

TrailBlazer Bulletin



January 2012



Note: Unless designated differently, all information herein pertains to both Part A and Part B audiences.

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The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

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From the Desk of the Medical Director

Billing for VeriStrat® [B]

VeriStrat® is a new blood test that will help determine if a patient is likely to benefit from a specific lung cancer therapy. It is reported to stratify patients with advanced non-small cell lung cancer into good or poor outcome categories after treatment with epidermal growth factor receptor tyrosine kinase inhibitors (e.g., gefitinib, erlotinib).

VeriStrat® consists of serum mass spectrometry, followed by computer processing or algorithmic analysis of the spectra to generate a patient-specific report.

Providers should bill Medicare for VeriStrat® using the following CPT code:

- 83789©: Mass spectrometry quant.
- Payment will be made based on the Medicare fee schedule amount for CPT code 83789.
- If this test is billed with an unspecified CPT code such as 84999, payment will be based on the payment amount for CPT code 83789.

Please refer to the instruction at the beginning of the “Chemistry” section of the *CPT Manual* noted below:

- “Clinical information derived from the results of laboratory data that is mathematically calculated (e.g., free thyroxine index (t7)) is considered part of the test procedure and therefore is not a separately reportable service.”

Front Page News

CMS Releases Important 5010 Deadline Information [A/B]

CMS has released Technical Direction Letter (TDL) 12148, dated December 22, 2011, which includes updated instructions for the ASC X12 Version 5010 transition. As stated in TDL 12148, TrailBlazer will not reject compliant ASC X12 Version 4010A1 transactions prior to April 1, 2012. The exact date and time 4010A1 transactions will be rejected will be published at a later date.

Trading partners that have tested and been approved for 5010, but are still submitting 4010A1 transactions, have 30 days to complete their cutover to submitting Version 5010 production transactions. All submitters must have tested and been moved into production for submitting 5010 transactions prior to April 1, 2012.

Please contact the Technology Support Center at (866) 749-4302 if you have any questions regarding the 5010 transition.

Provider News

Educational Notices

GENERAL

Providers Must Call Part B IVR Regarding Duplicate Denial Claims – Effective February 1, 2012 [B]

Note: This notice is being updated to notify providers that effective February 1, 2012, the Part B Provider Call Center (PCC) will no longer be able to assist with providing duplicate denial claim information. Providers will be required to use the detail information function in the claim status section of the Interactive Voice Response (IVR) system, effective February 1, 2012.

On December 22, 2011, the Part B Interactive Voice Response (IVR) was enhanced to provide additional information for duplicate claim denials. The new information will notify the provider if the claim was a duplicate against the same provider or against another provider's claim. If the claim denied against the same provider, it will give the Internal Control Number (ICN) of the duplicate claim, the process date and the remittance number. If the claim denied against another provider, it will give the other provider's National Provider Identifier (NPI) number and refer the caller to the National Plan and Provider Enumeration System (NPPES) Web site for further information.

This new information will be provided when the provider presses 1 for detailed information.

IVR – (877) 567-9230

Part B main menu options:

- Press **1** for Medicare eligibility and benefits.
- Press **2** for Medicare claim status.
- Press **3** for Medicare payment status.
- Press **4** for duplicate remits.
- Press **5** for general Medicare information.
- Press **#** (pound key) to repeat this menu.

The IVR will require the caller to enter the following information:

- NPI.
- Provider Transaction Access Number (PTAN).
- Last five digits of the Taxpayer Identification Number (TIN).
- Health Insurance Claim Number (HICN).
- Patient name.
- Date of service.

INITIAL CLAIM INFORMATION

The following information is played for all claims:

- The claim for services rendered on **MMDDYYYY** (*Services Rendered From Date*) through **MMDDYYYY** (*Services Rendered To Date*) was received on **MMDDYYYY** (*Received Date*).

For denied claims the caller will then hear:

- This claim was denied on **MMDDYYYY** (*Claim Denied Date*) and the remittance number was 99999 (*Check/Remittance Number*).

After listening to the claim status, the caller will need to press **1** to hear the details of the claim. One of the following messages will play for duplicate claim denials.

Example 1: The claim denied as a duplicate claim against the same provider.

The IVR will read as follows:

- This claim includes services rendered on **10/6/2011** through **10/6/2011**.
- The ICD-9 diagnosis code is **V7612**.
- The medical procedure code is **77052**.
- The amount billed was **\$26.74**.
- This **procedure code** was denied as a duplicate claim against ICN **1234567890123**, which processed on **01/03/2011**, and the remittance number was **999999999**, with a paid amount of (*this will only play if a paid amount is showing; in this case there isn't one*) **\$XXXX.XX**.

Example 2: The claim denied as a duplicate/overlapping claim of another provider.

The IVR will read as follows:

- This claim includes services rendered on **10/6/2010** to **10/6/2010**.
- The ICD-9 diagnosis code is **V7612**.
- The medical procedure code is **77057**.
- The amount billed was **\$116.74**.
- This **procedure code** denied as duplicate services rendered against NPI **11111111111** for the same date or dates of service.
- To locate the facility's contact information, go to the NPPES Web site at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Example 3: This claim denied with the first line item duplicating against the same provider and the second line item duplicated against another provider.

The IVR will read as follows:

- This claim includes services rendered on **10/6/2011** through **10/6/2011**.
- The ICD 9 diagnosis code is **V7612**.
- The medical procedure code is **77052**.
- The amount billed was **\$26.74**.
- This **procedure code** was denied as a duplicate claim against ICN number **1234567890123**, which processed on **01/03/2011**, and the remittance number was **999999999** with a paid amount of (*this will only play if a paid amount is showing; in this case there isn't one*) **\$XXXX.XX**.
- Also, services were rendered on (*next line item*) **10/6/2010 to 10/6/2010**.

- The ICD-9 diagnosis code is **V7612**.
- The medical procedure code is **77057**.
- The amount billed was **\$116.74**.
- This **procedure code** denied as duplicate services rendered against NPI **1111111111** for the same date or dates of service.
- To locate the facility's contact information, go to the NPPES Web site at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

The IVR will continue to loop through all line items and then transfer the caller to the claims submenu.

Claims Submenu

- To repeat this information, press the pound key (#).
- For detail information, press **1**.
- For a duplicate remittance, press **2**.
- For more claims on this date, press **3**.
- To change the date, press **4**.
- To change the Medicare number, press **5**.
- To change the NPI and PTAN, press **6**.
- To return to the main menu, press the star key (*).

Note: This information may not be provided for all duplicate denial claims. In these cases the provider may still need to contact the Customer Service Representative (CSR) for additional information.

President Obama Signs the Temporary Payroll Tax Cut Continuation Act of 2011 – New Law Includes Physician Update Fix Through February 2012 *[A/B]*

On December 23, 2011, President Obama signed into law the **Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)**. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 Medicare Physician Fee Schedule (MPFS) is now scheduled to take effect March 1, 2012, the administration remains strongly opposed to letting this cut take effect. As he has repeatedly made clear, President Obama is committed to a permanent solution to eliminating the sustainable growth rate's cut. CMS will continue to work with Congress to achieve this goal.

CMS has also recently implemented several important changes for Medicare providers and beneficiaries and would like to remind physicians and practitioners of some of these key changes for 2012. For many of your patients, Medicare costs will go down. Medicare cost-sharing for Part B services will decline in some cases and, for the first time, the Part B deductible will decrease, by \$22, to \$140.

Additionally, health care professionals will be paid more to provide certain important services for people with Medicare. CMS has increased the payment amount for the initial and annual wellness visit, which has no cost-sharing for patients, to account for the introduction of Health Risk Assessment (HRA). CMS believes it is important to balance the comprehensiveness of the HRA with the potential burden on patients and health professional time constraints. As such, in 2012, CMS will allow for variation in the content of the HRA.

The Medicare Part D prescription drug program has also been enhanced for 2012, with the coverage gap being further reduced as it is phased out over the next several years. These improvements to the drug benefit from the Affordable Care Act have already saved millions of seniors nearly \$2 billion.

We wish to remind physicians and practitioners about the Primary Care Incentive Program (PCIP). Again in 2012, primary care physicians, nurse practitioners, clinical nurse specialists and physician assistants may be eligible to receive an incentive payment equal to 10 percent of their allowed charges for primary care services under Medicare Part B. This incentive is paid in addition to any physician incentive payments for services furnished in Health Professional Shortage Areas (HPSAs). Please remember that if a practitioner has reassigned his benefits to another entity, such as a group practice, Medicare will pay that entity and not the individual practitioner.

The Affordable Care Act created the Center for Medicare and Medicaid Innovation that offers physicians, practitioners and other health care leaders the opportunity to propose innovative payment and service delivery models to lower costs, improve quality and improve health. More information can be found at <http://innovations.cms.gov/>.

Following are summaries of key provisions of the TPTCCA along with some information about how these changes may affect providers and provider billing.

Physician Payment Update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. CMS is currently developing the 2012 MPFS to implement the zero percent update. As previously advised, Medicare claims administration contractors will be holding new January 2012 claims for up to 10 business days to effectively test and implement the new 2012 MPFS. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected. Finally, Medicare contractors will be posting the new rates on their Web sites no later than January 11, 2012.

Extension of Medicare Physician Work Geographic Adjustment Floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted:

- Physician work.
- Practice expense.
- Malpractice expense.

Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index through February 29, 2012. As with the physician payment update, this change will be accomplished through a revised 2012 MPFS.

Extension of Physician Fee Schedule Mental Health Add-On Payments

For Calendar Year (CY) 2011, certain mental health services' payment rates continued to be increased by 5 percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the 5 percent increase in payments for these mental health services through February 29, 2012. Similar to the zero percent update and the physician work geographic adjustment floor extension, the 5 percent increase will be reflected in the revised 2012 MPFS.

Extension of Medicare Modernization Act Section 508 Reclassifications

Section 302 of the TPTCCA extends Section 508 reclassifications and certain special exception wage indexes for two months, from October 1, 2011, through November 30, 2011. For the period beginning on

or after October 1, 2011, and ending November 30, 2011, Section 302 also requires removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by Section 302 of the TPTCCA will be assigned a special wage index effective for only October and November 2011. The provision will be applied to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception wage index will be applicable from January 1, 2012, through February 29, 2012.

Extension of Exceptions Process for Medicare Therapy Caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

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

Extension of Moratorium on Independent Laboratory Billing for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients

In the final physician fee schedule regulation published in the *Federal Register* November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the TC of a pathology service provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the TC of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

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

Extension of Ambulance Add-On Payments

The provisions that were extended by Section 306 of the TPTCCA are:

1. The 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas.
2. The provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services.
3. The provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through February 29, 2012. As previously advised, Medicare claims administration contractors will be holding new January 2012 ambulance claims for up to 10

business days to effectively implement the new 2012 ambulance fee schedule. CMS expects these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected.

Extension of Outpatient Hold Harmless Provision

Section 308 of the TPTCCA extends the Outpatient Hold Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs), regardless of bed size.

Extension of Minimum Payment for Bone Mass Measurement

Section 309 of the TPTCCA extends the 2011 payment rate through February 29, 2012, for bone mass measurement. Similar to the zero percent update and other provisions, this extension will be reflected in the revised 2012 MPFS.

(CMS Learn Resource 201201-01, dated January 4, 2012, and Technical Direction Letters (TDLs) 12153, 12154, 12155 and 12156, dated December 2011)

DDE Beneficiary Eligibility (Option 10) Issue [A]

Providers are currently unable to access beneficiary eligibility via Direct Data Entry (DDE) beyond MAP 1752. The FISS is currently researching this issue to determine a resolution. Providers will be advised when a resolution is identified or additional information is received.

Until a resolution is identified, providers can use the Interactive Voice Response (IVR) system or the Common Working File (CWF) Part A Eligibility System (ELGA) to obtain beneficiary eligibility. The ELGA option allows providers to verify eligibility using all nine host sites.

IVR System

Correct patient information must be provided to receive eligibility information. The information provided is current at the time of the IVR call. The following eligibility menu is available:

- Press **1** for a **complete list** of all eligibility information.
- Press **2** for **Part A benefits** (effective/termination dates, date of last billing, hospital days remaining, skilled nursing days, psychiatric days and lifetime reserve days).
- Press **3** for **Medicare Advantage** managed care plans and **Medicare secondary payer** status for an employer group health plan.
- Press **4** for **preventive services**. (Please check all codes.)
- Press **5** for home health benefits.
- Press **6** for hospice benefits.
- Press **7** for **Part B benefits** (effective/termination dates, deductible remaining to be met for current and prior year, and speech, physical and occupational therapy caps remaining for the current year).
- Press **8** for **ESRD** benefits.
- Press **9** to check benefits under a different Medicare number (Health Insurance Claim Number (HICN)).
- Press ***** (star key) to return to the main menu.

CWF ELGA System

On the Part A Eligibility System Inquiry by Providers screen, enter the following information to access beneficiary eligibility:

- HICN as it appears on the beneficiary's Medicare card.
- Beneficiary's last name as it appears on his Medicare card.
- Initial of beneficiary's first name as it appears on his Medicare card.
- Beneficiary's date of birth (MMDDCCYY).
- Beneficiary's gender: M=Male; F=Female.
- Intermediary number.
- Provider number.

The Host ID identifies the host site where beneficiary records are stored. Records are stored based on the location in which the beneficiary became eligible for Medicare. The Host ID field defaults to Southwest (SW). If the beneficiary's information does not display, change the Host ID to one of the other host codes until the information displays.

The Eligibility Detail Inquiry screens display Medicare Part A and Part B entitlement information about a specific beneficiary.

Providers may access the DDE Beneficiary Eligibility 'Not Found Status' in DDE job aid for complete instructions on using the CWF ELGA system.

<http://www.trailblazerhealth.com/Publications/Job Aid/BeneEligibilityNotFoundStatusinDDE.pdf>

CMS Quarterly Provider Update [A/B]

The CMS Quarterly Provider Update (QPU) is a comprehensive resource that provides a list of non-regulatory changes to Medicare, including new and revised manual instructions and any other instructions that may impact Medicare providers or suppliers.

The QPU is published at the beginning of each quarter and is available on the CMS Quarterly Provider Updates Web page. Providers should bookmark this page and visit often to keep abreast of important Medicare information.

http://www.cms.gov/QuarterlyProviderUpdates/01_Overview.asp

Purpose

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding and complying with Medicare regulations and instructions.
- Announce new or changed Medicare requirements.
- Communicate published information in the *Federal Register*.

CMS QPU Listserv

The CMS QPU listserv mailing list makes it easier for providers to keep track of QPU updates. This service notifies subscribers via e-mail immediately of any regulations or program instructions released during the quarter that affect Medicare providers.

<http://www.cms.gov/AboutWebsite/EmailUpdates/itemdetail.asp?itemID=CMS1205639>

Joint Replacement Medical Review [A/B]

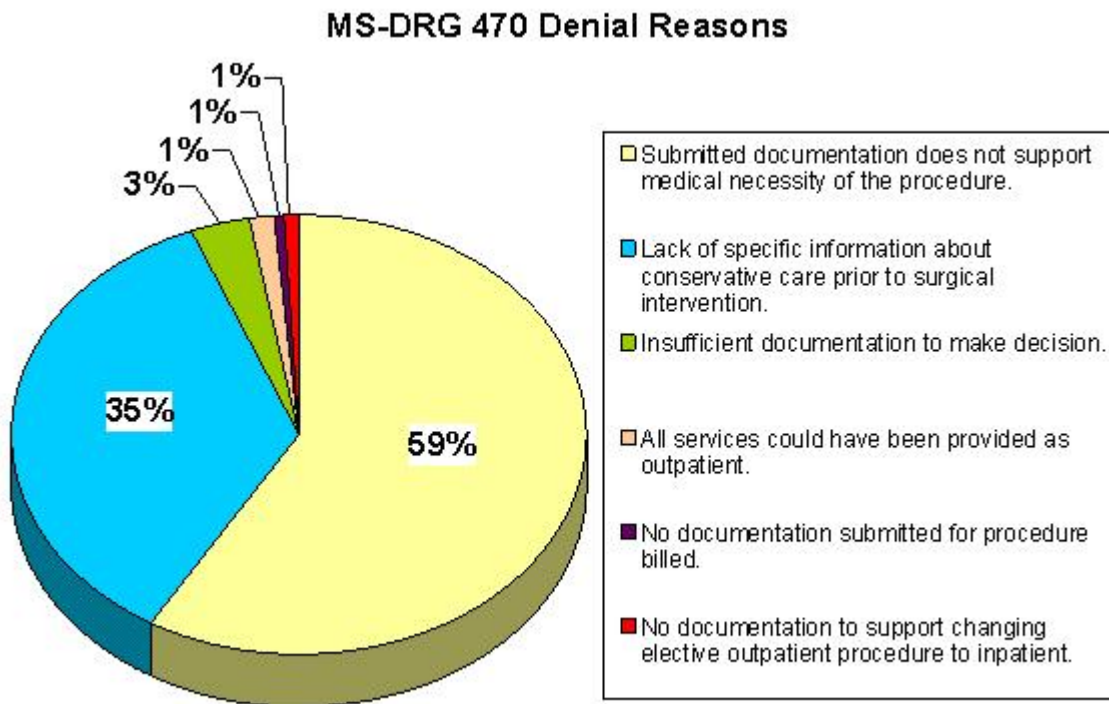
Applies to Part A inpatient providers located in, or with their corporate offices located in, Colorado, New Mexico, Oklahoma or Texas. Also applies to physicians who provide services in these facilities and bill Part B charges.

Medical Review of MS-DRG 470 Joint Replacement Services

TrailBlazer has been reviewing claims billed with Medical Severity Diagnosis-Related Group (MS-DRG) 470 (major joint replacement or reattachment of lower extremity without major complication or comorbidities). We have been looking at the inpatient hospital claim (Type of Bill 11X) and the associated part B provider's claims for services in the hospital. Recently we have found that about 68 percent of the claims reviewed for this DRG have denied. This article will examine the reasons these claims were denied.

General Reasons for Denial

The general reasons for denial are given in the chart below.



Detailed Denial Reasons

The top two reasons for denial (94 percent of the denials) are due to missing or insufficient documentation. Items missing or insufficient include documentation to substantiate the presence of end-stage joint disease and preoperative conservative measures taken. This documentation may be available from the Part B provider who billed services in the hospital, or other providers such as therapists. The list below contains examples of documentation that, if clearly documented, may help support payment for joint replacement care:

- Previous non-surgical treatment, including, but not limited to:

- Physical therapy.
- Occupational therapy.
- Medical management (analgesia, etc.).
- Assistive devices.
- Physical examination clearly documenting the progression of:
 - Pain levels.
 - Range of motion.
 - Activity modification.
 - Impact on Activities of Daily Living (ADLs).
- Preoperative diagnostic test results and interpretations showing:
 - End-stage joint disease.
 - Bone-on-bone disease.
 - Joint deformity.

For details on how to improve your documentation for joint replacements, including a helpful clinical example, please read the notice titled "Joint Replacement Documentation."

<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=14362>

Note: This notice refers to findings by the Comprehensive Error Rate Testing (CERT) contractor, but the problem and solution mirror TrailBlazer's data.

AMBULANCE

Texas Non-Emergency Ambulance Transports Billed With Modifiers RJ/JR [B]

Applies to Texas ambulance suppliers

Note: *This notice is being revised to include instructions effective January 1, 2012.*

In July 2011, TrailBlazer implemented automated utilization denials (for more than 12 transports in a year per patient) for non-emergency ambulance transports billed with modifiers RJ/JR in Texas.

Beginning January 1, 2012, TrailBlazer will not allow 12 transports per year without the review of medical records.

When claims are submitted, the Medical Review department will request medical record documentation for the first 12 non-emergency ambulance transports per patient billed with modifiers RJ/JR in Texas, to determine if patients meet Medicare's requirements for ambulance coverage and to develop a list of beneficiaries whose documentation meets coverage/benefit requirements. **Documentation should not be submitted with the initial claim. A Request for Additional Documentation letter will be sent to the suppliers if needed.**

Based on the submitted documentation, those patients who meet the requirements for coverage will be added to a list that will exclude them from the yearly transport restriction (Local Coverage Determination (LCD) utilization guidelines). Claims for patients who are included on this list will bypass the automated utilization denial edit (12 per year). All other claim and LCD requirements have to be met for payment to be allowed.

Note: If your patient(s) has been added to the bypass list, you will not receive the request for additional documentation, and the claims will continue to pay. TrailBlazer will not release the names of the patients who are on the bypass list to the suppliers; they will be notified by the payment.

Documentation Requirements

A detailed description of the patient's condition at the time of transport is necessary to "paint a picture" of the patient's condition. The documentation must include a description of the patient's functional or mental deficits that prevent safe transportation by another means. Please take this opportunity to ensure complete mental and physical assessments are performed and documented on run sheets and the information on the Physician Certification Statement (PCS) is consistent with the information on the run sheet. The physician who completes the PCS should have treated the patient; Medicare should be able to verify this by reviewing the patient's claim history.

When the request for documentation is received, if ambulance providers believe their documentation may have deficiencies, they are encouraged to submit any other supporting information from the patient's attending physician or dialysis facility that helps support the patient's eligibility for ambulance transportation. This information should be dated and signed by the author.

Denied Transports Due to the Automated Utilization Denials (for more than 12 transports in a year per patient)

Suppliers who have claims denied due to the utilization denial will need to follow the redetermination process.

<http://www.trailblazerhealth.com/Appeals/Redeterminations>

Based on the submitted documentation during the review, those patients who meet the requirements for coverage will be added to a list that will exclude them from the yearly transport restriction (LCD utilization guidelines). Claims for patients who are included on this list will bypass the automated utilization denial edit (12 per year). All other claim and LCD requirements have to be met for payment to be allowed.

Resources:

- Ambulance LCD. <http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1&ID=3316>
- Ambulance Run/Trip Record Documentation Computer-Based Training (CBT). <http://www.trailblazerhealth.com/Education/CBTs>

Job Aids:

- Ambulance Documentation. <http://www.trailblazerhealth.com/Publications/JobAid/AmbulanceDocumentation.pdf>
- Ambulance Non-Emergency Documentation Requirements. <http://www.trailblazerhealth.com/Publications/JobAid/AmbulanceNonEmerDocReq.pdf>
- Physician Guidelines for Certifying Ambulance Transfers. <http://www.trailblazerhealth.com/Publications/JobAid/PhysicianGuidelinesforCertifyingAmbulanceTransfers.pdf>
- Part B Texas Ground Ambulance Transports. <http://www.trailblazerhealth.com/Publications/JobAid/PartBTexasGroundAmbulanceMedicalReviewResults.pdf>
- Documentation Signature Requirements for Ambulance Services. <http://www.trailblazerhealth.com/Publications/JobAid/DocumentationSignatureRequirementsforAmbulanceServices.pdf>

Additional Resources

TrailBlazer maintains an Ambulance Web page that includes:

- Notices.
- Publications.
- Upcoming Events.
- CMS Links.
- Documentation Help.
- CBTs.
- LCDs.

http://www.trailblazerhealth.com/Specialty_Services/Ambulance

Additionally, **providers are encouraged to participate in educational opportunities** provided by Provider Outreach and Education. Frequent opportunities include seminars and workshops, Web-based trainings and teleconferences. For a listing of available training opportunities or to listen to a previously recorded training event, see the Calendar of Events.

<http://www.trailblazerhealth.com/Calendar>

ASC

ASC State Survey and Certification *[B]*

Ambulatory Surgery Centers (ASCs) must enter into a “participating provider” agreement with CMS. Once this has been accomplished, the ASC can then submit the CMS-855B enrollment application to Medicare for processing. The application can be submitted either electronically via Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) or by submitting the paper CMS-855B.

<https://pecos.cms.hhs.gov/pecos/login.do>
<http://www.cms.gov/CMSforms/downloads/cms855b.pdf>

As part of the enrollment process, an Ambulatory Surgical Center (ASC) must be surveyed and approved as complying with the conditions for coverage by state regulations. Medicare will send the pending application to the state agency for a review and the state will also perform a site survey. The state survey and certification agency schedules and performs a site inspection and then forwards the results to the CMS Regional Office (RO). The CMS RO will make the approval or denial determination and send the approval notice to the ASC facility and TrailBlazer.

The ASC facility generally receives the approval letter from the CMS RO a couple of weeks before TrailBlazer. The ASC can assist in reducing the overall processing time by forwarding the CMS approval letter to TrailBlazer’s enrollment department immediately upon receipt.

The application is then completed based upon the denial or approval notice that was received by CMS. TrailBlazer generally finalizes the enrollment within 14 days of receipt of the CMS approval letter and notifies the provider of the enrollment determination.

TrailBlazer has no control over the processing time for the state survey and CMS RO approval process. Completion of the survey and certification is generally expected within 90 days.

Complete enrollment information can be found on the Provider Enrollment Web page.

http://www.trailblazerhealth.com/Provider_Enrollment

CLAIM SUBMISSION UPDATES

55 Modifier and Postoperative Management Billing Reminder *[B]*

For successful reporting of the 55 modifier as it pertains to postoperative management, providers should adhere to the following claim filing instructions.

- **55 Modifier – Postoperative Management Only:** One physician performs the postoperative management and another physician performs the surgical procedure.
- **54 Modifier – Surgical Care Only:** When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

Postoperative Management Only – The 55 modifier is reported with the surgical procedure code for the “follow-up” physician’s claim, number of days/units and matching date range. (The surgeon reports the 54 modifier with the surgical procedure.)

Split Postoperative Management – If the surgeon chooses to follow the patient for any of the postoperative management days in addition to the surgery, his claim would reflect the surgery code with the 54 modifier **and** an additional detail line reflecting the surgery code, the 55 modifier, number of days/units and matching date range.

Note: The global period will begin the day following surgery.

Paper Claim Instructions

Item 19 “Range” of dates of postoperative care
Item 24a “From” date (postoperative care is assumed the day following surgery)
Item 24g Number of postoperative days. (This number must equal the date range shown in Item 19.)

Electronic Claim Instructions

Loop 2300 – Narrative Shared Postoperative Care Segments:

DTP01 – Report start	90 = Report start
DTP03 – First date of service	Date the physician assumes care of patient
DTP01 – Report end	91 = Report end
DTP03 – Last date of service	Date the care is relinquished

Loop 2400 – Time Qualifier and Date of Service Segments:

DTP01 Date time qualifier	472 = service
DTP03 Date time period “from” date	Date the physician assumes care of patient

Loop 2400 – Days or Units Segments:

SV103 Unit or basis for measurement code	UN = Unit
SV104 Quantity	Number of days or units

Common Billing Errors

- Incorrect qualifiers reported on electronic claims (90, 91, 472 and UN are necessary).

- Failed communication between surgeon and postoperative provider. (For example: Surgeon bills the surgery code with no modifier, receives payment for the surgery and all global days. The postoperative management provider bills Medicare with the 55 modifier and his claim is denied.)
- Date range does not match number of units reported and vice versa.
- Anatomical modifiers not reported (i.e., RT or LT).

Resources

- *Surgery* manual. http://www.trailblazerhealth.com/Publications/Training_Manual/Surgery.pdf
- Electronic Claims Crosswalk to the CMS-1500 Claim form. http://www.trailblazerhealth.com/Publications/Job_Aid/Crosswalkto1500ClaimForm.pdf

CODING UPDATES

Billing Drug Administration Codes *[B]*

Note: *This is a correction to a previously published notice. This correction includes language specific to the use of the KX modifier.*

Through the medical review of various infusion drugs, TrailBlazer identified two problems:

- Billing incorrect quantities of the drug administered.
- Billing chemotherapy administration codes inappropriately.

As a result of these findings, the Medical Review department implemented audits to suspend claims for specific drugs to determine if the quantity and administration codes are billed correctly. While reviewing these claims, TrailBlazer has also found that in some cases administration codes are billed without a corresponding drug on the same date of service.

Drug administration billed without a corresponding drug **will result in a denial** of the administration code. An example seen during the review was patients purchasing a drug and bringing it to the physician's office for the drug to be administered by the physician's staff. In this situation, the physician should:

- Bill the HCPCS code for the drug administered with the correct quantity (according to the dose per unit specified in HCPCS) and a zero charge.
- Append the KX modifier **to all of the administration codes billed for the same date of service.**

When administering drugs that do not fall under a specific HCPCS code, providers should:

- Use the appropriate Not Otherwise Classified (NOC) "J" code - J3490 or J3590 (non-chemotherapy) or J9999 (chemotherapy) and a zero charge.
- Append the KX modifier **to all of the administration codes billed for the same date of service.**

Please keep in mind that for reimbursement of the drug administration, the drug administered cannot fall under the Self-Administered Drug Exclusions list.

http://www.trailblazerhealth.com/Specialty_Services/Drugs_and_Biologicals/SADExclusionJ4.aspx

Also, as reminder, we would expect to only see chemotherapy drugs and monoclonal antibodies billed with chemotherapy administration codes.

TrailBlazer encourages providers to add a comment on the claim indicating the name of the drug administered. Following these steps will ensure accurate processing of the claim.

Additional Education and Resources

The TrailBlazer Web site offers a variety of educational resources to assist the provider community in the understanding the Medicare program payment rules and coverage policies. Providers and their billing staffs should visit the TrailBlazer Web site often and utilize the available information to effectively and correctly submit Medicare claims. Additionally, TrailBlazer has provided a Drugs and Biologicals specialty page to provide resources and frequent updates.

http://www.trailblazerhealth.com/Specialty_Services/Drugs_and_Biologicals

Providers are encouraged to participate in educational opportunities provided by Provider Outreach and Education to prevent errors in billing. Frequent opportunities include seminars and workshops, Web-based training sessions and teleconferences. For a list of available training opportunities or to listen to a previously recorded training event, see the Calendar of Events.

<http://www.trailblazerhealth.com/Calendar>

Reporting Inpatient Days for Version 5010 Institutional Claims [A]

The implementation of the Health Insurance Portability and Accountability Act (HIPAA) 837 institutional transaction removed the "inpatient days" fields from FISS and Direct Data Entry (DDE). Therefore, when submitting Version 5010 institutional claims, providers should report the following value codes for covered, non-covered, coinsurance and Lifetime Reserve (LTR) days:

- **80** – Covered days.
- **81** – Non-covered days.
- **82** – Coinsurance days.
- **83** – LTR days.

Providers can resubmit claims receiving reason codes 12206 or 12302 with the correct value codes or correct Return to Provider (RTP) claims via Direct Data Entry (DDE) by indicating the correct value codes and then F9 the claim.

DRUGS/BIOLOGICALS

Billing Instructions for Denosumab (Prolia[®] and Xgeva[®]) [A/B]

Beginning January 1, 2012, a new HCPCS procedure code has been assigned to the drug denosumab.

J0897 Injection, denosumab, 1 mg

The drug denosumab has two brand names with two different indications. The brand names and their indications are:

Prolia[®] – indicated to treat:

- Osteoporosis in women after menopause.
- Men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer.
- Women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.

Xgeva[®] - indicated for the prevention of Skeletal-Related Events (SREs) in patients with bone metastases from solid tumors.

When billing the drug denosumab (**Prolia[®]**) for patients with postmenopausal osteoporosis, one of the following ICD-9-CM codes must be present on the claim:

- 174.0–174.9 – Breast cancer
- 185 – Prostate cancer
- 733.01 – Senile osteoporosis
- 733.09 – Drug-induced osteoporosis

When billing the drug denosumab (**Xgeva[®]**) for patients with bone metastases from solid tumors, the following ICD-9-CM code must be present on the claim:

- 198.5 – Bone and bone marrow

Please also indicate in the comment section of the claim which drug is being administered, Prolia[®] or Xgeva[®].

Note: When denosumab (Prolia[®] or Xgeva[®]) is reported for Medicare payment using the recommend diagnosis code above, the medical record must clearly demonstrate the patient has, in fact, been so diagnosed. Utilizing the recommended diagnosis code in situations where medical records do not support the reported diagnosis is **not** appropriate.

Update to Coding of Xiaflex™ [A/B]

Note: *This article has been updated to include new coding for 2012.*

Effective January 1, 2011 the newly established HCPCS code J0775 described as injection, collagenase, clostridium histolyticum, 0.01 mg becomes active. Use of this new code will require minor changes in billing of **Xiaflex™**.

Xiaflex™ (collagenase clostridium histolyticum) is indicated for adult patients suffering from Dupuytren's contracture with a palpable cord. The package insert indicates health care providers experienced with hand injection procedures should administer 0.58 mg into a palpable Dupuytren's cord with contracture of the metacarpophalangeal or proximal interphalangeal joint. Injections may be administered up to three times per cord at approximately four-week intervals. Only one cord should be injected at a time.

Notes:

- Due to specific training requirements to identify and inject the cord, TrailBlazer would only expect to see Xiaflex™ injection services performed by an orthopedic surgeon, hand surgeon, general surgeon, plastic surgeon or rheumatologist. Educational certification must be available to Medicare upon request.
- This drug is only approved for release of Dupuytren's contracture. TrailBlazer would only expect to see Xiaflex™ billed with ICD-9-CM diagnosis code 728.6.

To bill Xiaflex™ services, use the following guidelines:

Day 1:

- 728.6 – ICD-9-CM diagnosis code.
- J0775 – Injection, collagenase, clostridium histolyticum, 0.01 mg.

- Bill J0775 with quantity billed equal to amount administered (e.g., 58 Units (equivalent to 0.58 mg based on HCPCS code description)) on one claim line.
- Bill J0775-JW with quantity billed equal to amount wasted (e.g., 32 Units (equivalent to 0.32 mg based on HCPCS code description)) on a second claim line of the same claim.
- 20550 – Injection; single tendon sheath, or ligament. (Use **only** for Dates of Service (DOS) before January 1, 2012.)
- 20527 – Injection; enzyme (e.g., collagenase), palmar fascial cord (i.e., Dupuytren's contracture). (Use for DOS on or after January 1, 2012.)
 - Use an appropriate modifier to indicate either right or left hand (RT or LT).
 - Use code 20550 for DOS prior to January 1, 2012, for the injection procedure.
 - Use code 20527 for DOS on or after January 1, 2012, for the injection procedure.
- Include the following information in the electronic documentation record (2400-NTE, 02), or for a paper claim in Item 19 or as an attachment to the CMS-1500 claim form:
 - Drug name – Xiaflex™.
 - Dose given and dose wasted.
- Submit the drug and the administration service on the same claim.

Day 2:

- 99213-25 – Evaluation and management includes manipulation(s) of the finger and local anesthesia or analgesia. Use of modifier 25 indicates the E/M is a separately identifiable service from the splint application (surgery with a global period of 000). (Use **only** for DOS before January 1, 2012.)
- 26341 – Manipulation, palmar fascial cord (i.e., Dupuytren's cord), post-enzyme injection (e.g., collagenase), single cord. (Use for DOS on or after January 1, 2012.)
 - Use code 99213-25 for DOS prior to January 1, 2012.
 - Use code 26341 for DOS on or after January 1, 2012.
- 29130 – Splint application.

TrailBlazer does not generally post a new article announcing coverage of a new drug. The New FDA Approved Drugs job aid on the TrailBlazer Web site provides instructions for submitting bills for new drugs.

<http://www.trailblazerhealth.com/Publications/Job Aid/New FDA-Approved Drugs.pdf>

Billing for Sipuleucel-T (Provenge®) [B]

Note: This notice is being updated to remove the note concerning the non-payment of the routine costs associated with the administration of Provenge®. TrailBlazer will pay separately for routine costs (e.g., intravenous infusion up to one hour) associated with Provenge®.

Provenge® has been approved by the FDA as an autologous cellular immunotherapy for the treatment of asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

The National Coverage Decision (NCD) (110.22) establishes the criteria for billing and reimbursement of Provenge®, effective for dates of service on or after June 30, 2011.

Billing of Provenge®

For dates of service on or after July 1, 2011, use the following HCPCS code: **Q2043** Sipuleucel-T auto CD54+.

For dates of service prior to July 1, 2011, use one of the following HCPCS codes: J3490, J3590 or C9273 (being replaced by Q2043).

NCD Established On-Label (FDA-Labeled) Indications

The primary ICD-9-CM diagnosis code **must** be 185 (malignant neoplasm of prostate). It **must** be billed with one of the following secondary ICD-9-CM diagnoses:

196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes.
196.2	Secondary and unspecified malignant neoplasm or intra- abdominal lymph nodes.
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb.
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites.
196.9	Secondary and unspecified malignant neoplasm of lymph node site. Unspecified – The spread of cancer to, and establishment in, the lymph nodes.
197.0	Secondary malignant neoplasm of lung – Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer or from a cancer at a distant site.
197.7	Malignant neoplasm of liver secondary - Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas or sarcomas.
198.0	Secondary malignant neoplasm of kidney - The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs.
198.5	Secondary malignant neoplasm of bone and bone marrow – Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland.
198.82	Secondary malignant neoplasm of genital organs.

NCD Established Off-Label Indications: To Be Determined By the Local Contractor

TrailBlazer has determined the following will represent off-label use:

- If ICD-9-CM diagnosis code 185 (malignant neoplasm of prostate) is billed without one of the secondary diagnoses listed above.
- If ICD-9-CM diagnosis code 233.4 (carcinoma in situ of prostate) is billed with or without one of the secondary diagnoses listed above.

If Provenge® is billed for off-label indications, documentation for that day’s services will be required. This documentation should be submitted at the time the claim is submitted.

TrailBlazer allows attachments to be faxed and/or mailed that will be matched with the electronic claim for processing. Instructions for faxing and/or attachments can be found in the “Fax/Mail EMC Documentation Instructions and Cover Sheet” document.

http://www.trailblazerhealth.com/Publications/PDF_Form/Fax-MailEMCDocForms.pdf

If the necessary documentation is not faxed or mailed with the claim submission, TrailBlazer will request the documentation. This will result in slower turnaround time for claim payment.

The **documentation must** reflect the following:

- The patient must have had:
 - Prostate-specific antigen value of at least 5 ng/dL.
 - Tumor progression while on hormonal therapy.
 - Castration levels of testosterone (defined as less than 50 ng/dL).
- The patient must not have:
 - The presence of known brain metastases.
 - Prior treatment with three infusions of sipuleucel-T (Provenge®).
 - Known malignancies other than prostate cancer that are likely to require treatment within six months of registration.
- The patient must not have had treatment with any of the following medications or interventions within 28 days of starting on Provenge®:
 - Systemic corticosteroids. Use of inhaled, intranasal, intra-articular, and topical steroids is acceptable, as is a short course (i.e., ≤ one day) of corticosteroids to prevent a reaction to the IV contrast used for CT scans.
 - Non-steroidal anti-androgens (e.g., bicalutamide, flutamide or nilutamide).
 - External beam radiation therapy or major surgery requiring general anesthetic.
 - Any other systemic therapy for prostate cancer including secondary hormonal therapies, such as megestrol acetate (Megace®), diethylstilbestrol (DES) and ketoconazole. Medical castration therapy is not exclusionary.
 - Chemotherapy.
 - Treatment with any other investigational product.
 - Visceral organ metastases.
 - Metastatic disease expected to be in need of radiation therapy within four months.
 - Concurrent therapy with experimental agents.

If the documentation does not describe the criteria (see FDA label) above or is not received, the services will be denied.

Resources:

- MM7431. <http://www.cms.gov/MLN MattersArticles/downloads/MM7431.pdf>
- CR 7431. (R2254CP) <http://www.cms.gov/transmittals/downloads/R2254CP.pdf>
- National Coverage Decision (NCD) 110.22. http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf

ELECTRONIC BILLING

Medicare Fee-for-Service Part A Editing of the National Drug Code [A]

On December 21, 2011, Medicare Fee-for-Service (FFS) turned off the current ASC X12 Version 5010 Common Edit and Enhancements Module (CEM) National Drug Code (NDC) validation edit for Medicare Part A. The specific NDC edit being turned off requires the NDC in Loop ID 2410 LIN03 to be validated against the Food and Drug Administration (FDA) NDC code list. A replacement NDC edit will be implemented in the Part A CEM for the January 2012 shared system quarterly release, which will perform syntactical editing only of the NDC submitted in Loop ID 2410 LIN03.

A similar announcement was disseminated December 19, 2011, for the deactivation of the Part B NDC edit. The Medicare Part B NDC edit was deactivated December 9, 2011.

NDC Code Background

The NDC is a unique product identifier used for drugs intended for human use and is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting or adjudication processes. The Drug Listing Act of 1972 requires registered drug establishments to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded or processed by it for commercial distribution. Drug products are identified and reported using the NDC.

The NDC is a unique number expressed in three sections. This numeric identifier is assigned to each medication listed under Section 510 of the U.S. Federal Food, Drug and Cosmetic Act. The sections identify the labeler or vendor, the product (within the scope of the labeler) and the type of package (of this product). The ASC X12 TR3 documents stipulate that the 5-4-2 expression of NDC values must be used. However, the FDA does not have a version of the NDC in this (5-4-2) format. Therefore, CMS has created a version of the NDC in the 11-byte numeric NDC derivative, which pads the product code (four positions) or package code (two positions) sections of the NDC with a leading zero, thus resulting in a fixed length 5-4-2 configuration.

(CMS Learn Resource 201112-55)

Submitting Electronic Claims Versus Paper Claims [A/B]

Submitting claims electronically versus paper offers many benefits. Claims processing is faster and reimbursement is sooner, improving providers' cash flow.

Benefits

- Payment for electronic claims can be released after the 14-day payment floor, while the payment floor for paper claims is 29 days.
- Immediate notification that TrailBlazer has received a provider's claims.
- Front-end editing notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system.
- The ability to correct rejected claims and retransmit if a claim was submitted incorrectly.

Note: CMS has released Technical Direction Letter (TDL) 12148, dated December 22, 2011, which includes updated instructions for the ASC X12 Version 5010 transition. As stated in TDL 12148, TrailBlazer will not reject compliant ASC X12 Version 4010A1 transactions prior to April 1, 2012. The exact date and time 4010A1 transactions will be rejected will be published at a later date.

Billing Software

The free electronic claims submission software, **PC-ACE Pro32**, is a complete, self-contained electronic processing system for claims submission and management. It can be used in a stand-alone configuration or in conjunction with existing claims management systems.

PC-ACE Pro32 Features

- User-friendly system with extensive help screens.
- Manual with step-by-step instructions.
- No charge when downloaded from the Software and Manuals Web page.
<http://www.trailblazerhealth.com/Electronic Data Interchange/Software - Manuals>

- Nominal charge when requested via CD-ROM.
- Claims transmission via telephone lines with modem speeds ranging from 9600 bps to 56k bps.
- Transmission lines available 24 hours a day, seven days a week.

Effective January 1, 2012, the only available output format for PC-ACE Pro32 Version 2.32 will be the 5010 version. This Pro32 v2.32 update file includes software changes necessary to ensure Pro32 claims are submitted in the ASC X12 837 v5010 format.

- The current Pro32 upgrade is applicable to 1.82.0.100 (January 2007) and later versions for the PC-ACE Pro32 software.
- ASC X12 Version 5010 Errata production software changes:
 - ASC X12 Version 4010A1 no longer an option after January 1, 2012.
 - ZIP code requires full nine-position value.
 - Billing provider must include physical address. Post office and lock boxes are not permitted.
 - ZIP code on all facility reference file records must include full nine-position value.

Resources

- The GPNNet System Status link is available to assist customers with obtaining the most up-to-date system information (including 5010 issues).
<http://www.palmettogba.com/internet/status.nsf/System+Status?OpenFrameSet>
- Visit the EDI Web page for information and links to helpful resources.
<http://www.trailblazerhealth.com/Electronic+Data+Interchange>
- View the Calendar of Events for EDI Direct Data Entry (DDE) training.
<http://www.trailblazerhealth.com/calendar>
- *Gateway Production Network (GPNNet) Communications Manual*.
<http://www.trailblazerhealth.com/Publications/Training+Manual/HipaaGpnet.pdf>

Clarification Concerning HIPAA 5010 and NCPDP D.0 Cutover and Impacts on Crossover Claims [A/B]

On December 5, 2011, CMS issued MLN Matters® SE1137 – “Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process.” CMS issued this guidance for the benefit of physicians, practitioners, providers and suppliers to help them understand why they were seeing greater instances of Medicare correspondence letters that made reference to error N22226 as the basis for why their patient’s claims could not be crossed over.

<http://www.cms.gov/MLNArticles/downloads/SE1137.pdf>

CMS has learned that concern exists in the provider community regarding whether billing of hard copy CMS-1500 or UB-04 claims or HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. This is not true.

During the 90-day Version 5010 non-enforcement period (January 1, 2012, through March 31, 2012), Medicare will have the systematic capability to perform up- or down-version conversion of incoming claim formats (i.e., convert incoming hard copy formats to HIPAA equivalent claim formats and convert incoming Version 4010A1 claim formats to 5010 formats and vice versa) in accordance with external supplemental payer specifications concerning production claims format. This practice will discontinue at the conclusion of the 90-day non-enforcement period, with the exception below. (This action is controlled

by information that the Common Working File (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode.)

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

(CMS Learn Resource 201201-28)

EVALUATION/MANAGEMENT

Common Errors Identified Through Medical Review [B]

TrailBlazer, like all Medicare contractors, is responsible for reducing the paid claims error rate as determined by the Comprehensive Error Rate Testing (CERT) contractor. Evaluation and Management (E/M) services have been identified as having a high error rate; therefore, TrailBlazer's Medical Review department has selected random samples of selected E/M services to review. The following describes the common errors seen during these reviews.

- Documentation is incomplete/insufficient:
 - Documentation does not support the level of service billed (i.e., upcoding or downcoding of services).
 - Required components (as required by the CPT book) are not documented in the medical record.
 - The history component is incomplete or absent.
 - The medical decision-making documented is inappropriate or incomplete.
- Services were rendered by one provider and billed by another provider.
- Documentation does not support a face-to-face encounter between physician and patient.
- Conflicting information in the medical record (e.g., the diagnosis on the claim is not consistent with the diagnosis in the medical record; documentation in the patient's history conflicts with the examination; the date of service in the documentation is different from the date of service billed).
- The service is not performed on the date of service billed, not dictated on the date of assessment or not documented on the date of the visit.
- Medical documentation does not support medical necessity for the frequency of the visit.

Additional educational resources are available on the CMS and TrailBlazer Web sites and provide detailed documentation requirements.

- CMS' *Evaluation and Management Services Guide*.
https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf
- TrailBlazer's Evaluation and Management Services Web page.
http://www.trailblazerhealth.com/Specialty_Services/Evaluation_and_Management
- "Tips for Preventing Most Common Evaluation and Management (E/M) Service Coding Errors" job aid. http://www.trailblazerhealth.com/Publications/Job_Aid/tips_for_preventing_most_common_e-m_coding_errors.pdf

General Principles of Medical Record Documentation for E/M Services [B]

To help ensure correct payment and proper documentation of Evaluation and Management (E/M) services, TrailBlazer's Medical Review department has listed the following general principles of documentation to assist providers:

- The medical record should be complete and legible; reasonable clinicians will easily recognize all abbreviations and symbols.
- Documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.
- The CPT/ICD-9-CM codes reported on the Medicare claim should be supported in the documentation in the medical record.
- Information in the record should reflect all of the work described by the code(s) and/or modifiers reported on the claim.
- The patient's progress, including response to treatment, change in diagnosis and patient non-compliance, should be documented.
- All E/M services should be coded according to the patient's presenting problems at the time of the encounter. Specific information on each family of codes can be found in your CPT book.

Documentation of each patient encounter should include:

- The patient's name and the date of service on every page of the record (including the back side of double-sided forms).
- The reason for the encounter.
- An appropriate history and physical exam including any relevant health risk factors identified.
- Review of lab, X-ray data and other ancillary services when applicable. The reason for and results of X-ray, lab tests and other ancillary services should be documented or included in the medical record.
- Patient assessment and a treatment plan, including a discharge plan (when appropriate). The written treatment plan should include, when appropriate: treatments and medications specifying frequency and dosage; labs and tests; referrals and consultations; patient/family education; and specific instruction for follow-up.
- The clear identity and professional credentials of all people who contributed to the service and/or record and who contributed which portion(s) of the service and/or record. All entries to the medical record should be dated and authenticated by the physician.

Signature requirements:

- Medicare requires a legible identifier for services provided/ordered. The method used must be either a handwritten or an electronic signature (stamped signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. Electronic signatures must be identified as such.
- A facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice.

Reference: CMS Pub. 100-08, Chapter 3 <http://www.cms.gov/manuals/downloads/pim83c03.pdf>

Additional information on E/M services including the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, the *Evaluation and Management Services Manual*, and the Coding and Documentation Pocket Reference can be found on the Evaluation and Management Services Web page. More information can be found in your CPT book under "Evaluation and Management (E/M) Services Guidelines" in the front of the book and in "Appendix C – Clinical Examples" in the back of the book.

http://www.trailblazerhealth.com/Specialty_Services/Evaluation_and_Management

Initial Office Care Medical Review Results [B]

The purpose of this notice is to clarify our previously published article regarding initial office care medical review results. Through statistical analysis, TrailBlazer identified potential improper utilization of CPT codes 99201–99205 for new patient office visits reported to Medicare. A widespread probe review was recently conducted to verify if this perceived improper utilization was actual. This review is called “widespread” because documentation is evaluated from multiple providers. TrailBlazer used the Progressive Corrective Action (PCA) process to identify a random sample of 100 claims containing initial office visit codes reported by 10 Colorado and Texas providers with Dates of Service (DOS) July 1, 2010, through December 31, 2010. The selection of providers for this review was based on a scoring methodology that considered the following variables for the period of July 1, 2010, through December 31, 2010:

- High claim volume of paid claims for CPT codes 99201– 99205.
- High frequency of claims for 99201–99205 compared to peers (same specialty).
- Relatively higher proportion of 99204–99205 services compared to 99201–99203.
- Frequently reported modifier 25.

The primary focus of this review was to evaluate the documentation for new patient office visits reported to Medicare to validate the services were reasonable and necessary, and requirements of Medicare coverage policies were met. In addition, all other services reported on the sampled claim were reviewed and a medical necessity determination was made.

Probe Review Findings

Overall error rate for the probe review was 40.37 percent. That means \$40.37 of every \$100 paid for initial office care services were paid in error.

Medical Review Findings

We identified the following errors:

- **Medical Necessity**

Identified coding errors related to medical necessity generally occur when the nature of the patient’s condition necessitates a lesser service than is reported. In our audit, high-level (99204 or 99205) new patient office care Evaluation and Management (E/M) services were reported for patients whose presenting problems were self-limited, minor, or not likely to cause mortality or significant morbidity between the current encounter and the next encounter with the physician. Additionally, those records often included excessive information that was not clinically relevant to the patient’s care but lacked critical clinical information needed to characterize the patient’s presenting problem.

- **CPT Work**

CPT E/M work is described in terms of key components. TrailBlazer denied payment (in part or in whole) for many of the new patient office care E/M services in our sample because the documentation of key component work failed to meet published requirements. Unfortunately, we also noted many cases in which clinically useless information was included in the record (as described in the “Medical Necessity” section above) even though the record was deficient to support the key components of the CPT code chosen. Here is a short list of observed key component deficiencies:

- Absent or minimally documented History of Present Illness (HPI). (An “extended” HPI is necessary for services reported with CPT codes 99203, 99204 and 99205.)
- Absent or insufficient Review of Systems (ROS). A “complete” ROS is necessary for services reported with CPT code 99204 and 99205.

- Past medical, Family and/or Social History (PFSH) were absent or insufficient. All three elements are required for services reported with CPT codes 99204 and 99205.
- Insufficient examination. A “comprehensive” exam is required for services reported with CPT codes 99204 and 99205.
- Insufficient Medical Decision-Making (MDM). A “moderate complexity” MDM is required for services reported with CPT code 99204 and a “high complexity” MDM is required for services reported with CPT code 99205.
- **Other Denials**
 - TrailBlazer denied other claims for new patient services for the following miscellaneous reasons:
 - No physician face-to-face encounter by the performing physician occurred on the reported date of service.
 - The encounter was clearly for an established patient (not a new patient) service.
 - The record was not properly authenticated according to CMS signature requirements.
 - Requested medical records were not submitted.

Example of Documentation That Failed to Support Reported CPT Code

This case demonstrates a record for which Medicare payment is appropriate for a lower level of new patient office visit service than was reported. We present first the case, then our discussion.

Reported CPT Code 99204-25

Medical Review Action: Downcode to CPT Code 99202

Chief Complaint (CC)

“My ear is hurting and I can’t hear as well as I could.”

HPI

This 66-year-old male presented to the office today stating he has had pain in his right ear and jaw for one week. He described the pain is a 5 on a 10-point scale on some days. For the last month, he has been having difficulty hearing on the telephone.

ROS

Constitutional: No fever, chills, fatigue
Eyes: No blurred vision
Ears/Nose/Mouth/Throat: No ear drainage, no sore throat, no popping or clicking of jaw joint
Respiratory: No shortness of breath, cough or congestion

PFSH

Medical history: Seasonal allergies relieved with over-the-counter medications, osteoarthritis in hands and legs, pain relieved with aspirin
Family history: Mother deceased – Chronic Obstructive Pulmonary Disease (COPD)/smoker
Father deceased – Heart disease
No family history of hearing loss
Social history: Lives alone, denies substance abuse

Examination

Vital signs: T = 98.6, P = 72, R = 18, B/P = 138/76
Eyes: Pupils are equal and reactive to light.
Lungs: cta
Cardiac: rrr
Abdomen: soft, non-tender
Musculoskeletal: Finger joints enlarged on both hands. Knees are swollen.

Neurological: Alert and oriented. Cranial nerves intact. No motor or sensory deficits.
Ears: No redness. No wax in external ear canals. TMs intact and translucent without effusion.

Impression

Otalgia and tinnitus
Sensorineural hearing loss

Plan

Warm compresses to right jaw and ear
Soft diet
Follow up with dentist if symptoms continue
Decrease aspirin intake
Schedule audiogram

TrailBlazer Discussion

Medical Necessity

Right away it is evident that the service documented is not 99204 in terms of medical necessity. CPT code 99204 describes problems usually of moderate to high severity. Moderate to high severity is defined by CPT as problems for which the risk of morbidity (between this encounter and the next one) without treatment is moderate to high; there is a moderate to high risk of mortality without treatment (the treatment offered at this time) or a moderate to high probability of severe, prolonged functional impairment (between this encounter and the next one).

The patient in the case above has a little or no likelihood of mortality or prolonged functional impairment due to the conditions described and the physician's planned management. CPT code 99202, or possibly 99201, seems to adequately describe this patient's condition. CPT code 99202 describes patients with problems that are low to moderate severity while CPT code 99201 describes patients with self-limited or minor problems.

Key Component Work

In order for Medicare to allow CPT code 99202, documentation of the service must contain at least the minimum required key components for CPT code 99202. CPT code 99202 requires **all** three of these key components:

1. Expanded problem-focused history.
2. Expanded problem-focused exam.
3. Straightforward MDM.

TrailBlazer believes the key component work demonstrated in this case does satisfy (and sometimes exceeds) key component requirements for CPT code 99202; therefore, TrailBlazer allowed payment for CPT code 99202 in this case.

Additional comment: The claim also contained modifier 25. In this case, modifier 25 is used incorrectly because no other procedure was rendered on the same day of service as the E/M service.

INPATIENT HOSPITAL

MS-DRG 460 Spinal Fusion Documentation [A/B]

Applies to Part A inpatient providers located in, or with their corporate offices located in, Colorado, New Mexico, Oklahoma or Texas. It also applies to physicians who provide services in these facilities.

TrailBlazer has been reviewing claims billed with Medical Severity Diagnosis-Related Group (MS-DRG) 460 (spinal fusion, except cervical, without major complication or comorbidities). By far the most common reason for denial has been a lack of specific information about conservative care before the surgical intervention. Through previous experience, we presume that in many cases this missing information may have existed in the outpatient records of the surgeon, primary care physician or other practitioner.

Sample Documentation List

This list contains examples of documentation that, if clearly documented, may help support payment for spinal fusion-related hospital care.

- Previous non-surgical treatment, including, but not limited to:
 - Physical therapy.
 - Occupational therapy.
 - Joint injections.
 - Analgesia.
 - Assistive devices.
- Physical examination clearly documenting the progression of any:
 - Neurological deficits.
 - Upper or lower extremity strength.
 - Activity modification.
 - Pain levels.
- Diagnostic test results and interpretations, such as Magnetic Resonance Imaging (MRI).

Strategies to Improve Documentation

The following strategies could reduce audit errors caused solely by information missing from the hospital record:

- Hospitals may proactively obtain previous diagnostic and therapeutic records from the surgeon and other practitioners. These records may include pertinent:
 - Physical assessment of condition, including pain level.
 - Physician history and physical.
 - Progress notes.
 - "Consultations."
 - Physical and occupational therapist evaluations and therapy notes.
 - Radiology reports.
 - Therapeutic procedure notes, such as joint injections.
- Practitioners should either create clinically meaningful inpatient records or supply the hospital with relevant documents from their outpatient records.

Documentation Example

Including adequate history of the presenting illness in the hospital record will improve the likelihood of Medicare payment of the hospital claim. It will also substantiate medical necessity for the payment of physician services performed in conjunction with the hospital stay. Please note that statements such as,

“Failed outpatient therapy, admit for spinal fusion,” are simply not sufficient evidence of medical necessity for the admission or the surgery.

Please consider the following as an example of helpful documentation:

MS-DRG 460 Example Documentation

- **Date:** 12/15/11.
- **Chief complaint:** Low back pain radiating down legs.
- **History:** Patient has spondylolisthesis, gradually progressing with increased spinal stenosis over the past 5–7 years. Most recent MRI (11/2/11) shows spondylolisthesis at L3-L4 and L4-L5 with moderately severe stenosis at both levels. She has been treated as follows: Ibuprofen 400 mg QID since January (allergic to codeine); PT 3 x week from 6/15/11 to 9/30/11. Epidural steroid injections in October and facet joint injections in November gave only minor temporary improvement. Pain is now constant at level 5/10 when sitting, but 9/10 on rising or ambulation and radiates down both legs. Is slightly better with water therapy. The pain keeps her awake at night with severe stabbing, throbbing and aching.
- **Physical exam:** Patient has limited lumbar range of motion and severe pain on palpation. Knee and ankle reflexes are reduced to 1+ (they were 2+ in October). She has diminished sensation in lower legs, but strength and pulses are within normal limits. The patient has positive sitting root and leg raises bilaterally. Faber Four is negative bilaterally.
- **Impression:** Worsening pain, deteriorating reflexes and significant interference with function. Current therapy ineffective. Lumbar fusion is only option for pain control.
- **Orders:** Admit to inpatient care for L3-L4 and L4-L5 lumbar fusion.

As in all Medicare audits, the quality of the information in a document is often more important than the volume of information. Including all of the needed information in the record is crucial. The more types of supporting records Medicare receives, the clearer the clinical picture will be. The more complete the record, the less likely Medicare will deny services or recoup money.

MS-DRG 246 Cardiovascular Procedure with Drug-Eluting Stent with MCC Documentation [A/B]

Applies to Part A inpatient providers located in, or with their corporate offices located in, Colorado, New Mexico, Oklahoma or Texas. It also applies to physicians who provide services in these facilities.

Medical Review of MS-DRG 246

TrailBlazer has been reviewing claims billed with MS-DRG 246 (percutaneous cardiovascular procedure with drug-eluting stent with major co-morbid condition or 4+ vessels/stents). This MS-DRG has a mean length of stay of 5.4 days. The review is showing that almost half of these claims, 42 percent, paid as billed. The remaining 58 percent were denied for a variety of reasons.

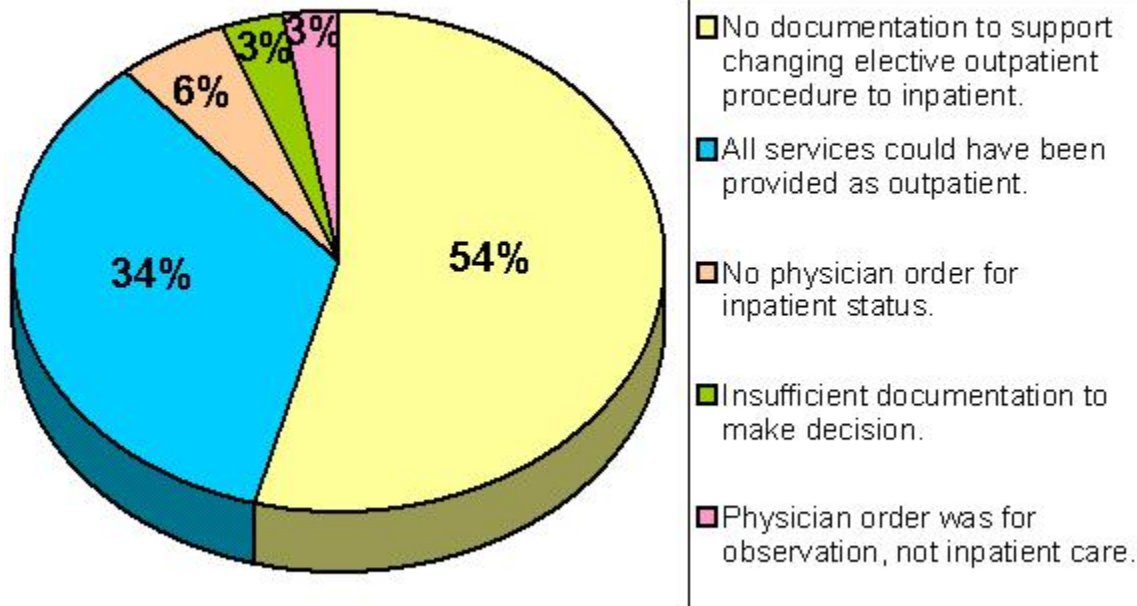
General Reasons for Denial

The chart below shows the general reasons for denials. As you can see, the top two denial reasons account for 88 percent of claims denied. Those reasons are quite similar to each other because the documentation submitted didn't support the inpatient admission status:

- The documentation submitted didn't support changing the planned elective outpatient stay to an inpatient admission.

- The documentation sent to TrailBlazer didn't support the medical necessity of the planned inpatient admission.

DRG 246 Denial Reasons



Detailed Denial Reasons

The detailed reasons for denial, both before and during the admission, include the following:

- The patient was not in acute distress, discomfort or pain.
- No shortness of breath or a fever was documented.
- The patient was hemodynamically stable.
- The pre-procedure cardiac enzyme levels were either normal or not documented.
- Other labs and imaging were negative for acute pathology.
- EKGs showed no acute pathology.
- No post-procedure complications.
- There were no changes during the admission that impacted the inpatient admission status.

Strategies to Improve Documentation

TrailBlazer believes that some denials may be caused because information is missing from the records sent to TrailBlazer or simply isn't present in hospital chart. If these items were retrieved and sent to TrailBlazer it could have led to a favorable audit outcome. Information missing from the hospital record may have existed in the outpatient records of the surgeon, primary care physician or other practitioner. The following strategies could reduce errors caused solely by missing information:

- Ensure all supporting medical records are sent to TrailBlazer. This may include retrieving test results or procedure notes of other services pertinent to the current inpatient procedure.
- Physicians could include documentation to support conservative treatment in the preoperative records sent to hospitals.

- If not already received from physicians, hospitals may proactively obtain previous diagnostic and therapeutic records from the surgeon and other pertinent practitioners. These records may include pertinent physician history and physical, progress notes, “consultations,” radiologic reports and relevant therapeutic procedure notes such as cardiac catheterizations.
- Hospitals should ensure that physicians and others who provide inpatient services produce clinically meaningful inpatient records.

Documentation Examples

Next, we will review two clinical documentation examples:



Example 1

Inpatient Level of Care Documentation

- **Date:** 12/25/11.
- **Chief Complaint:** Chest pain.
- **History of Present Illness:** Presented to ED with complaints of chest pain, nausea and shortness of breath. Chest pain described as heaviness and pain radiating down the left arm that worsened when he walked. Pain intensity 8/10 is unchanged despite nitro 0.4 mg SL.
- **Past Medical History:** Patient has history of coronary artery disease. Prior CABG x 2 in 2009. Had positive cardiac catheterization on 12/20/11 (balloon procedure on chronic occlusion of SVG to PDA, 100% occlusions in LAD, LC and RCA, but widely patent RA and patent grafts in place in the LC). He was scheduled for outpatient elective stent insertion on 12/27/11. History includes diabetes, hypertension, hyperlipidemia, peripheral vascular disease and DVT left leg. Meds include insulin, aspirin 81 mg daily, Isordil 5 mg, lisinopril 40 mg daily, Plavix® 75 mg daily and simvastatin 40 mg daily.
- **Tests:**
 - EKG – Absent Q waves & inverted T waves leads I–III.
 - CXR – No infiltrates, PTX or rib fractures.
 - BMP – Normal except NA 134, K 5.2, GLU 486.
 - CBC – Normal except HGB 12.8, HCT 37.7.
 - Cardiac Markers – Positive CK & Troponin T.
 - PT – Normal except PRO x 10.5, INR 1.0.
 - PTT – Normal 25.
- **Physical exam:** T - 36, HR - 57, Resp – 20, B/P - 154/84, O₂ sat 99% on 2L. Significant findings include pain 8/10, diaphoresis, shortness of breath but lungs clear.
- **Impression:** Chest pain, shortness of breath, diaphoresis unrelieved by nitro and positive cardiac cath.
- **Orders:** Admit to inpatient care for stat stents.



Example 2

NOT Inpatient Level of Care Documentation

Date: 12/15/11.

- **Chief Complaint:** Chest pain.
- **History of Present Illness:** Caretaker reports this patient had 10/10 chest pain this morning when she got up. The pain did not radiate but she was diaphoretic and short of breath. She took 0.4 mg of nitro SL and pain subsided on the way to the hospital.
- **Past Medical History:** Patient has history of coronary artery disease and heart attack in 2004. Coronary stents x3 in 2008. She has hyperlipidemia and peripheral vascular disease. Meds include nitro prn, aspirin 81 mg daily, Plavix[®] 75 mg daily and simvastatin 40 mg daily.
- **Tests:**
 - EKG – Normal sinus rhythm, no abnormalities seen.
 - CXR – No infiltrates, PTX or rib fractures.
 - BMP – WNL.
 - CBC – Normal except RBC 4.11, HGB 11.5, HCT 34.5.
- **Physical exam:** This 72-year-old, well-nourished female was brought to the ED by her caretaker. She is awake, alert and in no acute distress with no c/o pain. Eyes: PERRL, EOMs intact. Chest: Normal chest wall appearance and motion, non-tender. CV: rate normal, rhythm regular. Respiratory: breath sounds clear and equal bil. No rales, rhonchi or wheezes. Skin: Warm, dry. B/P - 120/68, HR – 100, R – 12, T – 37.0, O2 sat 100% on room air.
- **Impression:** Chest pain post-MI.
- **Orders:** Admit to inpatient telemetry bed. For cardiac cath in the morning.
- **Op Report:** Procedures: Left heart cath, coronary angiography, left ventriculography, saphenous vein graft angiography x1, PTCA and stenting of the IMA x 1. LV pressure 185/8-25, aortic pressure 188/70. Left ventricular function near normal. EF 50% with focal inferior wall hypokinesis and no mitral regurgitation. Patient tolerated procedure very well.
- **Discharge Summary:** Patient stable during hospitalization, no c/o chest pain during admission. MI ruled out. Underwent cardiac cath with single stent for 90% stenosis. To follow up with PCP in two weeks, cardiologist in three.

In Example 1, there is sufficient documentation to allow it to pay as an inpatient claim. The insufficient documentation in Example 2 doesn't support the inpatient status. The chest pain and other symptoms had already subsided before the patient got to the hospital and none of the lab tests submitted to TrailBlazer warranted an acute need for surgery. There was nothing else in the documentation sent to TrailBlazer that supported the inpatient admission. If we were reviewing Example 2 with only the documentation above, the claim would deny and money would be recouped.

Please remember, the quality of the information in a document is often more important than the volume of information. Including all of the needed information in the record is crucial. The more types of supporting records Medicare receives, the clearer the clinical picture will be. The more complete the record, the less likely Medicare will deny services or recoup money.

LAB/PATHOLOGY

Extension of Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients [B]

On December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This new legislation contains a number of Medicare provisions that change or extend Medicare Fee-for-Service (FFS) policies. Included in these provisions is an extension of a moratorium that allows certain practitioners and suppliers (such as pathologists and independent laboratories) to bill for the Technical Component (TC) of physician pathology services furnished to hospital patients through February 29, 2012.

Under previous law, including most recently, Section 105 of the Medicare & Medicaid Extenders Act of 2010, a statutory moratorium allowed certain pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B Medicare Administrative Contractor (MAC) for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire December 31, 2011. However, Section 305 of the TPTCCA extends that moratorium beginning January 1, 2012, through February 29, 2012. Therefore, qualified pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with dates of service January 1 through February 29, 2012.

For background and policy information regarding payment to independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to Change Request (CR) 5347, Transmittal 1221, issued April 18, 2007, and CR 5943, Transmittal 1440, issued February 7, 2008.

(CMS Learn Resource 201201-17, dated January 10, 2012, and Technical Direction Letter (TDL) 12156, dated December 27, 2011)

MEDICAL RECORD DOCUMENTATION

Avoid Part A Claim Denial 56900 – Respond to ADRs Timely and Properly [A]

TrailBlazer has identified that provider requests for reopening of claims for unanswered Additional Documentation Requests (ADRs) has significantly increased. The claim denials (56900) are the result of requested documentation not received within required time frames.

Providers are required to submit documentation as indicated in the ADR **within 30 calendar days** from the date of the ADR. If the Medical Review department does not receive the documentation within the required time frame, the claim **will be denied** as not medically necessary (56900) based on non-receipt of documentation.

In the event a reopening is required due to a provider missing the 30 calendar day time frame, the provider must submit the reopening request as follows to ensure proper routing of the request:

- Submit the reopening request using the Part A Provider Assistance Request form. http://www.trailblazerhealth.com/Publications/PDF_Form/assist.pdf
- On the Part A Provider Assistance Request form, check the box **“Medical Review Reopening Request/Request for Redetermination for Non-Receipt of Records.”**
- Include a brief statement in the comment field (second page of the form) documenting why the documentation is being submitted past the 30-day time frame.
- Required medical documentation as defined in the ADR must be submitted with a copy of the ADR.

If the proper box **is not** checked, the request will be rejected and not reopened.

Providers may reference the ADR Helpful Hints to learn more about the ADR process, including viewing ADRs via the Direct Data Entry (DDE) system.

http://www.trailblazerhealth.com/Publications/Job Aid/additional_dev.pdf

OUTPATIENT SERVICES

Documenting Outpatient Physical Therapy Services *[A/B]*

This article addresses the medical necessity and documentation for outpatient therapy services. It also includes the proper use of the KX modifier with therapy services, chronic disease or maintenance therapy and details of the current billing errors found by the Comprehensive Error Rate Testing (CERT) contractor.

Reasonable and Medically Necessary

To be considered reasonable and medically necessary, the following conditions must be met:

- The services must be considered under accepted standards of medical and physical/occupational/speech-language therapy practice to be a specific and effective treatment for the patient's condition.
- The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed **only** by a qualified physical/occupational/speech-language therapist (or, in the case of services reported by a licensed therapist in independent practice, an appropriate licensed therapy assistant under the therapist's supervision).
- There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- The quantity, type, frequency and duration of the services must be reasonable and necessary with respect to the patient's premorbid baseline function, condition and expectation/goals of improvement.

Documentation

Medical necessity documentation should include objective physical and functional limitations (signs and symptoms) to support that the patient requires therapy services. It is important to document information such as:

- The patient is under the care of a physician or Non-Physician Practitioner (NPP).
- Physician order for therapy services. An order (sometimes called a referral) for therapy service, documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. Payment is dependent on the certification of the plan of care rather than the order, but the use of an order is prudent to determine that a physician is involved in care and available to certify the plan.
- Initial evaluation and re-evaluation.
- Certification/recertification of the evaluation/plan of care signed by both the therapist and physician.
- Services require the skills of a therapist.
- Progress reports.
- Treatment notes.
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands the

reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

- Mental/cognitive disorders or other obstacles that directly and significantly influence the rate of recovery.
- Documentation supporting severity of condition and complexity of care:
 - Objective signs and symptoms including degrees of motion and strength grades.
 - Objective therapy goals and milestones to be used for measuring progress toward stated goals.
 - The documentation should include the specific body parts being treated for therapy services.
 - The specific therapy for each body part should also be identified in the treatment plan.
 - Document the functional limitations in the patient's medical record or on optional measurement instruments such as National Outcomes Measurement System (NOMS).

Therapy Caps

The 2012 cap for physical therapy and speech-language pathology combined is \$1,880 and the cap for occupational therapy is \$1,880 for this benefit period. The benefit period starts at the beginning of a new year, as does the therapy cap.

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve his prior functional status or maximum expected functional status within a reasonable amount of time.

When exceptions are in effect and when the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits

Proper Use of the KX Modifier for Therapy Services

The KX modifier may be used when the patient has met the financial cap for therapy services and still requires further medically necessary therapy services by a skilled therapist. By attaching the KX modifier, the provider is attesting that the services billed:

- Qualified for an exception using the automatic process exception.
- Are reasonable and necessary services that require the skills of a therapist.
- Are justified by appropriate documentation in the medical record.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

Improper Use of the KX Modifier

If therapy services were not medically necessary before the cap was reached, it would not be appropriate to bill with the KX modifier once the therapy cap was reached. For example:

A patient has been receiving therapy for several weeks to treat a shoulder injury; the yearly therapy cap has been reached and the patient does not show any measurable and objective progression toward goals. The clinician cannot provide further therapy services to the patient by billing with the KX modifier. Since the therapy services were not medically necessary before the therapy cap was reached, it is not appropriate to bill the claim with the KX modifier.

Remember, it is not appropriate to bill each service at the start of care with the KX modifier.

Chronic Disease/Maintenance Therapy

Maintenance therapy is defined as treatment provided after the therapeutic goals and/or rehabilitative potentials have been reached. Such therapy may be medically reasonable and necessary but is not covered by Medicare. Therapy services for chronic disease or for overall fitness and flexibility are considered maintenance therapy. Maintenance therapy services that do not require a skilled therapist may be performed by the patient alone or with the assistance of a family member. However, if medically necessary, periodic evaluations of the patient's condition and response to treatment may be covered if the judgment and skills of a qualified therapist are required.

Common Errors Found by CERT

The CERT contractor is finding the following errors when reviewing outpatient therapy services in the TrailBlazer jurisdiction:

- No order for therapy.
- Physician or NPP signatures and dates are missing or illegible.
- Treatment or care plan not signed by the physician or NPP.
- Time spent in therapy not documented for timed codes.
- Certification and recertification missing.

CMS has released fact sheets providing important general information on resources and correct documentation for outpatient therapy services. These resources also detail the claim errors found by the CERT contractor. They can be found on the CMS Web site:

- Comprehensive Error Rate Testing (CERT) Outpatient Rehabilitation Therapy Services.
http://www.cms.gov/MLNProducts/downloads/Outpatient_Rehabilitation_Fact_Sheet_ICN905365.pdf
- Rehabilitation Therapy Information Resource for Medicare.
http://www.cms.gov/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf

Other resources for outpatient therapy services can be found here:

- *Therapy Services* training manual. http://www.trailblazerhealth.com/Publications/TrainingManual/Physical_Therapy.pdf
- Therapy Services Local Coverage Determination.
<http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1&ID=3326>

Medicare Payments Exceeding Charges – Correct Reporting of Outpatient Services [A]

The Office of Inspector General (OIG) recently completed a review of outpatient claims processed by Wisconsin Physicians Service (WPS) during January 2006 through June 2009 to determine if certain Medicare payments in excess of charges for outpatient services were correct.

Medicare reimburses certain outpatient providers under the Outpatient Prospective Payment System (OPPS). When using this method of reimbursement, the Medicare payment is not based on the amount that the provider charges and, consequently, the billed charges generally do not affect the Medicare payment amounts.

Billed charges generally exceed the amount that Medicare pays providers. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Summary of Findings

Of the approximately 55.6 million line items for outpatient services that WPS processed during the period January 2006 through June 2009, 408 line items had:

- A Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000.
- Three or more units of service.

Of the 408 selected line items for outpatient services, 128 were correct. Providers refunded overpayments on 13 line items totaling \$459,380. The 267 remaining line items were incorrect and included overpayments totaling \$1,648,224.

Of the 267 incorrect line items, providers:

- **Reported incorrect units of service** on 190 line items resulting in overpayments totaling \$1,399,404.
- **Used HCPCS codes that did not reflect the procedures performed** on 15 line items resulting in overpayments totaling \$115,151.
- **Reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes** on 49 line items resulting in overpayments totaling \$87,142.
- **Billed for unallowable services** on eight line items resulting in overpayments totaling \$35,613.
- **Did not provide the supporting documentation** for five line items resulting in overpayments totaling \$10,914.

Incorrect payments were made due to the following reasons:

- Provider clerical errors or billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.
- The Medicare FISS and Common Working File (CWF) had insufficient edits in place during the review period to prevent or detect the overpayments.

Education Resources

Providers should ensure that the appropriate code and units of service are billed for services rendered to patients according to the coding guidelines and the full HCPCS descriptor in place at the time of service. Providers should use the appropriate HCPCS codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description.

The following resources provide information to assist providers with proper billing of outpatient services:

- CMS *Medicare Claims Processing Manual* (Pub. 100-04):
 - Chapter 1 – General Billing Requirements, Section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly. <https://www.cms.gov/manuals/downloads/clm104c01.pdf>
 - Chapter 17 – Drugs and Biologicals, Section 70 – When billing for a drug, the manual section states, “Where HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4.” <https://www.cms.gov/manuals/downloads/clm104c17.pdf>
 - Chapter 23 – Fee Schedule Administration and Coding Requirements, Section 20.3, states, “... providers must use HCPCS codes on the Form CMS-1450 or its electronic equivalent for most outpatient services.” <https://www.cms.gov/manuals/downloads/clm104c23.pdf>

- Chapter 25 – Completing and Processing the Form CMS-1450 Data Set, Section 75.5, states, “FL 46 – Units of Service – Required ... when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.”
<https://www.cms.gov/manuals/downloads/clm104c25.pdf>
- Updates to policies and billing instructions regarding outpatient services paid under the OPSS are published in Change Requests (CRs) in January, April, July and October each year. Providers can access CMS CRs and MLN Matters® articles on TrailBlazer’s Notices Web page and on CMS’ MLN Matters® Articles and Transmittals Web pages.
<http://www.trailblazerhealth.com/Tools/Notices.aspx>, <https://www.cms.gov/MLN MattersArticles/> and <http://www.cms.gov/Transmittals/>
- TrailBlazer’s OPSS Web page and *OPSS manual* provide billing and policy information.
<http://www.trailblazerhealth.com/Facility Types/OPSS> and
<http://www.trailblazerhealth.com/Publications/Training Manual/HospitalOutpatientManual.pdf>

PAYMENT/FEE SCHEDULE UPDATES

2012 Electronic Prescribing Incentive Program Payment Adjustment Feedback Report Update [B]

CMS would like to advise providers that due to the high volume of significant hardship exemption requests received, it is no longer technically feasible for CMS to provide a 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment feedback report as originally intended.

As CMS continues to explore alternative means to notify eligible professionals that they are subject to the 2012 eRx payment adjustment, CMS urges you to review your remittance advices for claims submitted for dates of service on or after January 1, 2012.

Eligible professionals and group practices participating in the eRx Group Practice Reporting Option (GPRO) that receive the 2012 eRx payment adjustment will see the term “LE” on their remittance advice for all Medicare Part B services rendered January 1 – December 31, 2012.

The remittance advice will also contain the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):

- CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code or RARC that is not an ALERT).
- RARC N545 – Payment reduced based on status as an unsuccessful e-prescriber per the eRx Incentive Program.

If an eligible professional or group practice that participated in the eRx GPRO receives the payment adjustment in error (e.g., the eligible professional or group practice submitted a hardship exemption request that is ultimately approved by CMS), the claim will be reprocessed to return the 1 percent and the remittance advice for the reprocessed claim will include the following codes and messages:

- CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code or RARC that is not an ALERT).
- RARC N546 – Payment represents a previous reduction based on the eRx Incentive Program.

For more information on how the 2012 eRx payment adjustment will be assessed and applied, refer to MLN Matters® Article SE1141 for additional information or visit the eRx Incentive Program Web page.

<https://www.cms.gov/MLN MattersArticles/downloads/SE1141.pdf>
<http://www.cms.gov/erx incentive/>

(CMS Learn Resource 201112-46)

Note: If you believe the payment adjustment was made in error, please **do not submit a redetermination or reopening request to TrailBlazer**. Instead, contact the QualityNet Help Desk at (866) 288-8912 or via e-mail at qnet support@sdps.org, Monday – Friday from 7 a.m. to 7 p.m. CT. If the Help Desk determines a correction is needed, the affected claims will be automatically reprocessed.

January 2012 Prompt Payment Interest Rate on Clean Non-PIP Claims Not Paid Timely [A/B]

Providers should access the U.S. Department of the Treasury Prompt Payment Web site for current and past prompt payment interest rates payable when clean non-Periodic Interim Payment (PIP) Medicare claims are not paid in a timely manner by Medicare contractors. **The prompt payment rate effective January 2012 – June 2012 is 2.000.**

<http://fms.treas.gov/prompt/rates.html>

Providers can also access the U.S. Department of the Treasury Web site on TrailBlazer's Payment Web page under the Resources section.

<http://www.trailblazerhealth.com/Payment>

Updated 2012 Medicare Physician Fee Schedule Now Available [B]

The updated 2012 Medicare Physician Fee Schedule (MPFS) is now available on the TrailBlazer Medicare Fee Schedule Web page. The updated 2012 MPFS lists the new fees for claims with dates of service January 1, 2012, through February 29, 2012.

http://www.trailblazerhealth.com/Tools/Fee_Schedule/MedicareFeeSchedule.aspx

Section 301 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) prevents a payment cut for physicians that would have taken effect January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor was adjusted for 2012.

Upcoming Dates for Medicare EHR Incentive Program and Information on Payment Threshold for Eligible Professionals [B]

As 2012 begins, Eligible Professionals (EPs) participating in the Medicare Electronic Health Record (EHR) Incentive Program are reminded of the following important deadlines and what can still be completed in 2012 to receive an incentive payment for Calendar Year (CY) 2011.

Important Medicare EHR Incentive Program Dates

On December 31, 2011, the reporting year ended for EPs who participated in the Medicare EHR Incentive Program in 2011. What does this mean? For participating EPs, they must have completed their 90-day reporting period by the end of 2011.

However, EPs have until February 29, 2012, to actually register and attest to meeting meaningful use to receive an incentive payment for CY 2011 through the Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

<https://ehrincentives.cms.gov/hitech/login.action>

Payment Threshold Information

February 29, 2012, is also the deadline for EPs to submit any pending Medicare Part B claims from CY 2011, as CMS allows 60 days after December 31, 2011, for all pending claims to be processed. This means that EPs have 60 days in 2012 to submit claims for allowed charges incurred in 2011.

Medicare EHR incentive payments to EPs are based on 75 percent of the Part B-allowed charges for covered professional services furnished by the EP during the entire payment year. If an EP did not meet the \$24,000 threshold in Part B-allowed charges by the end of CY 2011, CMS expects to issue an incentive payment for the EP in April 2012 for 75 percent of the EP's Part B charges from 2011.

Note: *Medicaid incentives will be paid by the states but the timing will vary according to state. Please contact your state Medicaid agency for more details about payment.*

Visit the EHR Incentive Programs Web site for the latest news and updates on the EHR Incentive Programs.

<http://www.cms.gov/EHRIncentivePrograms/>

(CMS Learn Resource 201201-31)

PROVIDER ENROLLMENT

Attention, Health Professionals: 2012 Annual Participation Enrollment Program Extension [B]

CMS is anticipating congressional action to avert the negative update for the 2012 Medicare Physician Fee Schedule. Therefore, CMS is extending the 2012 annual participation enrollment period through **February 14, 2012**. The enrollment period now runs November 14, 2011, through February 14, 2012.

The effective date for any participation status change during the extension, however, remains January 1, 2012, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are postmarked on or before February 14, 2012.

(CMS Learn Resource 201112-47 and Technical Direction Letter (TDL) 12144, dated December 22, 2011)

Mobile Radiology State Survey and Certification [B]

A portable X-ray supplier may enroll in Medicare by either submitting a CMS-855B enrollment application or electronically via Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) (<https://pecos.cms.hhs.gov/pecos/login.do>). As part of the enrollment process, a portable X-ray supplier must be certified by the state in which it performs the services. Medicare will send the pending application to the state agency for a review and the state will also perform a site survey. The state survey and certification agency schedules and performs a site inspection and then forwards the results to the CMS

Regional Office (RO). The CMS RO will make the approval or denial determination and send the approval notice to the mobile radiology facility and TrailBlazer.

The mobile radiology facility generally receives the approval letter from the CMS RO a couple of weeks before TrailBlazer. The portable X-ray supplier can assist in reducing the overall processing time by forwarding the CMS approval letter to TrailBlazer's enrollment department immediately upon receipt. The application is then completed based upon the denial or approval notice that was received by CMS. TrailBlazer generally finalizes the enrollment within 14 days of receipt of the CMS approval letter and notifies the provider of the enrollment determination.

TrailBlazer has no control over the processing time for the state survey and CMS RO approval process. Completion of the survey and certification is generally expected within 90 days.

Complete enrollment information can be found on the Provider Enrollment Web page.

<http://www.trailblazerhealth.com/Provider Enrollment>

Internet-Based PECOS – Who to Contact Regarding Questions *[B]*

An External User Services (EUS) Help Desk, which currently assists Medicare providers in using other Internet-based CMS applications, will also assist physicians and Non-Physician Practitioners (NPPs) with Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications. The following table lists the types of issues/problems physicians and NPPs may experience and which responsible entity they should contact to assist with resolving the issue/problem.

Issue/Problem	Responsible Entity
Access issues: Setting up user IDs and passwords; forgotten user IDs or passwords; user IDs or passwords that do not allow access	<p>EUS Help Desk (866) 484-8049</p> <p>EUSupport@cgi.com</p>
How to navigate through the Web screens and other related scenarios	<p>EUS Help Desk (866) 484-8049</p> <p>EUSupport@cgi.com</p>
PECOS is down, operating too slowly or not operating properly	<p>EUS Help Desk (866) 484-8049</p> <p>EUSupport@cgi.com</p>
System-generated error messages – Not PECOS messages or warnings that are generated when practitioners commit data entry errors, e.g., not entering required data or entering data incorrectly; not following screen directions; ignoring system prompts.	<p>EUS Help Desk (866) 484-8049</p> <p>EUSupport@cgi.com</p>
PECOS does not display any data for an enrolled practitioner. This occurs if a practitioner's enrollment record is not in PECOS. Practitioners need to submit initial enrollment via the Web or paper CMS-855.	<p>TrailBlazer Provider Enrollment Medicare Part B CO, NM, OK, TX, IHS (866) 539-5596</p> <p>http://www.trailblazerhealth.com/Provider Enrollment/EmailProviderEnrollment.aspx</p>

Issue/Problem	Responsible Entity
<p>PECOS does not display any data for a practitioner's enrolled solely owned corporation.</p> <p>The Medicare contractor will correct the situation so practitioners will be able to view or update the solely owned corporation's information using Internet-based PECOS.</p>	<p>TrailBlazer Provider Enrollment Medicare Part B CO, NM, OK, TX, IHS (866) 539-5596</p> <p>http://www.trailblazerhealth.com/ProviderEnrollment/EmailProviderEnrollment.aspx</p>
<p>Practitioner's description of a problem that appears to be a "bug" in PECOS that requires investigation and correction.</p> <p>The Medicare contractor will report the issue for resolution. The EUS Help Desk and CMS will be notified if needed.</p>	<p>TrailBlazer Provider Enrollment Medicare Part B CO, NM, OK, TX, IHS (866) 539-5596</p> <p>http://www.trailblazerhealth.com/ProviderEnrollment/EmailProviderEnrollment.aspx</p>
<p>A termination date exists in the practitioner's PAR data.</p> <p>The Medicare contractor will remove termination dates in the PAR data.</p>	<p>TrailBlazer Provider Enrollment Medicare Part B CO, NM, OK, TX, IHS (866) 539-5596</p> <p>http://www.trailblazerhealth.com/ProviderEnrollment/EmailProviderEnrollment.aspx</p>
<p>Enrollment policy questions</p>	<p>TrailBlazer Provider Enrollment Medicare Part B CO, NM, OK, TX, IHS (866) 539-5596</p> <p>http://www.trailblazerhealth.com/ProviderEnrollment/EmailProviderEnrollment.aspx</p>

More information can be obtained from TrailBlazer's Internet-Based PECOS Web page

<http://www.trailblazerhealth.com/ProviderEnrollment/InternetBasedPECOS.aspx>

Update – Provider Enrollment General Inquiries Fax Number and E-mail Address [B]

Note: Updated to include the provider enrollment general inquiries e-mail address and the provider enrollment general inquiries e-mail form link.

Many times providers have general inquiries concerning their application or the provider enrollment process. General inquiries may be sent via fax, mail and/or e-mail. They will be responded to within 45 business days.

- The general inquiries fax number is (903) 463-0613.
- The general inquiries e-mail address is partb.tbenrollment@trailblazerhealth.com.

An online Provider Enrollment E-mail Form is also available for submitting an inquiry to provider enrollment.

<http://www.trailblazerhealth.com/ProviderEnrollment/EmailProviderEnrollment.aspx>

The Provider Enrollment page includes links to mailing addresses as well as other important articles, publications and information.

[http://www.trailblazerhealth.com/Provider Enrollment](http://www.trailblazerhealth.com/Provider%20Enrollment)

Immediate Returns of Provider Enrollment Applications [A/B]

The most common reasons an application is returned are listed below.

1. The sections listed below were not signed **and** dated:
 - a. Sections 15/16 of the 855A application.
 - b. Sections 15/16 of the 855B application.
 - c. Sections 4A/4B of the 855R application.
 - d. Section 15 of the 855I application.
 - e. CMS-855B, Attachment 2, Section E for Independent Diagnostic Testing Facility (IDTF) Supervising Physicians.
 - f. Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Certification Statement is not signed and/or dated by the authorized or delegated official for a group/organization enrollment application submission.
 - g. Internet-based PECOS Certification Statement is not signed and/or dated by the individual practitioner applying for enrollment.
2. The **old version** of the application was submitted. CMS updated the 855A, 855B, 855I and 855R applications. The newest version of the 855A, 855B, 855I and 855R applications is the 07/11 version. The 2/08 version will not be accepted after January 1, 2012.
3. The version of the application is missing. The version of the application is located on the lower left side of every page except the cover sheet.
4. The signature is a copied or stamped signature.
5. The applicant failed to submit all forms needed to process the reassignment package. For example: **Only** the 855R application is received when the 855I and 855R applications are required. Both applications are required if:
 - a. Provider is reassigning benefits and is a new provider to Medicare.
 - b. Provider has not made any updates to his existing Medicare information since 2003.
 - c. Provider is not enrolled in PECOS.
6. The CMS-855R and/or 855I application was submitted to add a new group member and the group that the member is reassigning to is not in PECOS. No CMS-855B application was included in the enrollment submission.
7. The submitted application is completed in pencil. The application must be submitted in blue ink, black ink, or typed. Blue or black ink is required for the signature pages. Blue ink is preferred.
8. Web-generated application was submitted but does not appear to have been downloaded off the CMS Web site.
9. Application was not mailed (i.e., it was faxed or e-mailed).
10. The contractor received the application more than 30 calendar days prior to the effective date listed on the application. (This does not apply to certified providers, Ambulatory Surgical Centers (ASCs) or portable X-ray suppliers.)
11. The CMS-855 application is not needed for the transaction in question.

Example 1: The CMS-855I and CMS-855R applications are submitted for an actively enrolled practitioner who is reassigning benefits or changing his reassignment to another group. Only the CMS-855R application is needed; therefore, the CMS-855I will be returned.

Example 2: The submitted application is a duplicate of another application.
12. The CMS-855B new enrollment application for a group/organization was submitted without the CMS-855R and/or CMS-855I application for the member or members.

The exception is organizations that generally do not have members, such as:

- a. Ambulance service supplier.
- b. ASC.
- c. Independent clinical lab.
- d. IDTF.
- e. Mammography center.
- f. Pharmacy.
- g. Portable X-ray.
- h. Radiation therapy center.
- i. Slide preparation facility.

Note: IDTFs do not have members; however, the CMS-855R application must be submitted for each interpreting physician.

- 13. The Web application tracking ID from Internet-based PECOS could not be retrieved via PECOS. This occurs when the incorrect contractor is selected or the application payment has not cleared.
- 14. The CMS-855 application was sent to the wrong contractor. (TrailBlazer does not forward to the correct contractor.)

Why Was My Enrollment Application Delayed? *[B]*

Below is a list of the most common reasons that require further development on a pending application.

855I Application

Section 1A: The reason the application was submitted should be indicated. The Medicare identification number (Provider Transaction Access Number (PTAN)) (if issued), termination date (if applicable) or National Provider Identifier (NPI) must be stated. If "Change of Information" is selected, Section 1B should be completed.

Section 2A: The license number, effective date and expiration dates are required. The dates must be in mm/dd/yyyy format. The name of the medical school is required and the graduation year. The date of birth in mm/dd/yyyy format and the Social Security number are required. The country the provider was born in is required, and if the provider was born in the USA, the state is also required.

Section 2B: The correspondence address and telephone number where Medicare can contact the practitioner **directly** is required. The address may be a P.O. box but cannot be the billing agency. There can be only **one** correspondence address and correspondence telephone number listed for the provider. This information affects all Medicare numbers linked to that individual.

Section 2C: Residency questions are required to be answered if applicable. If the practitioner is not a resident or in a fellowship program, select "NO" in 2C1a and 2C1b, then skip to section 2D.

Section 2D: This section establishes the specialty information for the practitioner and will affect all of the Medicare numbers linked to that individual. If the practitioner is a physician, select one primary specialty. There may be multiple secondary specialties. The primary cannot be an undefined specialty. If the practitioner is a non-physician, one non-physician specialty should be selected. There are no secondary specialties for non-physician practitioners.

Section 2E-2G: This section is used for physician assistants only. The employer's Provider Transaction Access Number (PTAN)/Provider Identification Number (PIN)/provider number and the date employment began in mm/dd/yyyy format is required. This section may be used for multiple enrollments as well as terminations for that physician assistant.

Section 2H: Required for clinical psychologists.

Section 2I: Required for psychologist billing independently.

Section 2J: Required for occupational/ physical therapist in private practice.

Section 2K: Required for nurse practitioners and certified clinical nurse specialists.

Section 2L: If the practitioner supplies Advanced Diagnostic Imaging (ADI) services, that individual **MUST** be accredited in the ADI modality that practitioner furnishes. All fields should be completed with the Accrediting Organization information, effective date in mm/dd/yyyy format and expiration date in mm/dd/yyyy format.

Section 3: If there is any adverse legal information (including another fee-for-service jurisdiction) to report, all fields must be completed and documentation must be submitted with the application.

Section 4A: If this section is completed on the 855I application, it means that you are establishing a solo group. The legal business name as it is listed on the IRS tax document must be listed in this section, not the DBA or doing business as name. Include the tax identification number, NPI for the organization, and the Medicare identification number (PTAN) if issued. Identify the type of organizational structure the business has, as well as whether the business is proprietary or non-profit.

Section 4C: The date you started seeing Medicare patients at this location field must be completed and must be in mm/dd/yyyy format. If you are adding, changing or deleting the practice location, you must include the effective date of the change in mm/dd/yyyy format. The date of the first Medicare patient and the date listed in the Change, Add, Delete fields must be exact. If the application submission is for a change to a solo group, the NPI and PTAN listed in section 4C would be the organization NPI and PTAN.

Section 4E: The special payment address is required for a solo/solo group/ group. This may be a physical location, a P.O. box or a billing agency. There can be only **one** pay-to address per PTAN. If there are multiple practice locations and the address is one of those locations, the section box "'Special Payments' Address Is Different Than That Is Listed in 4C" must be selected and completed in the field below.

Section 8: If a billing agency is associated to the solo/ solo group/group, the address must be a physical location not a P.O. box. The tax identification number or Social Security number is required. If the billing agency is an individual, the date of birth in mm/dd/yyyy format is required.

855B Application

Section 1A: The reason the application was submitted should be indicated. The Medicare identification number (PTAN) (if issued), termination date (if applicable) or NPI must be stated. If "Change of Information" is selected, Section 1B should be completed.

Section 2: Identify the type of supplier of the organization. The legal business name is required in this section as it is stated on the IRS tax document. Identify the proprietary or non-profit organization as well as the type of organizational structure for the business.

Section 2H: If the organization supplies ADI services, it **MUST** be accredited in the ADI modality that is furnished. All fields should be completed with the accrediting organization information, effective date in mm/dd/yyyy format and expiration date in mm/dd/yyyy format. This section is generally used by Independent Diagnostic Testing Facilities (IDTFs).

Section 4A: The date you started seeing Medicare patients at this location field must be completed and in mm/dd/yyyy format. If you are adding, changing or deleting a practice location, the effective date of the

change is required and must be in mm/dd/yyyy format. The date of the first Medicare patient and the date listed in the Change, Add, Delete fields must be exact.

Section 4B: The special payment address is required. This may be a physical location, a P.O. box or a billing agency. There can be only **one** pay-to address per PTAN. If there are multiple practice locations and the address is one of those locations, the section box “Special Payments’ Address Is Different Than That Is Listed in 4A” must be selected and completed in the field below.

Section 6A/B: These sections are required for any individual with ownership interest and or managing control. In addition to listing the individual’s name, the Social Security Number (SSN), date of birth and Section 6B are all required. There **MUST** be two individuals listed in section 6. The supplier must have at least **ONE** owner and/or managing employee.

Section 8: If a billing agency is associated to the organization, the address for the billing agency must be a physical location, not a P.O. box. The tax identification number or Social Security number is required. If the billing agency is an individual, the date of birth in mm/dd/yyyy format is required.

Section 15/16: A Section 6 of the 855B application is required to be completed for each individual you are setting up as an authorized or delegated official.

Attachment 1: Required for ambulance service suppliers.

Attachment 2: Required for IDTFs.

IMPORTANT: A new signed and dated certification page is required on all corrections submitted for the application. If a new certification page is not submitted with the corrections, or not signed and dated, the corrections cannot be accepted.

CMS 588-Electronic Funds Transfer (EFT) Agreement

Part I Reason for Submission:

Indicate the purpose the EFT application was submitted as well as whether the provider has had a change of ownership or a change of practice location.

Part II Provider or Supplier Information:

- This section should be completed in the legal business name as indicated on the tax document.
- Indicate the provider’s practice location, city, state, and nine-digit ZIP code.
- In the tax identification field, the SSN or Employer Identification Number (EIN) box must be checked.
- The group’s or organization’s Medicare identification number (if issued) must be listed and not the member’s provider number.
- The NPI number is required.
- The PTAN or provider number, if one has been issued, is required.

Part III Depository Information (Financial Institution):

The complete address and phone number of the financial institution is required. The financial institution contact person is required. Indicate financial institution routing number and also the depositor account number.

Part V Authorization:

The authorized or delegated official must be listed on the application or already be established and listed in our Provider Enrollment, Chain and Ownership System (PECOS) if the EFT agreement is submitted with an application. The date must be in mm/dd/yyyy format. The authorized or delegated official is the only person that can sign the EFT agreement.

Supporting Documentation:

- The 855B, 855I and EFT agreements are not complete without all required supporting documentation.
- If the provider number will be linked to a TIN/EIN, the tax document must be submitted with the application. Note: Refer to Section 17 of the 855B and 855I applications for all required supporting documentation.
- The EFT agreement requires proof of the bank account by submitting a voided check or a letter from the bank.
- The legal business name on the EFT agreement should match the name on the checking account. If the name does not match, a bank letter on bank letterhead is required.
- The bank letter must include the legal business name and the other name associated to the account, the electronic transit number, account number and type. The bank officer's name signature is also required.

High Call Volume for Part B Provider Enrollment Customer Service [B]

TrailBlazer is currently experiencing an unusually high volume of calls to Part B Provider Enrollment Customer Service. As a result, the lines are busy and many providers are finding it difficult to reach a Customer Service representative for assistance.

The high call volume is due to several factors and TrailBlazer anticipates that this high call volume will be decreasing. Providers are requested to refrain from redialing at this time and to use the available online tools and various options to check the status of an enrollment application or to verify the National Provider Identifier (NPI).

- **Access the Enrollment Assistance page before calling Medicare** – Use the Enrollment Assistance page for information pertaining to average processing days for CMS-855 applications, how to request a confirmation letter, provider enrollment addresses for submitting applications, and provider enrollment appeal information including the Corrective Action Plan (CAP) Request form. [http://www.trailblazerhealth.com/Provider Enrollment/EnrollmentAssistance.aspx](http://www.trailblazerhealth.com/Provider%20Enrollment/EnrollmentAssistance.aspx)
- **Provider Enrollment Web page** – Use the “Part B Enrollment Status Inquiry Tool” to check the status of an enrollment application. This page also provides links to related notices, resources, forms and CMS Web sites. [http://www.trailblazerhealth.com/Provider Enrollment](http://www.trailblazerhealth.com/Provider%20Enrollment)
- **Internet-Based Provider Enrollment, Chain and Ownership System (PECOS)** – View or update existing enrollment information. Information about how to log on to the system is available at: <https://pecos.cms.hhs.gov/pecos/login.do>.
- **TrailBlazer Revalidation Web page** – Use the TrailBlazer Revalidation Web page for notices, publications, self-service tools, letter samples, addresses, and frequently asked questions for providers and suppliers who are instructed to be revalidated under new risk screening criteria required by the Affordable Care Act (Section 6401a). [http://www.trailblazerhealth.com/Provider Enrollment/revalidation.aspx](http://www.trailblazerhealth.com/Provider%20Enrollment/revalidation.aspx)
- **CMS Revalidation Web page** – The CMS Revalidation Web page contains information and downloads on the revalidation project implemented to those providers and suppliers who were enrolled prior to March 25, 2011, and have not updated their provider enrollment after March 25,

2011. Medicare Administrative Contractors (MACs) will send notices on a regular basis through March 23, 2015, informing each provider and supplier to revalidate. Revalidation listings are included on the CMS Revalidation page.

https://www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp

Providers' patience and continued support is appreciated. We regret any inconvenience this high call volume may have caused.

Importance of 'Complete' Medicare Provider/Supplier Enrollment Applications [A/B]

Correcting the CMS-855 enrollment form can be critical to ensuring providers' claims are processed. When a claim is unprocessable due to a National Provider Identifier (NPI) mismatch, providers need to compare the legal business name, address and Provider Transaction Access Number (PTAN) listed on the Explanation of Medicare Benefits (EOMB) to the information they have submitted to the National Plan and Provider Enumeration System (NPPES). The information on the EOMB is a reflection of the contractor's current information in the claims processing system. If the NPPES information is correct, providers are required to submit a CMS-855 enrollment form indicating all changes needed to update enrollment information. CMS is urging providers to avoid delays in CMS-855 processing caused by missing or incomplete information.

CMS has instructed its Medicare Fee-for-Service (FFS) contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the Electronic Funds Transfer (EFT) authorization agreement (CMS-588) and licensing information, within prescribed processing time frames. Incomplete or incorrect application information will result in an extension of these processing times to obtain the correct information within a specific time period provided by the provider. The developmental information needed to complete the application, if not received within that allotted time, may cause the submitted application to close or deny and **may result in deactivation or revocation** of the PTAN. This wastes precious time, especially for those seeking to rectify NPI/PTAN conflicts and poses unnecessary work for both the contractor and the provider.

For an enrollment application to be considered complete:

- All applicable sections of the CMS-855 and fields, including check-boxes, within a section must be completed at the time of filing.
- The application must contain an original signature and date of signature (blue ink is preferred).
- The application must be accompanied by all supporting documentation listed in Section 17 of the enrollment application.

The applications may be found on the TrailBlazer Provider Enrollment Web page. Current information about **average** processing days for applications may be found on the Average Processing Days for CMS-855 Application and Appeals chart.

http://www.trailblazerhealth.com/Provider_Enrollment
<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=12383>

CMS-855 Provider Enrollment Application Contact Person [A/B]

The CMS-855 Provider Enrollment Application includes a section for "contact person." The contact address is located in Section 13, page 44 of the CMS-855A; Section 13, page 28 of the CMS-855B; Section 13, page 22 of the CMS-855I; Section 7, page 7 of the CMS-855R; Section 4, page 8 of the CMS-855O, and in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the contact person is

listed in the last section. Providers and suppliers should indicate the appropriate person to assist with clarifications and additional information. If questions arise during processing of the CMS-855 application, TrailBlazer Provider Enrollment will contact the person listed in this section. The default for Internet-based PECOS is always the provider, so if the contact individual for that application submission is different, the last section of that application should be updated.

Furthermore, all correspondence related to that application will be mailed, faxed or e-mailed to the contact person's information indicated in the CMS-855 application. This includes acknowledgment, development, confirmation, and change letters. This process ensures that the person responsible for the application at the provider/supplier's facility receives all related information. Ensuring these sections of the applications are completed will aid in an efficient and accurate credentialing verification process.

The only exceptions are:

- If the provider and/or organizational provider furnishes a written letter on the provider's letterhead signed by the contact person, authorized or delegated official stating that the release of the provider data is authorized, and there is no reason to question the authenticity of the person's signature.
- The release of the data is specifically authorized in some other CMS instruction or directive.

Once the provider's eligibility is established, all correspondence will be sent to the correspondence address.

The contact person for Part B enrollment also has the capability of obtaining provider enrollment verification and confirmation pertaining to the approved application for which that individual was responsible.

Providers should visit the TrailBlazer Provider Enrollment Web page for helpful information and resources.

[http://www.trailblazerhealth.com/Provider Enrollment](http://www.trailblazerhealth.com/Provider%20Enrollment)

Reminder – Internet-Based PECOS Certification Statement Requirements [A/B]

Note: The time frame to submit the certification statement to the contractor was updated. Providers must submit a signed and dated certification statement within seven days of submitting an Internet-Based PECOS enrollment application. **The electronic enrollment application is not considered received until the contractor obtains the original signed and dated certification statement printed from the Web.**

Medicare contractors are mandated by CMS to reject any pending Internet-based application if the completed certification statement is not received within 15 days of the Internet-based application creation date. Providers should also include any mandatory supporting documentation along with the certification statement to ensure timely processing.

It is very important that providers print, sign, date and mail the original certification statement generated at the end of the online enrollment process. The effective date of filing the enrollment application is based on the date the Medicare contractor receives the signed certification statement. Blue ink is preferred.

More information about the Internet-based PECOS is available on the Internet-Based PECOS Web page.

[http://www.trailblazerhealth.com/Provider Enrollment/InternetBasedPECOS.aspx](http://www.trailblazerhealth.com/Provider%20Enrollment/InternetBasedPECOS.aspx)

CMS-855 Medicare Enrollment Applications – Reporting Adverse Legal Actions *[A/B]*

The CMS-855 Medicare enrollment applications capture information on adverse legal actions, such as convictions, exclusions, revocations and suspensions. If providers have any history of adverse legal action (state disciplinary action, Office of Inspector General (OIG)/General Services Administration (GSA) sanctions), it is important to check “Yes” under “Adverse Legal History” in the appropriate section of the CMS-855 application.

Even in situations where the provider’s license is currently active and legal action occurred several years ago, the provider must still report any adverse legal history when completing the CMS-855 application including whether the action took place in another fee-for-service contractor’s jurisdiction. The application submission should also include proof of the outcome. If a provider selects “No” and subsequent research identifies past adverse legal history, CMS requires Medicare contractors to deny the initial application and may revoke the number of an existing provider.

Following are the CMS-855 application sections relative to this information:

- CMS-855A – Institutional Providers, Sections 3, 5.B and 6.B.
- CMS–855B – Clinics/Group Practices and Certain Other Suppliers, Sections 3, 5.B and 6.B.
- CMS-855I – Physicians and Non-Physician Practitioners, Sections 3 and 6.B.
- CMS-855O – Eligible Ordering and Referring Physicians and Non-Physician Practitioners, Sections 3.
- Internet-based Provider Enrollment, Chain and Ownership System (PECOS).
- The CMS-855 Medicare enrollment applications are available on the CMS Web site.
http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp

In addition, TrailBlazer’s Provider Enrollment Web page includes links to the CMS-855 Medicare enrollment applications.

<http://www.trailblazerhealth.com/Provider Enrollment>

Options to Verify Part B TrailBlazer Enrollment Status *[B]*

TrailBlazer offers two self-service tools for providers to verify their Part B TrailBlazer enrollment status by entering their provider enrollment tracking number. Using the Part B Provider Enrollment Status Inquiry Tool or the Interactive Voice Response (IVR) can save time and eliminates the need to call Customer Service.

<http://www.trailblazerhealth.com/Tools/ProviderEnrollmentStatus.aspx>

The application tracking number used in both tools refers to the application tracking number received in the acknowledgement letter sent to the provider or contact person once the application is received. If Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) was used in the application submission, the tracking number Internet-Based PECOS provides may be monitored through the PECOS Self Service Application.

<https://pecos.cms.hhs.gov/pecos/sscHome.do>

Following are instructions to assist Part B providers with verifying their enrollment status using either option.

Part B Provider Enrollment Status Inquiry Tool

Access the Provider Enrollment Web page and enter your tracking number found on the acknowledgment letter received from Provider Enrollment.

http://www.trailblazerhealth.com/Provider_Enrollment

The tool provides detailed status information, including:

- Status – A comprehensive explanation of the current status of a provider enrollment application.
- Details – A detailed explanation of the current status and/or actions being taken.
- History – Allows the provider to track the date when each step occurred in the application process. It also provides a complete history of the application process and a comprehensive description of each status indicator.

Note: To gain access to information provided using the Provider Enrollment Status Inquiry Tool, you must be logged in to the TrailBlazer Web site

IVR

Step 1

Call the IVR: (877) 567-9230.

Step 2

Press **2** for Part B Medicare.

Step 3

Select the state the provider inquiry is for:

- CO, press **1**.
- NM, press **2**.
- OK, press **3**.
- TX, IHS, Veterans Affairs press **4**.

Step 4

Press **7** to access provider enrollment information.

Step 5

Press **2** to check enrollment application status.

Step 6

Select the correct tracking number option:

- Press **1** for an alphanumeric tracking number.
- Press **2** for a numeric tracking number.

Step 7

If numeric tracking number is selected, enter the full number sequence. The IVR will provide the status for the application tracking number that was entered.

If alphanumeric is selected, enter the alpha portion of the tracking number:

- CO, press **1**.
- IHS, press **2**.
- NM, press **3**.
- OK, press **4**.
- TX, press **5**.

Step 8

Enter the numeric portion of the tracking number and press #.
The IVR will provide the status for the application tracking number that was entered.

For information on how to verify PECOS status, refer to the notice, titled "Options for Verifying PECOS Status."

<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13527>

Options for Verifying PECOS Status *[B]*

Due to the requirements of Change Requests (CRs) 6417 and 6421, it is important for providers to be able to verify their enrollment in Medicare (i.e., enrollment records in the Provider Enrollment, Chain and Ownership System (PECOS) that contain a National Provider Identifier (NPI)). Providers have three options for PECOS verification:

1. **TrailBlazer Interactive Voice Response (IVR)** – Providers may check to see if their own NPI is in PECOS by calling the TrailBlazer IVR. Instructions are available in the article titled NPI Status in PECOS Available by Calling the IVR.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13519>
2. **CMS Ordering/Referring File** – CMS has posted a file that contains the NPI and the name (last name, first name) of all physicians and non-physician practitioners who are eligible to order/refer in the Medicare program and who have current enrollment records in Medicare. Providers can access this file on the CMS Ordering Referring Report Web page by clicking **Medicare Ordering and Referring File** under "Downloads."
http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp
3. **Internet-based PECOS** – Providers may view or update existing enrollment information by accessing Internet-based PECOS. Information about how to log on to the system is available at:
<https://pecos.cms.hhs.gov/pecos/login.do>.
4. **CMS Revalidations Web Page** – The CMS Revalidation Web page contains information and downloads on the revalidation project implemented for those providers and suppliers who were enrolled prior to March 25, 2011, and have not updated their provider enrollment after March 25, 2011. Medicare Administrative Contractors (MACs) will send notices on a regular basis through March 23, 2015, notifying each provider and supplier to revalidate. Revalidation listings for providers and suppliers are included on the CMS Revalidation page. Each provider and supplier included in this listing must respond with a PECOS revalidation application.
https://www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp

Please refer to the following articles in reference to CRs 6417 and 6421 for more information about these requirements:

- Expanded Editing of Ordering/Referring Providers – CMS CR 6417.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13079>
- Editing of Ordering/Referring Providers for DMEPOS Suppliers' Claims Processed by DME MACs – CMS CR 6421. <http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13377>
- MLN Matters® Article SE1126: Further Details on the Revalidation of Provider Enrollment Information. <http://www.cms.gov/MLNMattersArticles/Downloads/SE1126.pdf>
- MLN Matters® Article MM7350: Implementation of Provider Enrollment Provisions in CMS-6028-FC. <http://www.cms.gov/MLNMattersArticles/Downloads/MM7350.pdf>

Additional information and any updates to the NPI requirements for ordering/referring providers will be posted in the Provider Enrollment section of the TrailBlazer Web site.

<http://www.trailblazerhealth.com/Provider Enrollment>

NPI Status in PECOS Available by Calling the IVR [B]

Note: *This notice was updated to include new option for PECOS status in Step 2.*

Providers are reminded that the status of their National Provider Identifier (NPI) in the Provider Enrollment, Chain and Ownership System (PECOS) can be verified by calling the Interactive Voice Response (IVR) system and entering the NPI and Provider Transaction Access Number (PTAN).

The simple steps below will allow providers to obtain information in an easier and faster manner:

Step 1

- Call the IVR: **(877) 567-9230**.

Step 2

From the Part B main menu, make the following selections:

- To check the NPI status in PECOS, press **7**.
- Press **1** for PECOS status.
- The caller will be prompted to enter their NPI.
- The IVR will repeat the NPI entered to allow the caller to confirm if correct.

IVR Response

The IVR will inform the caller if the NPI/PTAN is in PECOS. If it is not, the IVR will direct the caller to contact Provider Enrollment customer service.

Step 3

Once the caller has received the NPI Status the following actions can be taken:

- Check another NPI and PTAN by pressing **1**.
- Return to the Main Menu by pressing ***** (star key).

Note: If the caller chooses to check another NPI and PTAN, they will be instructed to enter their NPI/PTAN and continue with the same steps as listed above.

Helpful Information:

To enter a PTAN, the following chart identifies the appropriate sequence that should be keyed to represent the alphabetic characters indicated.

A *21	B *22	C *23	D *31	E *32	F *33	G *41	H *42	I *43	J *51	K *52	L *53	M *61
N *62	O *63	P *71	Q *11	R *72	S *73	T *81	U *82	V *83	W *91	X *92	Y *93	Z *12

Note: Although the letter **Q** may appear on the **7** key on your phone keypad and the letter **Z** may appear on the **9** key on your phone keypad, please enter the letters **Q** and **Z** as indicated in the above chart.

Example: PTAN Z01234 should be entered as ***1201234#**.

An IVR PTAN conversion tool is available to assist providers entering the PTAN into the IVR. In the conversion tool, simply type the PTAN, press the convert button, and the tool will automatically convert the PTAN to the numbers/characters that are required by the IVR.

<http://www.trailblazerhealth.com/Tools/IVRTools.aspx>

Please view the "IVR Hours" notice for IVR availability.

<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13470>

If you wish to provide feedback, press ***7** from the Eligibility or Main Menu.

Time Limits for Reporting Changes to Provider Enrollment and How to Expedite the Change of Information Process [A/B]

Medicare providers/suppliers are required by federal regulation 42 CFR 424.516 to submit updates and changes to their Medicare enrollment information within specified reporting time frames. Providers who have not submitted a CMS-855 application within the past five years must complete a CMS-855 application in its entirety to populate the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and make the requested changes.

To ensure your application is processed as quickly as possible, providers should:

- Make sure all supporting documentation is submitted with the application.
- Report the change within the time limit allotted.
- Complete the appropriate application form.
- Take advantage of Internet-based PECOS to enroll in Medicare, view their Medicare enrollment data and update their Medicare enrollment information.

Supporting Documentation Needed for Changes

- IRS tax document (if provider has an Employer Identification Number (EIN)). The document must have the provider's name and EIN "imprinted" on the IRS form (W-9 form is not acceptable).
- Copy of state medical license.
- Type 1 National Provider Identifier (NPI) for solo/individual.
- Type 2 NPI for group, solo group or organization.
- If changing or adding practice location, will need verification of new address (e.g., copy of utility bill, copy of phone bill or postmarked envelope for new address).
- Type 2 NPI must match the legal business name verbatim, as noted on the top line of the IRS document.
- CMS-588 Electronic Funds Transfer (EFT) Agreement: If the provider is not currently receiving reimbursement via EFT, per 42 CFR Parts 405, 424 and 498, providers/suppliers are required to enroll in EFT at the time of initial enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request.
- To comply with CMS requirements, the provider/supplier may be requested to provide signature verification when a change application is submitted.

Time Limits for Reporting Changes

Institutional Providers (Part A)

30-Day Reporting Time Frame	90-Day Reporting Time Frame
<ul style="list-style-type: none"> Change of Ownership (CHOW) or control. 	<ul style="list-style-type: none"> All other changes.

Physicians, Non-Physician Practitioners, Physician or Non-Physician Group Practices, and All Other Part B Providers Except IDTFs

30-Day Reporting Time Frame	90-Day Reporting Time Frame
<ul style="list-style-type: none"> Change of ownership. Final adverse action change in practice location. Change of practice location. 	<ul style="list-style-type: none"> Legal Business Name (LBN)/Tax Identification Number (TIN). Special pay-to address. Authorized/delegated officials. Changes in payment information such as changes in EFT information. Change of business structure. Practice status. Change in reassignment of benefits.

Independent Diagnostic Testing Facilities (IDTFs)

30-Day Reporting Time Frame	90-Day Reporting Time Frame
<ul style="list-style-type: none"> Change of ownership. General supervision. Final adverse action change in practice location. Change of practice location. 	<ul style="list-style-type: none"> All other changes.

Type of Change Application Forms

Institutional providers	CMS-855A
Group	CMS-855B
Organization	CMS-855B
Solo provider operating under its Social Security number	CMS-855I
Sole proprietorship operating under its EIN	CMS-855I
Sole owner (solo group)	CMS-855I

Internet-Based PECOS

Refer to the Internet-based PECOS page for information on how to access this online tool. Internet-based PECOS allows providers to enroll, make changes to their enrollment or view Medicare enrollment information.

[http://www.trailblazerhealth.com/Provider Enrollment/InternetBasedPECOS.aspx](http://www.trailblazerhealth.com/Provider%20Enrollment/InternetBasedPECOS.aspx)

Internet-based PECOS offers the following benefits:

- Faster than paper-based enrollment.
- Scenario-driven application process.
- Built-in help screens.

A physician or non-physician practitioner **cannot** use Internet-based PECOS to:

- Change his name or Social Security number.
- Change an existing business structure.
- Change a primary specialty.

A provider and supplier organization **cannot** use Internet-based PECOS to:

- Make changes in ownership, acquisitions and mergers, and consolidations.
- Make changes to a TIN.
- Change an LBN.

All the above scenarios must be done using the paper enrollment application (CMS-855). All other types of changes may be completed using Internet-based PECOS.

Additional Reminders

- Section 2B of the 855I is the personal correspondence address where the provider can be reached.
- The application must be signed by the appropriate provider.
- If submitting an 855A or an 855B, the application must also be signed by the individual designated as an authorized official. Although a person may be authorized to submit applications via Internet-based PECOS, he may not have the credentials to be an authorized official.

Resource

- Provider Reporting Changes Web page. [http://www.trailblazerhealth.com/Provider/Enrollment/Provider Reporting Changes](http://www.trailblazerhealth.com/Provider/Enrollment/Provider%20Reporting%20Changes)

RURAL HEALTH CLINIC

Rural Health Clinic Negative Reimbursements [A]

At the beginning of each Calendar Year (CY), Medicare beneficiaries must meet the Part B deductible for outpatient services. In order for Medicare to render payment, the patient must first satisfy the \$140 deductible. This can present a troubling issue for those unaware of the negative reimbursement policy that pertains to Rural Health Clinics (RHCs). If the billed amount on a claim is greater than the RHC's encounter rate **and** the patient still has an outstanding amount on his deductible, this will create a negative reimbursement as shown on the Medicare Remittance Advice (RA). The reason code that will appear on the RA will be 37206.

The example below illustrates a situation that would create a negative reimbursement:

Total Billed Amount	\$186
Provider Reimbursement Rate	\$64.78
Beneficiary's Remaining Deductible	\$100
Beneficiary's Coinsurance	\$17.20

The beneficiary's responsibility will be \$117.20 (\$100 deductible and \$17.20 coinsurance). Medicare's responsibility will show as -\$35.22 (reimbursement rate minus deductible).

For more information concerning billing information or policy questions, visit the TrailBlazer RHC Web page.

http://www.trailblazerhealth.com/Facility_Types/RHC

SKILLED NURSING FACILITY

Temporary Workaround for Assessment Reference Date Reason Code 31742 for Skilled Nursing Facility and Swing Bed Claims *[A]*

CMS has developed a workaround for Skilled Nursing Facility (SNF) and Swing Bed (SB) claims incorrectly returned to the provider for Assessment Reference Date (ARD) reason code 31742 to allow these claims to process.

Providers with claims returned due to the incorrect application of this reason code should resubmit them to Medicare for processing. Be sure to bill the correct ARDs with occurrence code 50 prior to sending these claims to Medicare for processing.

(CMS Learn Resource 201201-16, dated January 10, 2012, and Technical Direction Letter (TDL) 12140, dated December 27, 2011)

TrailBlazer Instructions

Providers can correct affected claims via Direct Data Entry (DDE) to indicate the correct ARDs with occurrence code 50 and press **F9** to resubmit.

WEB UPDATES

December 2011 Web Site Enhancements *[A/B]*

TrailBlazer continues to update and enhance its Web site based on valuable feedback from users. The latest updates are outlined below:

Provider Enrollment Status Inquiry – A link to the Provider Enrollment Status Inquiry tool has been added to the left navigation menu under Provider Enrollment.

<http://www.trailblazerhealth.com/Tools/ProviderEnrollmentStatus.aspx>

Top Billing Errors (Part A) – The Top Billing Errors Web page has been updated to include both Part A Return to Provider (RTP) and rejection reason codes. Part A billing errors can now be distinguished as "Part A Top RTP Errors" or "Part A Top Claim Rejections." Each section defines the type of error and describes the appropriate action(s) to correct the error. The top 10 reason code lists are updated quarterly and link to each reason code's description and resolution.

<http://www.trailblazerhealth.com/Claims/Reports>

Your suggestions for additional resources or improvements that would benefit the provider community or feedback about these changes are welcome and can be e-mailed to:

provider.feedback@trailblazerhealth.com

CMS Notices

Workaround for Claims With POA-Exempt Diagnosis Codes Effective October 1, 2011, Editing With Reason Code 34931 [A]

Note: The "TrailBlazer Instructions" section has been updated to clarify that POA indicator "W" is required when the ICD-9-CM diagnosis code is on the list of exempt codes in CR 7024 **and** CR 7680/CMS Coding Web page.

Change Request (CR) 7680 updates the list of ICD-9-CM codes exempt from Present on Admission (POA) reporting for discharges on or after October 1, 2011. This CR is planned to be implemented July 2, 2012.

Inpatient claims received with a POA-exempt ICD-9-CM code effective October 1, 2011, are currently receiving reason code 34931. Affected claims will Return to Provider (RTP) requesting a valid POA indicator. CMS has created a workaround to resolve this issue by adding a POA indicator "W" to the affected ICD-9-CM code instead of leaving it blank.

In the interim, providers are instructed to add POA indicator "W" to claims containing a POA-exempt ICD-9-CM code that receive reason code 34931, effective for discharges on or after October 1, 2011.

(CMS Technical Direction Letter (TDL) 12137, dated December 27, 2011)

TrailBlazer Instructions

A list of categories and codes exempt from the diagnosis POA requirement is included in CR 7024, 5010 Implementation – Changes to Present on Admission (POA) Indicator '1' and the K3 Segment.

<http://www.cms.gov/Transmittals/downloads/R756OTN.pdf>

CR 7680 and the CMS Coding Web page provide the diagnosis codes that are exempt from reporting as of October 1, 2011.

http://www.cms.gov/HospitalAcqCond/05_Coding.asp

Until CR 7680 is implemented in July 2012, providers will need to follow the instructions below:

- Report the POA indicator "**W**" if the ICD-9-CM diagnosis code is on the list of exempt codes in CR 7680. These codes are also listed on the CMS Coding Web page.
- Leave the POA indicator field **blank** if the ICD-9-CM diagnosis code is **only** on the list of exempt codes in CR 7024.
- Report the POA indicator "**W**" if the ICD-9-CM diagnosis code is on the list of exempt codes in CR 7024 and in CR 7680/CMS Coding Web page.

It will be necessary for providers to view the exempt codes listed in CR 7024 prior to viewing the exempt codes in CR 7680 or on the CMS Coding Web page.

General Information

MM7502 – Bundling of Payments for Services Provided to Outpatients Later Admitted as Inpatients: Three-Day Payment Window Policy on Wholly Owned or Wholly Operated Physician Offices [A/B]

Physicians, suppliers and providers must ensure that their billing staffs are aware of the new changes to the rules for services provided to outpatients who are later admitted as inpatients, effective for services furnished on or after January 1, 2012.

CMS has established new **modifier PD**, “Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within three days.” Modifier PD will be required to be appended to the entity’s preadmission diagnostic and admission-related non-diagnostic services reported with HCPCS/CPT codes, which are subject to the three-day payment window policy.

The modifier should be used for claims with dates of service on or after January 1, 2012, and entities may begin to coordinate with their hospitals to ensure compliance with the three-day payment window policy no later than for claims received on or after July 1, 2012.

When modifier PD is present, Medicare will pay:

- Only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the three calendar day (or one calendar day) payment window.
- The facility rate for codes without a TC/PC split.

Wholly owned or wholly operated entities will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the three-day (or, when appropriate, one-day) payment window prior to the inpatient stay.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7502, titled “Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: Three-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Offices,” is available on the CMS MLN Matters[®] Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7502.pdf>

Providers may reference [Change Request \(CR\) 7502](#), Transmittal 2373, dated December 21, 2011.

MM7436 – Recovery Audit Program: Medicare Administrative Contractor-Issued Demand Letters [A/B]

Change Request (CR) 7436 announces that Medicare’s recovery auditors will no longer issue demand letters to providers as of January 3, 2012.

Effective January 3, 2012, recovery auditors will submit claim adjustments to the Medicare Administrative Contractor (MAC) who will perform the adjustments based on the recovery auditor's review and issue an automated demand letter to providers.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7436, titled "Recovery Audit Program: Medicare Administrative Contractor (MAC)-issued Demand Letters," is available on the CMS MLN Matters® Web page. See the "Background" and "Additional Information" sections for further details regarding these changes.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7436.pdf>

***Note:** This article was revised January 9, 2012, to reflect revised CR 7436. In the article, the CR release date, transmittal number and Web address for accessing CR 7436 were revised. All other information is the same.*

Providers may reference [CR 7436](#), Transmittal 202, dated January 6, 2012.

Ambulance

MM7557 – FISS Claims Processing Updates for Ambulance Services [A]

Change Request (CR) 7557 identifies the following two changes in ambulance claims submissions. The first change applies to UB-04 hard copy claims beginning with dates of service on or after January 1, 2011, submitted August 1, 2011, or after:

- Mileage must be reported as fractional units. When reporting fractional mileage, providers must round the total miles up to the nearest tenth of a mile and the decimal must be used in the appropriate place (e.g., 99.9). For trips totaling less than one mile, enter a "0" before the decimal (e.g., 0.9). This applies on trips of up to 100 miles.

The second change applies to claims with dates of service on or after April 1, 2012:

- Only non-emergency trips (i.e., HCPCS codes A0426 and A0428) require a National Provider Identifier (NPI) in the Attending Physician field. Entry of an NPI in the Attending Physician field is not required for emergency trips (i.e., HCPCS codes A0427, A0429, A0430, A0431, A0432, A0433 and A0434).

Effective: August 1, 2011 (for UB-04 hard copy claims)

April 1, 2012 (for NPI requirement changes)

Implementation: April 2, 2012

M7557, titled "Fiscal Intermediary Standards System (FISS) Claims Processing Updates for Ambulance Services," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7557.pdf>

***Note:** This article was revised January 19, 2012, to clarify that certain statements on pages 2 and 3 apply to institutional claims. This article was revised January 13, 2012, to reflect revised CR 7557. The CR revised the HCPCS code requirements for emergency and non-emergency trips on or after April 12, 2012*

(pages 2 and 3). The transmittal number, CR release date and Web address for the CR were also changed. All other information remains the same.

Providers may reference [CR 7557](#), Transmittal 2383, dated January 12, 2012.

ASC

MM7682 – January 2012 Ambulatory Surgery Center Payment System Update [B]

Change Request (CR) 7682 describes changes to and billing instructions for payment policies implemented in the January 2012 Ambulatory Surgery Center (ASC) payment system update. CR 7682 also includes updates to the HCPCS.

Included are Calendar Year (CY) 2012 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files) and the CY 2012 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with CR 7682 reflect the most recent changes to CY 2012 MPFS payment.

MM7682 discusses the following topics:

- New device pass-through category and device offset from payment.
- Billing instructions for C9732 and C1840.
- New procedure codes.
- Cardiac resynchronization therapy payment for CY 2012.
- Reporting HCPCS codes for all drugs, biologicals and radiopharmaceuticals.
- Drugs and biologicals with payment based on Average Sales Price (ASP) effective January 1, 2012.
- New CY 2012 HCPCS codes and dosage descriptors for certain drugs, biologicals and radiopharmaceuticals.
- Other changes to CY 2012 HCPCS for certain drugs, biologicals and radiopharmaceuticals.
- Updated payment rates for certain HCPCS codes effective October 1 – December 31, 2011.
- Correct reporting of biologicals when used as implantable devices.
- ASC quality measures.
- Billing for thermal anal lesions by radiofrequency energy.
- Payment when a device is furnished with no cost or with full or partial credit.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7682, titled "January 2012 Update of the Ambulatory Surgery Center (ASC) Payment System," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7682.pdf>

Providers may reference [CR 7682](#), Transmittal 2378, dated December 29, 2011.

Coding Updates

MM7668 – January 2012 Integrated Outpatient Code Editor Specifications Version 13.0 [A]

Change Request (CR) 7668 describes changes to the Integrated Outpatient Code Editor (I/OCE) and Outpatient Prospective Payment System (OPPS) to be implemented in the January 2012 OPPS and I/OCE updates. The full list of I/OCE specifications can be found on the CMS OCE Web page.

<http://www.cms.gov/OutpatientCodeEdit/>

A summary of the changes for January 2012 is within Appendix M of Attachment A of CR 7668. Providers should refer to MM7668 for a summary of the key points of Appendix M.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7668, titled "January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLNMArticles/Downloads/MM7668.pdf>

Providers may reference [CR 7668](#), Transmittal 2370, dated December 16, 2011.

MM7683 – April 2012 CARC, RARC, MREP and PC Print Update [A/B]

Change Request (CR) 7683 updates the Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Medicare Remit Easy Print (MREP) and PC Print, effective April 1, 2012.

It instructs Medicare contractors and the shared system maintainers to make programming changes to incorporate new, modified and deactivated CARCs and RARCs that have been added since the last recurring code update, and instructs Medicare systems to update the PC Print and Medicare Remit Easy Print (MREP) software.

CR 7683 lists only the changes that have been approved since the last code update and does not provide a complete list of codes in these two code sets. Providers must access the Washington Publishing Company (WPC) Web site for the complete list of CARCs and RARCs, which is updated three times a year (around March 1, July 1 and November 1).

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

The WPC Web site has four listings available for both CARCs and RARCs:

1. **All** – All codes including deactivated and to be deactivated codes.
2. **To Be Deactivated** – Only codes to be deactivated at a future date.
3. **Deactivated** – Only codes with prior deactivation effective date.
4. **Current** – Only currently valid codes.

Note: *In case of any discrepancy in the code text posted on the WPC Web site and reported in any CR, the WPC version is implemented by Medicare.*

Effective: April 1, 2012

Implementation: April 2, 2012

MM7683, titled "Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLNMattersArticles/Downloads/MM7683.pdf>

Providers may reference [CR 7683](#), Transmittal 2372, dated December 22, 2011.

TrailBlazer Instructions

Part B providers who use the MREP software will need to download the updated RARC/CARC code file when it is available in April 2012, to use in conjunction with the MREP software. The MREP user guide provides instructions to assist providers with importing the updated RARC/CARC codes file into the MREP software. The MREP user guide and software can be accessed on CMS' MREP Web page.

http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp

Part A providers who use the PC Print software can access the software and *PC Print manual* on TrailBlazer's Software & Manuals Web page.

[http://www.trailblazerhealth.com/Electronic_Data_Interchange/Software - Manuals](http://www.trailblazerhealth.com/Electronic_Data_Interchange/Software_-_Manuals)

MM7678 – Revised RARC N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries [A/B]

CMS is amending Remittance Advice Remark Code (RARC) N103 to include language that further explains the newly modified RARC N103 – denying claims for services to federally incarcerated beneficiaries. Change Request (CR) 7678 is limited to providers billing for services for beneficiaries while they are in federal, state or local custody and specifically explains the accompanying adjustment.

Effective: July 1, 2012

Implementation: July 2, 2012

MM7678, titled "Use of Revised Remittance Advice Remark Code (RARC) N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries," is available on the CMS MLN Matters® Web page. See the "Background," "Key Points" and "Additional Information" sections for details regarding these changes.

<http://www.cms.gov/MLNMattersArticles/Downloads/MM7678.pdf>

Providers may reference [CR 7678](#), Transmittal 1012, dated January 6, 2012.

MM7726 – April 2012 Quarterly Correct Coding Initiative Edits, Version 18.1 [B]

Change Request (CR) 7726 reminds physicians of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2012.

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

- Column 1/Column 2 Correct Coding Edits.
- Mutually Exclusive Code (MEC) Edits.

Additional information about the CCI, including the current CCI and MEC edits, is available on the CMS National Correct Coding Initiative Edits Web page.

<http://www.cms.gov/NationalCorrectCodInitEd/>

Effective: April 1, 2012

Implementation: April 2, 2012

MM7726, titled "Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 18.1, Effective April 1, 2012," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7726.pdf>

Providers may reference [CR 7726](#), Transmittal 2384, dated January 13, 2012.

Drugs/Biologicals

MM7431 – Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer [A/B]

Change Request (CR) 7431 provides information regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

CMS has concluded that the use of autologous cellular immunotherapy treatment, sipuleucel-T (Provenge®), improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. Therefore, it is reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)), effective for services performed on or after June 30, 2011.

Medicare contractors will continue to process claims for Provenge® with dates of service on or after June 30, 2011, as they do currently when providers submit Not Otherwise Classified (NOC) HCPCS code(s) J3590, J3490 or C9273. **Note:** HCPCS code C9273 will be **deleted June 30, 2011**.

Effective: June 30, 2011

Implementation: August 8, 2011

MM7431, titled "Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7431.pdf>

Note: This article was revised January 10, 2012, to reflect revised CR 7431. The article has been revised to show that a separate payment for the cost of administration is allowed. In addition, the transmittal numbers, release date and Web address for accessing CR 7431 were revised. All other information remains the same.

Providers may reference [CR 7431](#), Transmittal 2380, dated January 6, 2012.

Electronic Billing

SE1138 – Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims [A/B]

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes, a corresponding description of the service is now required. Please ensure:

- Billing and coding staff follow these requirements for submitting a Health Insurance Portability and Accountability Act (HIPAA)-compliant claim when non-specific procedure codes are used.
- These implementation guide requirements are followed when submitting a HIPAA-compliant claim for all non-specific procedure codes.

SE1138, titled "Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/SE1138.pdf>

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

Important TrailBlazer Instructions:

CMS has released updated information regarding the 5010 transition. As stated in Technical Direction Letter (TDL) 12148, TrailBlazer will not reject compliant ASC X12 Version 4010A1 transactions prior to April 1, 2012. The exact date and time 4010A1 transactions will be rejected will be published at a later date.

SE1137 – Additional HIPAA 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement National Crossover Process [A/B]

Supplemental payers are transitioning to the Health Insurance Portability and Accountability Act (HIPAA) 5010 or National Council for Prescription Drug Programs (NCPDP) D.0 under the national crossover process.

Currently, CMS is transitioning supplemental payers that participate in the national Coordination of Benefits Agreement (COBA) crossover process from their production version 4010A1 HIPAA 837 claims to HIPAA versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production version 4010A1 claims for 14 full calendar days after their cutover to the new claim formats. As provided in Change Request (CR) 6658 and CR 6664, the COBA activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226 – 4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims.
- N22230 – NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims.

<http://www.cms.gov/transmittals/downloads/R1844CP.pdf>
<http://www.cms.gov/transmittals/downloads/R1841CP.pdf>

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

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

SE1137, titled "Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/SE1137.pdf>

***Note:** This article was revised January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to the COBA supplemental payers who have cut over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers who are permitted to submit claims using the CMS-1500 or UB-04 hard copy formats. All other information remains unchanged.*

End Stage Renal Disease

MM7064 – ESRD PPS and Consolidated Billing for Limited Part B Services [A/B]

***Note:** This notice has been updated to include a note indicating the MLN Matters® article was revised. In addition, a link to the current notice about the low-volume facility adjustments was added under the "TrailBlazer Instructions."*

Change Request (CR) 7064 announces the implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011.

The ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD-related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including:

- Supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home.
- ESRD-related drugs and biologicals.
- ESRD-related laboratory tests.
- Training and support services.

Phase-In Period

The ESRD PPS provides a four-year phase-in (transition) period during which facilities will receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. **Facilities wishing to exercise this option must notify their Medicare contractor on or before November 1, 2010.**

TrailBlazer Instructions

ESRD facilities should view the notice, titled "ESRD Provider Low-Volume Facility Adjustment Request Process," for details regarding low-volume eligibility and adjustment requests.

<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13926>

New Modifier – Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable. When these laboratory services and limited drugs are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new **AY modifier** to allow for separate payment outside of the ESRD PPS.

Method 2 Treated as Method 1 – All claims billed on Type of Bill (72X) with condition code 74 will be treated as Method 1 home dialysis claims. All home dialysis claims must be billed by a renal dialysis facility and will be paid under the ESRD PPS. Effective January 1, 2011, submission of the CMS-382 form to Medicare contractors is no longer required for home dialysis patients.

Effective: January 1, 2011

Implementation: January 3, 2011

MM7064, titled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/downloads/MM7064.pdf>

***Note:** This article was revised December 21, 2011, to clarify the cost report language for low-volume facility adjustments on page 6. All other information remains the same.*

Providers may reference [CR 7064](#), Transmittal 2134, dated January 14, 2011.

Inpatient Hospital

MM7685 – Due January 30, 2012 – Teaching Hospitals Reporting the IRS Refund of Medical Resident FICA Taxes [A]

On March 2, 2010, the Internal Revenue Service (IRS) made an administrative determination that medical residents are exempt from FICA taxes based on the student exception for tax periods ending before April 1, 2005. Recently, the IRS began contacting hospitals, universities and medical residents who filed FICA (Social Security and Medicare tax) refund claims for these periods.

Change Request (CR) 7685 informs teaching hospitals of the proper way to report the FICA refund for medical residents on the Medicare cost report. The FICA refund must be reported in such a way that it does not impact a hospital's wage-related costs used to compute the wage index under the hospital

Inpatient Prospective Payment System (IPPS). However, cost reimbursement principles for cost reporting purposes must be followed on Worksheet A.

The FICA refund has two parts:

- Under Part I, the IRS will refund FICA and Medicare taxes to the hospitals for the employer's share.
- Under Part II, the IRS will refund FICA and Medicare taxes to the hospitals for the resident employee's share and the hospitals must return the refund to the residents employed by the hospital between approximately 1994 and 2005.

Although both refunds apply for tax periods ending before April 1, 2005, hospitals are receiving these refunds during cost reporting periods that occur during Fiscal Years (FYs) 2009, 2010 or 2011. It is important that a hospital's wage-related costs are properly reported in these FYs, so as not to impact the calculation of the IPPS wage index for FYs 2013, 2014 or 2015.

Teaching hospitals must work with TrailBlazer Part A Audit & Reimbursement to make any necessary changes to their FY 2009 cost reports by January 30, 2012, (cost reports beginning on or after October 1, 2008) to be used in the FY 2013 wage index, so that the wage index will be calculated correctly for the FY 2013 IPPS proposed rule. Teaching hospitals should contact the TrailBlazer Home Office Team manager in Medicare Part A Audit & Reimbursement responsible for their facility.

<http://www.trailblazerhealth.com/Publications/Job Aid/auditcontacts.pdf>

For purposes of this instruction, a "teaching hospital" is defined as a hospital that completed Worksheet E, Part A for Indirect Medical Education (IME) and/or Worksheet E-3, Part IV for direct Graduate Medical Education (GME) (or Worksheet E-4 if applicable) on its cost report that was most recently submitted as of the time of issuance of this CR.

Note: CR 7685 makes an exception to the December 5, 2011, deadline specified in CR 7450 to allow hospitals to submit revisions to Medicare contractors after December 5, 2011, but **only** to properly report the FICA tax refund. CR 7450 is otherwise unchanged.

In accordance with Technical Direction Letter (TDL) 11452, issued September 2, 2011, cost reports that end prior to April 30, 2011, would still be filed on Form 2552-96. Cost reports ending on or after April 30, 2011, are to be filed on Form 2552-10.

FICA Refund Part I – Hospital Employer's Share

Cost Reporting on Worksheet A – For cost reporting purposes, on Worksheet A of both Forms 2552-96 and 2552-10 of the Medicare cost report, the FICA employer's portion of the refund must follow Medicare reimbursement principles in accordance with 42 CFR Section 413.98. Refunds of the employer portion of FICA costs from previous periods are to be treated as a reduction of the current cost reporting employer portion of FICA costs.

- If the teaching hospital reported the FICA employer's portion of expense net of the FICA refund on Worksheet A, column 2, no adjustment is necessary on Worksheet A-8.
- If the teaching hospital did not report the employer's portion of the FICA expense net of the FICA refund on Worksheet A, column 2, the teaching hospital must ensure that the employer's portion of the FICA refund is identified as a revenue offset on Worksheet A-8.

The FICA employer portion of expenses is classified as an employee benefit and will be reported on Worksheet A in the employee benefits cost center. The refund of the FICA employer's portion will be offset against the expense reported on Worksheet A. If the FICA employer's portion of expenses is directly

assigned to individual cost centers other than employee benefits, the teaching hospital will offset the refund, not to exceed the total current year FICA expense, against the employee benefits cost center, as the residual costs of this cost center will be allocated through step-down accordingly.

Wage-Related Cost for the Wage Index – It is possible that teaching hospitals filing on Form 2552-96 and receiving their employer's share of the FICA refund have subtracted the refund amount from their current year FICA expense on line 17 (FICA-Employer's Portion Only) of Form 339.

For wage index purposes, the FICA refund to a teaching hospital for its employer's share is not to be used to reduce the current year employer's portion of FICA expense on Worksheet S-3, Part II and Form 339 of Form 2552-96. Therefore, the employer's portion of the FICA refund must be added back to line 17 of Form 339 so that line 17 and Worksheet S-3, Part II reflect the full FICA employer's portion of the expense incurred for that year.

If a teaching hospital is filing on the Form 2552-10, then for wage index purposes, the employer's portion of the FICA refund must be excluded from line 17 of Worksheet S-3, Part IV so that line 17 reflects the FICA employer's portion of the expense incurred for that year.

After ensuring that the FICA employer's portion of the expense incurred for the cost reporting year is properly reflected on line 17 of the Form 339 or Worksheet S-3, Part IV as applicable, a teaching hospital will also ensure that the FICA employer's portion of the expense for the year is properly reflected in its allocation of wage-related costs to lines 13 through 20 of Worksheet S-3, Part II of the respective cost report.

FICA Refund Part II – Hospital Resident Employee's Share

If a teaching hospital has already reported the resident employee's share of the FICA refund as an accrued expense on Worksheet A, column 2, then the teaching hospital must ensure that a revenue offset equal to that accrued expense is submitted on Worksheet A-8. A teaching hospital will identify this offset on Worksheet A-8 as the "resident employee FICA refund." The amount is accrued as an expense on Worksheet A and the offset on Worksheet A-8 must net to zero.

If a teaching hospital has not reported the resident employee's share of the FICA refund as an accrued expense on Worksheet A or has not filed a cost report in which the employee's portion of the FICA refund is received, then upon receipt of the refund, the proper reporting for the refund is an offset of the actual or accrued employee portion of the FICA refund expense, resulting in a net of zero.

Interest Earned on FICA Refunds

The interest income earned on the employee and employer portions of the FICA refund is considered non-capital-related and will be offset against the interest expense that will be incurred in refunding the residents as well as any additional non-capital-related interest expense.

Effective: January 30, 2012

Implementation: January 30, 2012

MM7685, titled "Instructions to Teaching Hospitals for Reporting the Internal Revenue Service (IRS) Refund of Medical Resident FICA Taxes," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7685.pdf>

Note: This article was revised January 9, 2012, to reflect revised CR 7685. The article was revised to change the date at the end of item IV on page 4 to show January 30, 2012, instead of 2011. Also, the CR

release date, transmittal number and Web address for accessing CR 7685 were revised. All other information is the same.

Providers may reference [CR 7685](#), Transmittal 1014, dated January 6, 2012.

Outpatient Services

MM7672 – January 2012 Hospital OPPS Update [A]

Change Request (CR) 7672:

- Describes changes to and billing instructions for various payment policies implemented in the January 2012 Outpatient Prospective Payment System (OPPS) update.
- Implements several changes and clarifications in the manual requirements for the provision of hospital outpatient therapeutic services finalized in the Calendar Year (CY) 2012 OPPS/Ambulatory Surgical Center (ASC) Final Rule.

MM7672 provides specific details regarding the following topics:

- Physician supervision.
- New device pass-through categories.
- Device offset from payment for C1886.
- Revised device offset from payment for category C1840.
- New procedure code C9732.
- Billing instructions for C9732 and C1840.
- Billing for thermal anal lesions by radiofrequency energy.
- Cardiac resynchronization therapy payment for CY 2012.
- Billing for drugs, biologicals and radiopharmaceuticals:
 - Reporting HCPCS codes for all drugs, biologicals and radiopharmaceuticals.
 - New CY 2012 HCPCS codes and dosage descriptors for certain drugs, biologicals and radiopharmaceuticals.
 - Other changes to CY 2012 HCPCS and CPT codes for certain drugs, biologicals and radiopharmaceuticals.
 - Drugs and biologicals with payments based on Average Sales Price (ASP) effective January 1, 2012.
 - Updated payment rates for certain HCPCS codes effective October 1 – December 31, 2011.
 - Correct reporting of biologicals when used as implantable devices.
 - Payment for therapeutic radiopharmaceuticals.
 - Payment offset for pass-through diagnostic radiopharmaceuticals.
 - Payment offset for pass-through contrast agents.
- Clarification of coding for drug administration services.
- Provenge[®] administration.
- Billing for screening and behavioral counseling interventions in primary care to reduce alcohol misuse – National Coverage Determination (NCD).
- Screening for depression in adults – NCD.
- Billing for Sexually Transmitted Infections (STIs) screening and High Intensity Behavioral Counseling (HIBC) to prevent STIs – NCD.
- Billing for intensive behavioral therapy for cardiovascular disease – NCD.
- Intensive behavioral therapy for obesity – NCD.
- Payment window for outpatient services treated as inpatient services.
- Partial hospitalization Ambulatory Payment Classifications (APCs).
- Molecular pathology procedure test codes.

- Use of modifiers for discontinued services (modifiers 52, 53, 73 and 74).
- Changes to OPPS Pricer logic.
- Coverage determinations.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7672, titled "January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7672.pdf>

***Note:** This article was revised January 10, 2012, to change the date in the last sentence of the first page to January 2012. All other information is the same.*

Providers may reference [CR 7672](#), Transmittal 2386, dated January 13, 2012.

Payment/Fee Schedule Updates

MM7671 – Summary of Policies in the CY 2012 MPFS Final Rule and Telehealth Originating Site Facility Fee Payment Amount [A/B]

Change Request (CR) 7671 summarizes the policies in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the telehealth originating site facility fee payment amount for CY 2012.

MM7671 provides detailed information about the following topics:

- Summary of policies in the CY 2012 MPFS:
 - Misvalued codes under the physician fee schedule.
 - Multiple procedure payment reduction policy.
 - Revisions to the practice expense geographic adjustment.
 - Implementation of the three-day payment window policy in wholly owned or wholly operated entities.
 - Annual wellness visit providing a personalized prevention plan.
 - Molecular pathology procedure codes.
- Telehealth services:
 - Telehealth originating site facility fee payment amount.

Effective: January 1, 2012

Implementation: January 3, 2012

MM7671, titled "Summary of Policies in the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7671.pdf>

***Note:** This article was revised January 6, 2012, to reflect revised CR 7671. The CR was revised to amend language in the summary of the multiple procedure payment reduction and revisions to the practice expense geographic adjustment policies described in the "Background" section of this article. In addition,*

the article now reflects a new transmittal number, CR release date and a revised Web address for accessing the CR. All other information remains the same.

Providers may reference [CR 7671](#), Transmittal 2371, dated January 4, 2012.

SE1202 – Health Professional Shortage Area Bonus Payment Policy Reminders [A/B]

Physicians who furnish services to Medicare beneficiaries in areas designated as primary care geographic Health Professional Shortage Areas (HPSAs) by the Health Resources and Services Administration (HRSA) as of December 31, 2011, are eligible for a 10 percent bonus payment for services furnished from January 1, 2012, to December 31, 2012. If an area does not have a geographic primary care HPSA designation, but does have a geographic mental health HPSA designation, then only psychiatrists furnishing services to Medicare beneficiaries in the designated area are eligible for the 10 percent bonus.

The physician must determine whether a service is furnished in a geographic primary care (or mental health) HPSA. Eligibility is determined annually based on the status of the designation, as of December 31 of the prior year.

CMS publishes an annual list of ZIP codes that automatically receive the HPSA bonus. Only areas where the entire ZIP code falls within the designated area at the time the list is developed are listed. Services provided in eligible areas that are not listed for automatic bonus payment must use the AQ modifier to receive the bonus.

Information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic payment of the bonus, is available on the CMS HPSA/PSA Bonuses Web page.

http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp

SE1202, titled "Health Professional Shortage Area (HPSA) Bonus Payment Policy Reminders," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLNMattersArticles/Downloads/SE1202.pdf>

Radiology

MM7442 – Multiple Procedure Payment Reduction on Certain Diagnostic Imaging Procedures [B]

Medicare is making a change to the Multiple Procedure Payment Reduction (MPPR) on certain diagnostic imaging procedures. Specifically, CMS is applying the MPPR to the Professional Component (PC) services as well as to Technical Component (TC) services.

The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Currently, the MPPR on diagnostic imaging services applies only to the TC services. It applies to both TC-only services and to the TC portion of global services. Full payment is made for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

CMS is expanding the MPPR by applying it to PC services. Full payment is made for each PC and TC service with the highest payment under the Medicare Physician Fee Schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day.

Note: Due to operational considerations, CMS is not applying the imaging MPPR to group practices at this time.

The complete list of codes subject to the MPPR on diagnostic imaging is in Attachment 1 of Change Request (CR) 7442.

Effective: January 1, 2012
Implementation: January 3, 2012

MM7442, titled "Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7442.pdf>

Providers may reference [CR 7442](#), Transmittal 995, dated November 4, 2011.

MM7681 – Advanced Diagnostic Imaging Accreditation Enrollment Procedures (CR 7681 Fully Rescinds and Replaces CR 7177) [B]

Change Request (CR) 7681 fully rescinds and replaces CR 7177. CR 7177 established that Advanced Diagnostic Imaging (ADI) providers/suppliers would need to provide their ADI accreditation information by completing an Internet-based Provider Enrollment, Chain and Ownership System (PECOS) application or a CMS-855 application.

CR 7681 changes this requirement and allows for the accrediting organizations to provide the listing of who is accredited through a weekly file. **Since this change, providers/suppliers no longer need to complete the ADI information in Internet-based PECOS or on a CMS-855 form(s).**

CR 7681 instructs that Medicare contractors will:

- Not require documentation from the ADI provider/supplier for proof of their accreditation.
- Not require providers/suppliers to complete the ADI section in the Internet-based PECOS application nor in the appropriate CMS-855 form.
- Receive this information directly from the accrediting organizations.

Effective: January 27, 2012
Implementation: January 27, 2012

MM7681, titled "Advanced Diagnostic Imaging (ADI) Accreditation Enrollment Procedures (Change Request (CR) 7681 Fully Rescinds and Replaces CR 7177)," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLN MattersArticles/Downloads/MM7681.pdf>

Providers may reference [CR 7681](#), Transmittal 402, dated January 13, 2012.

TrailBlazer Instructions

Providers may refer to the following resources for more information:

- Provider Enrollment Web page. http://www.trailblazerhealth.com/Provider_Enrollment
- Radiology Web page. http://www.trailblazerhealth.com/Specialty_Services/Radiology
- IDTF Web page. http://www.trailblazerhealth.com/Facility_Types/IDTF
- Advanced Diagnostic Imaging Accreditation Services job aid. http://www.trailblazerhealth.com/Publications/Job_Aid/AdvDiagImagAccrSvcs.pdf
- *Diagnostic Radiology manual*. http://www.trailblazerhealth.com/Publications/Training_Manual/DiagnosticRadiology.pdf
- CMS Advanced Diagnostic Imaging Accreditation Web page. http://www.cms.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp

Skilled Nursing Facility

MM7701 – Allowing Physician Assistants to Perform SNF Level of Care Certifications and Recertifications [A]

Section 3108 of the Affordable Care Act adds physician assistants to the list of practitioners who can perform Skilled Nursing Facility (SNF) level of care certifications and recertifications. Performing this function is a requirement for Medicare coverage of SNF services under Part A.

Change Request (CR) 7701 directs Medicare contractors to recognize that, **effective with services furnished on or after January 1, 2011**, physician assistants can perform the required initial certification and periodic recertifications of a beneficiary's need for a SNF level of care.

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

Effective: Items/services furnished on or after January 1, 2011
Implementation: February 13, 2012

MM7701, titled "Allowing Physician Assistants to Perform Skilled Nursing Facility (SNF) Level of Care Certifications and Recertifications," is available on the CMS MLN Matters® Web page.

<http://www.cms.gov/MLNMattersArticles/Downloads/MM7701.pdf>

Providers may reference [CR 7701](#), Transmittal 76, dated January 13, 2012.



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