Matters Number: MM6211 Revised
Related CR Release Date: December 12, 2008
Related CR Transmittal #: R62MSP

Related Change Request (CR) #: 6211
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Note: This article was rescinded on March 27, 2009, when the related CR 6211 was rescinded. CR 6211 was replaced by CR 6427, which may be found at <http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf> on the CMS Website. The related MLN Matters article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6427.pdf> on the CMS Website.

**INSTRUCTIONS FOR UTILIZING 837 PROFESSIONAL CLAIM
ADJUSTMENT SEGMENTS (CAS) FOR MEDICARE SECONDARY
PAYER (MSP) PART B CLAIMS (THIS CR RESCINDS AND FULLY
REPLACES CR6211)**

~CMS MLN Matters~

~Part B~

MLN Matters Number: MM6427
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R67MSP

Related Change Request (CR) #: 6427
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and/or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6427 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

CAUTION – What You Need to Know

CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

GO – What You Need to Do

Include your CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements;
- Physician and suppliers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the CMS Internet Only Manuals 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Additional Information

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

The official instruction (CR6427) issued to your Medicare contractor is available at <http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf> on the CMS Website.

MEDICARE REMIT EASY PRINT (MREP) – APRIL 2009

~ Part B ~

The Centers for Medicare & Medicaid Services (CMS) released the quarterly update to the Medicare Remit Easy Print (MREP) software on April 6, 2009. MREP Version 2.6 is now available at the following Web page:

http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp

To download the 2.6 version, you must remove the prior version of Medicare Remit Easy Print from your system.

There are four changes being made to the software.

1. An updated “Codes.ini” file will be available on the CMS Website for the provider/supplier community. When the user finds it necessary to import this updated file into their version of MREP, the instructions can be obtained from the MREP User Guide Manual under the “Working with MREP Remittances Advices” section (How to Update (Import) the CARC/RARC codes). Additionally, since updates are being made to the MREP software, the updated list of RARCs and CARCs will be included with the updated Version 2.6 MREP software. If you are a current user of the MREP software and do not install version 2.6, you

will need to download the Codes.ini file in order to update the RARCs and CARCs in your version.

2. The MREP User Manual will be updated to correct the “Remittance Advice/HIPAA 835 Segment Field Crosswalk” in Appendix A. The “Provider adjustment details: FCN” label will be updated to “Provider adjustment details: FCN/Other Identifier” to correspond with the software change included with CR6073 in the October 2008 release.
3. A user reported that the “Display Claim” option with the MREP software is not available after selecting the “Check All” function. This option is not available whether the “Check All” function is used from the TAB menu option or the “Check All” button on the screen. Please note that the “Display Claim” option is available if a user checks the box in front of the claim on the ‘Claim List’ screen.

Changes will be made to MREP so that the “Display Claim” option is available after “Check All” function is used from either the TAB menu option or the button on the screen.

(866) A user reported that the “Display Claim” option with the MREP software is available after selecting the “Uncheck All” function. This option is available whether the “Uncheck All” function is used from the TAB menu option or the “Uncheck All” button on the screen.

Changes will be made to MREP so that the “Display Claim” option is not available after “Uncheck All” function is used from either the TAB menu option or the button on the screen.

If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA), please download the ERA information sheet at http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf and submit it to our office. If you already receive the ERA and want to try MREP, please download the MREP software at <http://www.wpsmedicare.com/j5macpartb/business/mrep.shtml>. If you are not an electronic biller and want to receive an ERA to use the MREP software, you will also need to submit an EDI enrollment form. Please label MREP only. You can download this form at http://www.wpsic.com/edi/pdf/medb_enroll.pdf.

For assistance, please contact EDI at (866) 503-9670.

Take advantage of this software. Begin using MREP today.

General Information**INITIAL ENROLLMENT ASSIGNMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), END STAGE RENAL DISEASE (ESRD) FACILITIES, AND RURAL HEALTH CLINICS (RHCS)**

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6207

Related CR Release Date: March 27, 2009

Related CR Transmittal #: R1707CP

Related Change Request (CR) #: 6207

Effective Date: April 27, 2009

Implementation Date: April 27, 2009

Provider Types Affected

Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) facilities, and Rural Health Clinics (RHCs) that are currently enrolled with a Fiscal Intermediary (FI) or a Medicare Administrative Contractor (MAC), and FQHCs, RHCs, and ESRD facilities that are planning to submit an 855 initial enrollment application.

Provider Action Needed**STOP – Impact to You**

This article is based on Change Request (CR) 6207, which describes initial enrollment policy for assignment of FQHCs, ESRD facilities, and RHCs.

CAUTION – What You Need to Know

As FQHCs, ESRD facilities, and RHCs seek to enroll in the Medicare program, they should file their enrollment applications with the legacy FI or MAC that covers the state where they are located. Exceptions to the geographic assignment rule are set forth in MM 5979, which can be found at <http://www.cms.hhs.gov/MLNMMattersArticles/downloads/MM5979.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. This represents a shift from legacy-world assignment policy where there existed regional and national Fis for these distinct provider types.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 911) amended the Social Security Act (the Act; Title XVIII) to add Section 1874A (Contracts with Medicare Administrative Contractors (MACs)) which replaces the prior Medicare intermediary and carrier contracting authorities formerly found in Sections 1816 and 1842 of the Act. CMS procured the first Part A/B Medicare Administrative Contractor (A/B MAC) in 2006 and continues to award the fifteen A/B MAC contracts. The process of moving workload from legacy contractors to the MACs continues.

The MMA also repealed the provider nomination provision of the Social Security Act and replaced it with the geographic assignment rule. Generally, a provider or supplier will be

assigned to the MAC that covers the state where the provider or supplier is located. Exceptions to the geographic assignment rule are described in MM 5979, which can be found at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5979.pdf> on the CMS Website.

In the legacy FI environment, FQHCs, RHCs, and ESRD facilities were concentrated within the workloads of several regional and national Fis.

Most of the providers that were assigned to regional or national Fis represent “out-of-jurisdiction providers” (OJPs). An OJP is defined as a provider that is not currently serviced by the FI or MAC that covers the state where the provider is located. Regional and national Medicare contractors for FQHCs, RHCs, and ESRD facilities will not exist in the MAC environment.

FQHCs

Most FQHCs are currently within the workload serviced by National Government Services (NGS) Wisconsin. The Jurisdiction 6 MAC will absorb this workload. FQHCs in the NGS workload will be transferred to their destination MACs during the OJP migration. The destination MAC will not always be the geographic MAC.

Indian Health Service (I) facilities will be assigned to the Jurisdiction 4 MAC. For purposes of CR6207, “tribal FQHC” means a Medicare FQHC operated by a tribe or tribal organization under the Indian Self-Determination Act (25 USCS 40(b)) or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 USCS 13). All other freestanding FQHCs, not meeting that tribal description, will be assigned to the MAC that covers the state where the facility is located.

CMS is implementing the geographic assignment rule for initial enrollment FQHCs now to avoid creating additional OJPs. An initial enrollment for an I FQHC will be submitted to the Jurisdiction 4 MAC. A new, non-tribal FQHC will submit its initial CMS-855A application to the FI or MAC that covers the state where the facility is located.

Some classes of FQHCs may present latent challenges for the geographic assignment rule. However, CMS will make accommodations for these providers. For example, if an initial enrollment FQHC satellite is located in the jurisdiction of a MAC other than the audit MAC, then the geographic MAC will service the claims, and the audit MAC will service the cost report.

RHCs and ESRD Facilities

RHCs and many ESRD facilities have been serviced by a limited set of regional Fis in the legacy environment. Those legacy FI workloads will be absorbed by incoming MACs. Out-of-jurisdiction RHCs and ESRD facilities will be transferred to their destination MACs during the OJP migration. An initial enrollment for a RHC or ESRD facility will be submitted to the MAC or FI that serves the state where the RHC or ESRD facility is located.

Note: If the FQHC, RHC or ESRD facility is provider-based, it will be assigned to the FI or MAC that covers the state where the main provider is located.

Misfiled CMS 855-A Applications

If a FQHC, RHC or ESRD facility submits a CMS-855A initial application to an incorrect Medicare contractor, the receiving contractor will mail the application to the appropriate contractor and notify the provider that its application has been sent to the new contractor and that all future questions regarding the application should be directed to the new contractor.

Internet-based PECOS

FQHCs, RHCs, and ESRD facilities will not be able to use Internet-based PECOS for the filing of CMS-855A initial applications, changes of ownership, or changes of information. Only paper forms will be accepted for these transactions.

The following is a table that summarizes the changes of CR 6207:

Facility	New Enrollment Applications
FQHC	FI/MAC covering the state where they are located
RHC	FI/MAC covering the state where they are located
ESRD	FI/MAC covering the state where they are located
I FQHC	J4 MAC
Provider-based FQHC	FI/MAC servicing the main provider

Additional Information

The official instruction (CR 6207) issued to your Medicare contractor, regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1707CP.pdf> on the CMS Website.

A listing of contractor addresses can be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage on the CMS Website.

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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

MULTIPLE AMBULANCE TRIPS PER DAY FOR THE SAME PATIENT**~Part B~**

When an ambulance supplier provides multiple transports for the same patient on the same date of service, the supplier needs to provide specific important information. The run sheets and documentation on the claim or in the narrative record should contain the information listed below. Place the information listed below in item 19 (CMS-1500) or electronic equivalent for extra narrative record for electronic claims (2300 or 2400).

1. Reason for the ambulance transport
2. Treatment given/services provided
3. Patient's condition en route

4. Statement indicating there were multiple trips on the same day:

Examples:

- 2 trips on the same day or
- Second trip on the same day or
- Third trip on the same day

Note: For an EMC claim, this would have to be reported at line level or same as claim level.

5. Name/address of the destination- facility name if applicable
6. If space is limited, place "Documentation available upon request"

Since the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP codes.

Note: Electronically, a provider can bill with a claim level (2310D) point of pick up as well as a line level point of pick up (2420C).

See the CMS Internet-Only Manual (IOM) Pub. 100-4, Chapter 15, Section 30.1.2:
<http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf>

Failure to supply documentation may cause delays or denials.

Bill the appropriate base rate and mileage codes with the appropriate origin and destination modifiers for the services rendered to the patient. For additional information on procedure codes, refer to "Ambulance Procedure Codes" at the following Web address:
http://www.wpsmedicare.com/j5macpartb/education/amb_codes.pdf

For additional information regarding modifiers for ambulance services, refer to "Ambulance Modifiers" at the following Web address:
http://www.wpsmedicare.com/j5macpartb/education/amb_modifiers.pdf

PROGRAM OVERVIEW: 2009 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) AND THE 2009 ELECTRONIC PRESCRIBING (E-PRESCRIBING) INCENTIVE PROGRAM

~CMS MLN Matters~

~Part B~

MLN Matters Number: MM6394
Related CR Release Date: March 20, 2009
Related CR Transmittal #: R459OTN

Related Change Request (CR) #: 6394
Effective Date: January 1, 2009
Implementation Date: June 22, 2009

Provider Types Affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) or the new 2009 E-Prescribing Incentive Program.

Provider Action Needed

This article is based on Change Request (CR) 6394, which gives high-level overviews of the 2009 PQRI implementation and the new 2009 E-Prescribing Incentive Program implementation. Make sure that your billing staffs are aware of the PQRI reporting changes and the E-Prescribing Incentive Program.

Background

The 2006 Tax Relief and Health Care Act (P.L. 109-432) (TRHCA) required CMS to establish a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. CMS named this program the Physician Quality Reporting Initiative (PQRI).

For the 2009 PQRI, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (P.L. 110-173) (MMSEA) required the Secretary to select measures for 2009 through rulemaking and to establish alternative reporting criteria and alternative reporting periods for reporting measures groups and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. The 2009 PQRI requirements are outlined in the 2009 Medicare Physician Fee Schedule (MPFS) final rule with comment period that was published in the **Federal Register** on November 19, 2008 (visit <http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf> on the Internet) and are summarized below.

Section 132 of the MIPPA also authorizes a new and separate incentive program for eligible professionals who are successful electronic prescribers (e-prescribers) as defined by MIPPA. This new incentive is separate from and is in addition to the PQRI. The 2009 program requirements for the E-Prescribing Incentive Program are also outlined in the 2009 MPFS final rule with comment period and summarized below.

The purpose of this article is to give high-level overviews of the 2009 PQRI implementation and the new 2009 E-Prescribing Incentive Program implementation, as directed by the statute. Detailed information, educational materials, and supportive tools for the 2009 PQRI and the 2009 E-Prescribing Incentive Program will be posted as they become available on the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage and the CMS E- Prescribing Incentive Program Website at http://www.cms.hhs.gov/ErxIncentive/01_Overview.asp#TopOfPage, respectively. In addition, there are fact sheets available for the 2009 PQRI and E-Prescribing programs at <http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf> and http://www.cms.hhs.gov/ErxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf, respectively.

The 2009 PQRI overview section below highlights changes from the 2008 PQRI with respect to: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment for reporting, (5) individual quality measures, (6) measures groups, (7) determination of satisfactory reporting, (8) validation, (9) appeals, and (10) confidential feedback reports.

The 2009 E-Prescribing Incentive Program overview section of this article addresses: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment

for reporting, (5) determination of a successful e-prescriber, and (6) confidential feedback reports.

2009 PQRI Overview

1. *Eligible Professionals*

Beginning with the 2009 PQRI, the definition of “eligible professional” has been expanded to include qualified audiologists, as required by the MIPPA. Therefore, for the 2009 PQRI, the following professionals are eligible to participate in PQRI:

Medicare physicians

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Podiatric Medicine;
- Doctor of Optometry;
- Doctor of Oral Surgery;
- Doctor of Dental Medicine; and
- Doctor of Chiropractic.

Practitioners

- Physician Assistant;
- Nurse Practitioner;
- Clinical Nurse Specialist;
- Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant);
- Certified Nurse Midwife;
- Clinical Social Worker;
- Clinical Psychologist;
- Registered Dietician;
- Nutrition Professional; and
- Audiologists (as of January 1, 2009)

Therapists

- Physical Therapist;
- Occupational Therapist; and
- Qualified Speech-Language Therapist.

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons.

Professionals eligible to participate but not able to participate include:

1. Professionals paid under or based upon the MPFS billing Medicare Carriers or Medicare Administrative Contractors (MACs) who do not bill directly. For example, Qualified Speech-Language Therapists do not currently bill Medicare directly. It is anticipated that Qualified Speech-Language Therapists will begin billing Medicare directly on July 1, 2009, at which point they would be able to participate.

2. Professionals paid under the MPFS billing Medicare fiscal intermediaries (Fis) or MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:
 - Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the FI/MAC for the professional services provided by the physician or practitioner.
 - All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

Services payable under fee schedules or methodologies other than the MPFS are not included in PQRI (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

Form and Manner of Reporting

For 2009, eligible professionals can continue to choose whether to report through claims-based submission or through a qualified PQRI registry. In addition, eligible professionals can continue to choose to report on individual quality measures or on measures groups.

- For claims-based submission, there is no need to enroll or register to begin claims-based reporting for the 2009 PQRI. Participating eligible professionals whose Medicare patients fit the specifications of the 2009 PQRI quality measures and/or measures groups will simply report the appropriate current procedural terminology (CPT) Category II codes or G-codes (where CPT Category II codes are not yet available) on their claims. CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. Additional guidance about how to implement 2009 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by eligible professionals for the 2009 PQRI is available in the *2009 PQRI Implementation Guide*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage on the CMS Website.

- For registry-based reporting, eligible professionals should submit information to a qualified PQRI clinical data registry and authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

For 2009, CMS will conduct another self-nomination process for registries so additional registries can potentially be approved for submitting quality measures data for the 2009 PQRI. Registries qualified to submit data on behalf of their eligible professionals in 2008 are not required to self-nominate again for 2009 unless they are unsuccessful at submitting 2008 data by March 31, 2009. The list of qualified registries for the 2009 PQRI will be available on the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage on the CMS Website in the summer of 2009.

3. Reporting Periods

There are no changes to the PQRI reporting period or the alternative reporting periods for measures group reporting or for registry-based reporting for 2009. In other words, the 2009 PQRI reporting period continues to be the entire calendar year. There also continues to be two alternative reporting periods for measures group reporting and for registry-based reporting (i.e., the entire calendar year and a six-month reporting period beginning July 1, 2009).

4. Payment for Reporting

Participating eligible professionals who satisfactorily report as prescribed by the 2009 MPFS final rule with comment period (and as summarized below in the Determination of Satisfactory Reporting section) may earn a 2.0% incentive payment. Because claims processing times may vary, participating eligible professionals should submit claims from the end of 2009 promptly, so that those claims will reach the Medicare's National Claims History (NCH) file by February 28, 2010. PQRI incentive payments will be paid as a lump sum in mid-2010.

The PQRI incentive payment will apply to allowed charges for all covered professional services, under the MPFS not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the MPFS do not apply to the PQRI incentive payment.

For 2009, the analysis of satisfactory reporting will continue to be performed at the individual eligible professional level using individual-level National Provider Identifier (NPI) data. CMS, however, will continue to use the Taxpayer Identification Number (TIN) as the billing unit, so any PQRI incentive payments earned will be paid to the TIN holder of record. PQRI incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will continue to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the PQRI incentive payment under more than one TIN will receive a separate PQRI incentive payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, Section 1848(m)(1)(A)(ii) of the Act specifies that any PQRI incentive payment earned will be paid to the employers or facilities.

5. Individual Quality Measures

The 2009 PQRI includes a total of 153 quality measures. This total includes 52 new measures. In addition, whereas all of the 2008 PQRI quality measures were reportable either through claims-based submission or registry-based reporting, 18 of the 153 PQRI quality measures for 2009 are reportable **only** through registries. A complete list of the 2009 PQRI individual quality measures can be found in the *2009 PQRI Quality Measures List*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage on the CMS Website.

6. Measures Groups

There are seven measures groups for the 2009 PQRI. More detailed information on these measures groups is available in the fact sheet at <http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf> on the CMS Website.

7. Determination of Satisfactory Reporting

In order to qualify to earn an incentive payment, eligible professionals must meet the criteria for satisfactorily reporting data on PQRI quality measures. For the 2009 PQRI, there are a total of nine reporting options, or ways in which an eligible professional can attempt to satisfactorily report. Although there are multiple reporting options for satisfactory reporting, an eligible professional only needs to satisfactorily report under one option to qualify for the 2.0% incentive payment for the applicable reporting period. An eligible professional who qualifies for more than one reporting period will receive the incentive payment for the longest reporting period for which the professional qualifies. Only one incentive payment may be obtained regardless of how many reporting options the eligible professional chooses.

While the number of reporting options remains the same as in 2008, there are some differences between the 2008 PQRI reporting options and the 2009 PQRI reporting options. The 2009 PQRI reporting options, including any changes, are also detailed in the fact sheet at <http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf> on the CMS Website and are included in CR6394 at <http://www.cms.hhs.gov/transmittals/downloads/R459OTN.pdf> on the CMS Website.

As stated in the Payment for Reporting section, the analysis of whether an eligible professional has satisfactorily reported will continue to be performed at the individual eligible professional level using the individual-level NPI. The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2009 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures and/or measures groups that are applicable to their practices. If an eligible professional submits data for a quality measure or a measures group, then that measure or measures group is presumed to be applicable for the purposes of determining satisfactory reporting. For eligible professionals choosing to report on individual quality measures, CMS recommends that

eligible professionals report on every quality measure that is applicable to their patient populations to increase the likelihood that they will reach the 80% satisfactorily reporting requirement for the requisite number of measures.

As detailed information, education, and tools to support satisfactory claims-based reporting of individual quality measures and/or measures groups become available, they will be posted on the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage on the CMS Website.

8. Validation

Section 1848(m)(5)(D)(ii) of the Social Security Act (the Act) permits CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. Under the claims-based reporting method of individual measure(s), the determination of satisfactory reporting, as defined by statute, will itself serve as a general validation because the analysis will assess whether quality-data codes are appropriately submitted by an eligible professional in a sufficient proportion of the instances when a reporting opportunity exists. In addition, for those eligible professionals who satisfactorily submit quality-data codes for fewer than three (3) PQRI measures, a two-step measure-applicability validation (MAV) process will determine whether they should have submitted quality-data codes for additional measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the incentive payment. More information on the MAV process for the 2009 PQRI is available in the Analysis and Payment section of the CMS PQRI Website at http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage on the CMS Website.

9. Appeals

For the 2009 PQRI, the statute specifically states that there will be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, or (3) the incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

10. Confidential Feedback Reports

CMS will provide confidential feedback reports on 2009 PQRI reporting to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2009 PQRI or to receive an incentive payment.

In addition, Section 1848(m)(5)(G) of the Act requires CMS to post on the CMS Website, in an easily understandable format, a list of the names of the eligible professionals who satisfactorily submitted data on quality measures under PQRI. Therefore, the names of eligible professionals who satisfactorily submitted data on quality measures for the 2009 PQRI will be posted at <http://www.medicare.gov> on the Internet after the lump sum incentive payments are made in 2010.

E-Prescribing Incentive Program Overview

1. *Eligible Professionals*

For the 2009 E-Prescribing Incentive Program, “eligible professional” includes the same list of professionals as previously shown as eligible for the PQRI program.

However, in order to participate in this incentive program, a professional in one of categories of eligible professionals must be authorized by his or her respective state laws to prescribe medication and prescribing medications must fall within the individual eligible professional’s scope of practice.

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 E-Prescribing Incentive Program, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons and the reasons are the same as those which preclude professionals from participating in PQRI as mentioned earlier in this article.

Professionals not eligible to participate in the E-Prescribing Incentive Program and not able to qualify to earn an incentive payment are those that are not defined as eligible professionals in the Medicare Improvements for Patients and Providers Act of 2008.

Services payable under fee schedules or methodologies other than the MPFS are not included in E-Prescribing Incentive Program (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

The E-Prescribing Incentive Program Fact Sheet at http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf on the CMS Website provides an excellent guide for participation in the program.

2. *Form and Manner of Reporting*

For 2009, participation in the E-Prescribing Incentive Program is limited to the submission of quality data codes for the e-prescribing measure through Medicare’s claims processing system, as described in the 2009 MPFS final rule with comment period. There is no need to enroll or register to begin claims-based reporting for the 2009 E-Prescribing Incentive Program.

Participating eligible professionals who bill for the services or procedures included in the denominator of the 2009 e-prescribing measure will report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the 2009 e-prescribing measure are available on the CMS E-Prescribing Incentive Program Website at http://www.cms.hhs.gov/ERxIncentive/01_Overview.asp#TopOfPage on the CMS Website.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the billable service or procedure to which the quality-data code applies.

The 2009 e-prescribing measure does not require a diagnosis code to help determine the denominator.

3. Reporting Periods

For 2009, the reporting period for the E-Prescribing Incentive Program is the entire calendar year, or January 1, 2009 – December 31, 2009.

4. Payment for Reporting

For 2009, eligible professionals, who are determined to be “successful e-prescribers” (as discussed below), may earn an incentive payment equal to 2.0 percent of the total estimated allowed charges for all such MPFS covered professional services: (1) furnished by the eligible professional during the reporting period of January 1 through December 31, 2009, (2) received into the CMS NCH file by February 28, 2010, and (3) paid under or based upon the MPFS. Because claims processing times may vary, participating eligible professionals should submit claims service dates late in 2009 promptly, so that those claims will reach Medicare’s NCH file by February 28, 2010. CMS anticipates that the e-prescribing incentive payments will be paid as a lump sum in mid-2010. There is no beneficiary co-payment or notice to the beneficiary regarding the e-prescribing incentive payments.

According to the statute, however, there is a limitation with regard to the application of the incentive. For 2009, the incentive **does not** apply to eligible professionals, for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the e-prescribing measure applies are less than 10% of the total of the allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional. Under the E-Prescribing Incentive Program, covered professional services are those paid under or based upon the MPFS.

The e-prescribing incentive payment will apply to allowed charges for all covered professional services, not just those charges associated with the e-prescribing measure. The term “allowed charges” refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the MPFS amounts for assigned and non-assigned claims will not apply to the incentive. The statute defines e-prescribing covered services as those paid under or based upon the MPFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

For 2009, the analysis of determining successful e-prescribers will be performed at the individual eligible professional level using individual-level NPI data. CMS, however, will use the TIN as the billing unit, so any e-prescribing incentive payments earned will be paid to the TIN holder of record. E-prescribing incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the e-prescribing incentive payment under more than one TIN will receive a separate e-prescribing incentive payment associated with each TIN. In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, section 1848(m)(2)(A) of the Act specifies

that any e-prescribing incentive payment earned will be paid to the employers or facilities.

5. Determination of a Successful E-Prescriber

For purposes of qualifying for the e-prescribing incentive payment for 2009, an eligible professional will be considered a successful e-prescriber if he/she reported the applicable e-prescribing quality measure in at least 50 percent of the cases in which such measure is reportable by the eligible professional during the reporting period.

6. Confidential Feedback Reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. As with PQRI, access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2009 E-Prescribing Incentive Program or to receive an incentive payment.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS Website, in an easily understandable format, a list of the names of the eligible professionals who are successful e-prescribers. Therefore, the names of eligible professionals who are determined to be successful e-prescribers for the 2009 E-Prescribing Incentive Program will be posted at <http://www.medicare.gov> on the Internet after the lump sum incentive payments are made in 2010.

Additional Information

The official instruction (CR 6394) issued to your carrier and/or A/B MAC, regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R459OTN.pdf> on the CMS Website.

Once again, there are fact sheets available for the 2009 PQRI and E-Prescribing programs at <http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf> and http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf, respectively.

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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

Provider Education**EDUCATION SCHEDULE****~Part A & Part B~**

Be sure to visit the WPS Medicare Education Schedule to learn more about the educational events we have scheduled for the upcoming months.

~Part A Education Schedule~

<http://www.wpsmedicare.com/j5macparta/education/schedule.shtml>

~Part B Education Schedule~

<http://www.wpsmedicare.com/j5macpartb/education/schedule.shtml>

Some of the educational events WPS Medicare is hosting include the following:

- CAH Billing Hospital Seminar (Part A)
- Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT) (Part A & Part B)
- Making the Most of the WPS Medicare and CMS Websites Webinar (Part B)
- Medicare 101 and Clinical for Skilled Nursing Facilities Seminar (Part A)
- Medicare Part B Preventive Services (Part B)
- National Correct Coding Initiative & The Physician Fee Schedule Relative Value File Teleconference (Part B)
- Outpatient Prospective Payment Billing Seminar (Part A)
- Skilled Nursing Facility Billing Seminar (Part A)

We hope you can join us to learn more about the Medicare program.

ELECTRONIC DATA INTERCHANGE (EDI) ASK-THE-CONTRACTOR TELECONFERENCES (ACTS)**~Part A & Part B~**

WPS Medicare is pleased to announce the 2009 schedule for our Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT). The calls will be for Legacy Part A (institutional providers who joined WPS in November 2007) and Part B (IL, MI, WI, and MN), as well as MAC J5 A and B states (IA, KS, MO, and NE). These teleconferences will last one and one-half hours. We encourage providers, billing staff, vendors, and clearinghouses to call with any Medicare EDI questions they deem appropriate.

We will approach the call much in the same way CMS approaches their valuable Open Door Forums, promoting a forum that is less structured, and encourages participants to ask whatever they choose, as long as it pertains to Medicare EDI. We look forward to your participation in these calls!

What are Ask-the-Contractor Teleconferences (ACTs)?

The Medicare Modernization Act (MMA) requires Medicare contractors to hold Ask-the-Contractor Teleconferences (ACTs). This requirement is based on CMS' goal of giving those

who provide service to beneficiaries, the information they need to understand the Medicare program, be informed often and early about changes, and, in the end, bill correctly.

The ACT promotes valuable interaction between the Medicare Contractor (WPS) and EDI customers. As stated previously, we modeled our ACTs after CMS Open Door Forums.

Participants are encouraged to ask questions and raise concerns. EDI staff is available during the call to provide education, program updates, answer questions, and take feedback. In addition, we will provide necessary follow-up to any issues that cannot be resolved during the call time.

WPS Medicare encourages providers to participate in this important educational activity. You can access a recording of the EDI ACT teleconference on this Website approximately one week following the event.

Please Note: No Registration is Necessary

EDI Ask-the-Contractor Teleconference

We will conduct our 2009 EDI Ask-the-Contractor Teleconference (ACT) on the dates below. You will need the following information to participate in the call:

Date	Time	Dial In	ID
May 14, 2009	1 pm CST	800-305-2862	70745640
July 9, 2009	1 pm CST	800-305-2862	70745908
September 10, 2009	1 pm CST	800-305-2862	70746156
November 12, 2009	1 pm CST	800-305-2862	70746399

Remember, you can access a recording of this session on our Website approximately one week following the teleconference.

Reimbursement**HOSPICE CAP CALCULATIONS LETTERS AND ADMINISTRATIVE
APPEALS**

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6400
Related CR Release Date: April 3, 2009
Related CR Transmittal #: R1708CP

Related Change Request (CR) #: 6400
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Hospice providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6400 which requires Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap. The letter you receive will include the inpatient and aggregate cap calculation results. Additionally, it will include appeals language in every determination of program reimbursement letter. If you have exceeded the cap, the letter will include a demand for repayment.

Background

The law governing payment for hospice care subjects hospice payments to two statutory caps:

- A cap on payments for inpatient days, described in Section 1861(dd)(2)(A)(iii) of the Social Security Act and
- An aggregate cap on total payments, described in Section 1814(i)(2)(A)-(C).

These statutory caps limit total hospice payments during a cap year. Payments in excess of either cap must be refunded. Currently, after the end of the cap year, the applicable contractor (RHHI, FI, or A/B MAC) computes both cap amounts, and determines the amount of program reimbursement for each hospice provider they serve.

Important Information:

The latest hospice cap amount for the cap year ending October 31, 2008 is \$22,386.15. The hospice cap is discussed further in the Medicare Claims Processing Manual (Chapter 11 - Processing Hospice Claims, Section 80.2) which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the Centers for Medicare & Medicaid Services Website. Your contractor (RHHI, FI, or AB MAC) will issue a letter to notify you of the results of the contractor's cap calculations and to serve as your determination of program reimbursement. If there is a cap overpayment, there will be an accompanying demand for repayment.

Administrative Appeals:

As indicated in section 418.311 of 42 CFR, if you believe that your payments have not been properly determined, you may request a review from the applicable contractor if the amount in controversy is \$1,000 or more, but less than \$10,000, or from the Provider Reimbursement Review Board (PRRB) if the amount in controversy is \$10,000 or more. Appeal requests must be in writing and be filed within 180 days from the date of the determination. Your appeal rights are discussed further in the Medicare Claims Processing Manual (Chapter 11 - Processing Hospice Claims, Section 80.3), which is attached to CR 6400.

Additional Information

The official instruction, CR 6400, issued to your RHHI, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1708CP.pdf> on the CMS Website.

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

IMPLEMENTATION OF CAPITAL TO INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) INDIRECT MEDICAL EDUCATION (IME) AND LONG TERM CARE HOSPITAL (LTCH) PROVISIONS FROM THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) OF 2009

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6444
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R466OTN

Related Change Request (CR) #: 6444
Effective Date: February 17, 2009
Implementation Date: April 6, 2009

Provider Types Affected

Inpatient Acute Care Hospitals and LTCHs that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article discusses provisions of the ARRA that impact capital IPPS payments to hospitals for indirect medical education (IME) and changes to certain LTCH Prospective Payment System (PPS) payment policies. Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed with an incorrect payment amount for IME and/or short-stay outlier claims of LTCHs with a teaching program. **You need take no action to initiate the reprocessing of the claims.** You should notify your billing office staff that adjustments to payments will be made within six months of Pricer software installation at your contractor. That installation is scheduled to occur on or before April 6, 2009.

Background

The ARRA was signed into law on February 17, 2009. Change Request (CR) 6444 provides a summary of the legislation as well as implementation instructions on certain provisions that affect the Medicare Fee-for-Service program.

The first key point of the legislation affects capital IPPS IME payments for fiscal year (FY) 2009. Beginning in FY 2009, hospitals were to receive 50 percent of the capital IME adjustment provided under the current formula. Section 4301(b)(1) of the ARRA removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009. The AARA also explicitly specifies that the elimination of the capital IME adjustment in FY 2010 and subsequent years is not to be affected. Therefore, beginning in FY 2010 and after, under current law, hospitals will no longer receive a teaching adjustment under the capital IPPS. This provision also affects LTCH PPS payments as part of the Short Stay Outlier (SSO) calculation. The revision to the capital IPPS IME adjustment for FY 2009 provided for by section 4301(b)(1) of the ARRA also affects the payments for some SSO cases from LTCHs with teaching programs since the calculation of the "IPPS comparable amount" component of the SSO "blend" option must also be revised to reflect the change to the capital IME adjustment for FY 2009 provided for in the ARRA. In the same way as with the SSO calculation, changes to the capital IME payments specified by the ARRA of 2009 affect LTCH PPS payments governed by the "25 percent" threshold payment adjustments. Under these policies, those cases in excess of the applicable thresholds are paid an amount based on an amount **equivalent** to what would be paid under the IPPS. Therefore, the revision to the capital IPPS IME adjustment for FY 2009 provided for in section 4301(b) would apply to those LTCHs with teaching programs.

A second key point of the legislation affects LTCHs. The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 placed a moratorium on new LTCHs or new LTCH satellites and expansions in the number of beds in existing LTCHs, effective December 29, 2007. MMSEA allowed for limited exceptions to the moratorium. The ARRA makes one additional exception to the moratorium that will allow existing LTCHs to expand the number of beds in the LTCH or its satellite if the hospital obtained a certificate of need for an increase in beds in a State for which such certificate of need is required that was issued on or after April 1, 2005, and before December 29, 2007.

A third key point of the legislation also affects LTCHs. As noted above, CMS regulations create special payment provisions for LTCHs or LTCH satellites that receive more than 25 percent of their admissions from a single referral source. The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located. The ARRA also extended the increase in percentages under the 25 percent threshold policy to include "grandfathered" LTCH satellites, i.e., those in existence prior to October 1, 1999 and changed the implementation date of all changes to the 25 percent threshold payment adjustment from the date of enactment of the MMSEA (December 29, 2007), to either July 1, 2007 or October 1, 2007, as appropriate for the specific provision.

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) Website.

The official instruction (CR6444) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R466OTN.pdf> on the CMS Website.

INCORPORATION OF PHYSICIAN FEE SCHEDULE REGULATORY CHANGES INTO CHAPTER 10 OF THE PROGRAM INTEGRITY MANUAL (PIM)

~ Revised CMS MLN Matters ~

~ Part A & Part B ~

MLN Matters Number: MM6310 Revised
Related CR Release Date: April 15, 2009
Related CR Transmittal #: R289PI

Related Change Request (CR) #: 6310
Effective Date: January 1, 2009
Implementation Date: April 1, 2009

Note: This article was revised on April 16, 2009, to reflect a revision made to CR 6310. Specifically, the Centers for Medicare & Medicaid Services modified two requirements of CR6310. The specific change in this article is in the last bullet point under "Timeframes for reporting changes of information" on page 3. That bullet point was changed to show that an overpayment may be assessed. Previously, it stated an overpayment will be assessed. The CR release date, transmittal number, and the Web address for accessing the CR have also been revised. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

All Medicare physicians, providers, and suppliers, as well as those who are considering applying to participate in the program should be aware of the new rule and of upcoming changes to the Medicare enrollment process.

Background

Change Request (CR) 6310 implements regulatory changes found in the CY 2009 Medicare Physician Fee Schedule final rule with comment (CMS-1403-FC). Significant changes are summarized below.

Effective date of Medicare billing for physicians, certain non-physician practitioners, and Physician and Non-Physician Practitioner Organizations

- Carriers and Part A and Part B Medicare Administrative Contractors (A/B MACs) will establish the effective date of Medicare billing privileges (see 42 CFR 424.520(d)) for physicians, non-physician practitioners, and physician or non-physician practitioner organizations. Physicians, non-physician practitioners and physician and non-

- physician practitioner organizations will no longer be allowed to establish retrospective Medicare effective billing dates.
- Carriers and A/B MACs will establish an effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and physician and non-physician practitioner organizations (e.g., clinics/group practices).
 - The effective date of Medicare billing privileges for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. Note: The date of filing for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement that were both processed to completion.
 - The individuals and organizations identified above may, however, retrospectively bill for services when:
 - The supplier has met all program requirements, including state licensure requirements, **and**
 - The services were provided at the enrolled practice location for up to:
 - 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
 - 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

Timeframes for reporting changes of information

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph; the following changes must be reported within 30 days:
 - A change of ownership;
 - A final adverse action; or
 - A change in practice location.
- If an individual or organization identified above does not comply with the reporting requirements relating to, respectively, final adverse actions and practice location changes, the supplier may be assessed an overpayment back to the date of the final adverse action or change in practice location.

Application rejections and denials for physician and certain non-physician practitioner applications

- Carriers and A/B MACs will deny, rather than reject, incomplete applications submitted by physicians, non-physician practitioners, and physician or non-physician practitioner organizations.
- This change will allow the individuals and organizations identified above to preserve their effective date of filing by submitting a corrective action plan or an appeal and

submitting the missing information/documentation to allow the carrier or A/B MAC to adjudicate the enrollment application to completion.

Revocation effective dates

- A revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction, (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that the Centers for Medicare & Medicaid Services (CMS) or its contractor determined that the provider or supplier is no longer operational.
- Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., clinic/group practices) consisting of the individuals previously identified, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

Requirements for maintaining ordering and referring documentation

- Carriers or A/B MACs may revoke the billing privileges of any provider or supplier that fails to comply with Medicare's ordering and referring documentation requirements as specified in 42 CFR 424.5216 (f).
- Such revocation is also possible in cases where the physician or non-physician practitioner fails to maintain written ordering and referring documentation for seven (7) years from the date of service.
- Off-site or electronic storage of the ordering and referring documentation described in 42 CFR §424.516(f) is not precluded, as long as these records are readily accessible and retrievable.

Other changes

- Final adverse action is defined.

Additional Information

The official instruction (CR 6310) issued to your carrier, FI, and A/B MAC, regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R289PI.pdf> on the CMS Website.

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

WPS MEDICARE PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of an LMRP/LCD, or if you experience difficulties obtaining a policy on our Website, please contact a customer service representative at the telephone numbers/addresses listed below.

Part A	
Iowa Part A	Kansas Part A
WPS Medicare Part A General Correspondence P.O. Box 7665 Madison, WI 53707-7665 (866) 518-3285	WPS Medicare Part A General Correspondence P.O. Box 7576 Madison, WI 53707-7576 (866) 518-3285
Missouri Part A	Nebraska Part A
WPS Medicare Part A General Correspondence P.O. Box 8890 Madison, WI 53707-8890 (866) 518-3285	WPS Medicare Part A General Correspondence P.O. Box 8799 Madison, WI 53708-8799 (866) 518-3285
Part B	
Iowa	Kansas
WPS Medicare Part B General Correspondence P.O. Box 8550 Madison, WI 53708-8550 (866) 503-3807	WPS Medicare Part B General Correspondence P.O. Box 7238 Madison, WI 53707-7238 (866) 503-3807
Missouri (Western)	Missouri (Eastern)
WPS Medicare Part B General Correspondence P.O. Box 7128 Madison, WI 53707-7128 (866) 503-3807	WPS Medicare Part B General Correspondence P.O. Box 14260 Madison, WI 53708-0260 (866) 503-3807
Nebraska	
WPS Medicare Part B General Correspondence P.O. 8667 Madison, WI 53708 (866) 503-3807	

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<http://www.wpsmedicare.com/listserv>

Follow our site's instructions for signing up and simply check your e-mail regularly to receive the latest Medicare information.