# Medicare B Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC
Cahaba GBA is the J10 A/B Medicare Administrative Contractor

**June 2012**

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

## News From Cahaba GBA



## News From Cahaba GBA continued….



## News From CMS



## Key For Icons

| | | |
|---|---|---|
| All Providers | End Stage Renal Disease (ESRD) | Skilled Nursing Facility (SNF) |
| Claims | Radiology | |

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

We encourage users to review the specific statues, regulations and other interpretive materials for a full and accurate statement of their contents. Although this material is not copyrighted, CMS prohibits reproduction for profit making purposes.

**American Medical Association Notice and Disclaimer**


**ICD-9 Notice**

## Please Route

Remember that this newsletter, and all other Medicare publications, serves as your official notice of Medicare coverage and billing information. If you have any questions about the information included in this newsletter, please call your Provider Contact Center.

This bulletin shall be shared with all health care practitioners and managerial members of your provider staff. Bulletins are available at no cost from our website https://www.cahabagba.com/part_b/education_and_outreach/newsletters/index.htm.

**Routing List**

- ☐ Provider/Supplier
- ☐ Administrator
- ☐ Office/Clinic Manager
- ☐ Medical Personnel
- ☐ Billing/Insurance Staff
- ☐ Other Additional Staff

## General Medicare Questions for Medicare Recipients

Do some of your patients have questions regarding their Medicare benefits and you are not sure how to answer? Medicare recipients should call **1-800-MEDICARE (1-800-633-4227)** for all questions related to Medicare services. Questions regarding specific claims will be automatically routed to the appropriate Medicare contractor's call center for response. **Please do not ask your patients to contact Medicare on a claim that you accepted assignment on.**

# Holiday Closure Schedule-2012

Cahaba GBA's Medicare offices in Birmingham, Alabama, Douglasville, Georgia, and Chattanooga, Tennessee are closed on the following days listed below in 2012. In addition, all Medicare Provider Contact Centers (PCC) close on federal holidays for continuing education training; therefore, customer service representatives will not be available on those days to receive your calls.

| Holiday / Date | Closure Schedule |
|---|---|
| **New Year's Day Observed**<br>January 2, 2012<br>Monday | All Offices Closed |
| **Martin Luther King Birthday**<br>January 16, 2012<br>Monday | All Offices Closed |
| **President's Day**<br>February 20, 2012<br>Monday | PCC Closed for Training |
| **Good Friday**<br>April 6, 2012<br>Friday | All Offices Closed |
| **Memorial Day**<br>May 28, 2012<br>Monday | All Offices Closed |
| **Independence Day**<br>July 4, 2012<br>Wednesday | All Offices Closed |
| **Labor Day**<br>September 3, 2012<br>Monday | All Offices Closed |
| **Columbus Day**<br>October 8, 2012<br>Monday | PCC Closed for Training |
| **Veterans Day Observed**<br>November 12, 2012<br>Monday | PCC Closed for Training |
| **Thanksgiving**<br>November 22-23, 2012<br>Thursday/Friday | All Offices Closed |
| **Christmas**<br>December 24-25, 2012<br>Monday/Tuesday | All Offices Closed |
| **New Year's Day**<br>January 1, 2013<br>Tuesday | All Offices Closed |

## Provider Contact Center– Training Schedule

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the Provider Contact Centers the opportunity to offer training to our Customer Service Representatives (CSRs). Listed below are the dates and times the Provider Contact Center will be closed for training.

| PCC Training Dates | Time |
|---|---|
| Friday, June 1, 2012 | 9:30 a.m.- 11:30 a.m. CT/10:30 a.m.- 12:30 p.m. ET |
| Friday, June 8, 2012 | 9:30 a.m.- 11:30 a.m. CT/10:30 a.m.- 12:30 p.m. ET |
| Friday, June 15, 2012 | 9:30 a.m.- 11:30 a.m. CT/10:30 a.m.- 12:30 p.m. ET |
| Friday, June 22, 2012 | 9:30 a.m.- 11:30 a.m. CT/10:30 a.m.- 12:30 p.m. ET |

## Provider Contact Center Telephone Numbers

- Alabama B, Georgia B, and Tennessee B: 877 567-7271
- Mississippi B: 866 419-9454

Our Interactive Voice Response (IVR) system is designed to assist providers in obtaining answers to numerous issues through self-service options. Options on our IVR include information regarding patient eligibility, checks, claims, deductible and other general information. Please note that our Customer Service Representatives (CSRs) are available to answer questions that cannot be answered by the IVR. CSRs are physically located in Birmingham, Alabama and Douglasville, Georgia. When your call is received, it is routed to the next available representative. CSRs are available Monday through Friday 8:00 a.m. until 4:00 p.m. in your time zone.

# Using the Interactive Voice Response (IVR) System for Claim Status and Eligibility Requests

Cahaba Government Benefit Administrators®, LLC is experiencing a high volume of providers who are opting out of the Interactive Voice Response (IVR) system to speak to a Customer Service Representative (CSR) for information that can be accessed through the IVR.

The Centers for Medicare and Medicaid Services (CMS) *Internet Only Manual (IOM) Chapter 6 Section 50.1* states:

> "Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning."

**If you are requesting whether Cahaba has received a claim or if a claim has finalized, this is considered a claim status request.**

In addition, according to IOM Chapter 6 Section 80.3.4, "If a CSR or written inquiry correspondent receives an inquiry about information that can be found on a Remittance Advice (RA), the CSR/correspondent should take the opportunity to educate the inquirer on how to read the RA, in an effort to encourage the use of self-service. The CSR/correspondent should advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers should also be advised that any billing staff or representatives that make inquiries on his/her behalf will need a copy of the RA."

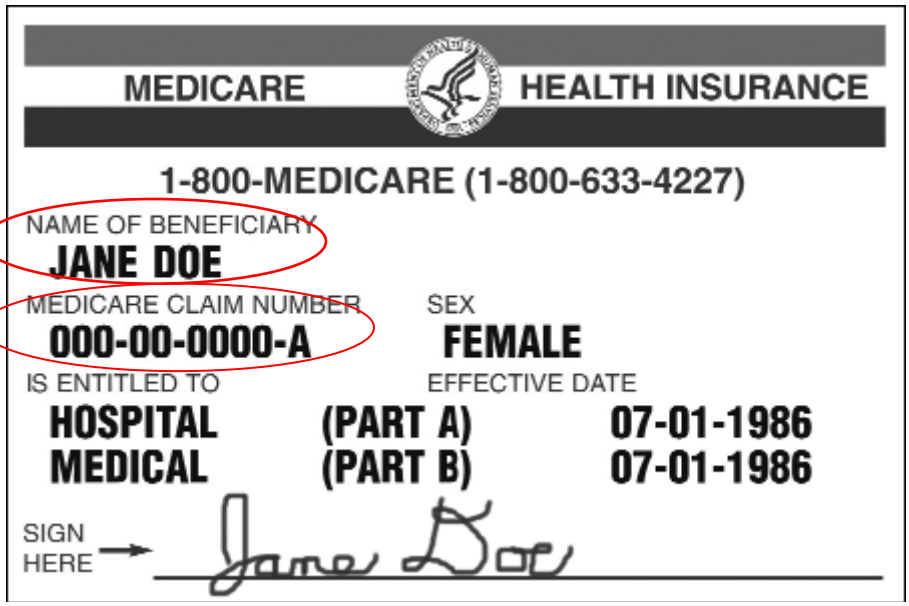
Cahaba CSRs have visibility as to the path the provider takes in the IVR and/or whether they opt out to speak with a representative up front. The CSR will instruct the provider to call back and utilize the IVR if they did not attempt to use this self service option as required by CMS.

***Provider Contact Center (PCC)***

# Medicare Health Insurance Claim (HIC) Number

A Medicare card is issued to every person who is entitled to Medicare benefits and may be identified by its red, white and blue coloring. This card identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the Social Security records);
- Medicare Health Insurance Claim (HIC) number;
- Beginning date of Medicare entitlement for hospital and/or medical insurance;
- Sex and Beneficiary's signature.




Three of the top five reasons for claim rejection in any given month are for:

- The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim. The beneficiary's last name must include apostrophes, spaces, hyphens, etc., if they appear in the beneficiary's last name on his or her Medicare card.
- The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim. The beneficiary's first name must appear as it does on the beneficiary's Medicare card. This includes spaces, hyphens, apostrophes, etc.
- The HIC number not matching the name we have on record. The Medicare Claim Number must appear on the claim exactly as it does on the beneficiary's card, without the dashes and with no spaces.

It is extremely important that you submit the patient's complete name and HIC number to Medicare or any other health care provider you use (i.e. clinical laboratories, radiology imaging groups, or outpatient therapy providers, etc.). This will ensure that those providers have the correct patient information to file their claims as well.

# Cahaba's E-mail Notification Service Subscription Process

Cahaba GBA recently implemented changes that simplify the process in which providers subscribe to our e-mail notification service (Listserv). New members simply provide their name, city, state, zip code, e-mail address, and an optional password. In addition, they can select from two different lists to subscribe to:

- J10 Part A News
- J10 Part B News*****

Once you are a member, you can edit your profile to:

- unsubscribe from all lists
- subscribe to additional lists
- update your e-mail address
- change your name or address information
- change what Cahaba lists you are subscribed to.

**Already a Member?**

If you enrolled to Cahaba's Listserv prior to November 1, 2009, you will continue to receive messages. However, depending on the selections you made on the subscription form when you originally enrolled, you may receive messages from more than one Cahaba list. To change the list you are subscribed to, access the "Edit Your E-mail Notification Service Member Profile" Web page to review and edit your profile.

In order to ensure that you receive your subscription emails and announcements from Cahaba GBA, please add us to your contact lists, adjust your spam settings, or follow the instructions from your email provider on how to prevent **our emails** from being marked "Spam" or "Junk Mail".

*****Mississippi Medicare Part B providers will choose J10 Part B News for their selection to receive Medicare Part B information.

# Alabama Medicare Part B
## Top Five Reasons for EDI Claim Rejections for April 2012

Audit trails show which of your claims were accepted by the Cahaba GBA processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA EDI Services is providing you with the top five reasons for claim rejections. For the month of **April 2012**, these are:

| Claim Rejection | Description | Number of Claims |
|---|---|---|
| 382 | **NPI REQUIRED IN LOOP : XXXXXX WHEN PROVIDER IDENTI**<br>Provider information was submitted in the indicated loop but there was no XX qualifier in the NM108 for that provider. | 1,809 |
| 384 | **INVALID NPI/EIN COMBINATION IN LOOP : XXXXXX**<br>The NPI submitted in the indicated loop is not associated with the tax ID number used. For providers who use a SSN the qualifier in the NM108 in the indicated loop should be SY. For tax ID number issues contact Provider Enrollment at 877-567-7271. | 443 |
| 317 | **INVALID TAXONOMY CODE IN LOOP XXXXXX**<br>The taxonomy code submitted in the indicated loop is not valid. For a list of taxonomy codes visit the Washington Publishing Company's website at www.wpc-edi.com. | 165 |
| 888 | **INSTREAM REJECTION**<br>There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred | 136 |
| 387 | **NPI : XXXXXXXXXX NOT FOUND ON CROSSWALK FILE IN LO**<br>The NPI submitted was not found on the crosswalk. If the NPI submitted is correct contact Provider Enrollment at (877) 567-7271. | 110 |

# Georgia Medicare Part B

## Top Five Reasons for EDI Claim Rejections for April 2012

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|---|---|---|
| 888 | **INSTREAM REJECTION**<br>There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred | 653 |
| 421 | **DIAG CODE (XXXXX) INVALID FOR DATE SVC**<br>The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis. | 441 |
| 202 | **RAILROAD**<br>The first character in the beneficiary's HIC number was non-numeric, indicating the beneficiary is a Railroad Retiree. The claim needs to be submitted to the Railroad Medicare carrier. | 132 |
| 207 | **INVALID HIC NUMBER SUFFIX**<br>The suffix in the Health Insurance Claim (HIC) number submitted for the beneficiary is invalid. For an explanation of HIC numbers and suffixes please visit https://www.cahabagba.com/part_b/education_and_outreach/general_billing_info/hic_suffixes.htm. | 111 |
| 307 | **DIAG CODE (XXXXX) INVALID OR INACTIVE**<br>The indicated diagnosis code is either invalid or inactive for the date of service. | 47 |

# Mississippi Medicare Part B
## Top Five Reasons for EDI Claim Rejections for April 2012

Audit trails show which of your claims were accepted by the Cahaba GBA processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA EDI Services is providing you with the top five reasons for claim rejections. For the month of **April 2012**, these are:

| Claim Rejection | Description | Number of Claims |
|---|---|---|
| 888 | **INSTREAM REJECTION**<br>There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you can do this: http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm. | 1,510 |
| 480 | **LINE PAID AMOUNT CANNOT BE GREATER THAN ALLOWED AM**<br>For a Medicare Secondary Payer (MSP) claim, the amount the primary paid in the 2430 loop, SVD02, cannot be greater than the amount the primary allowed in the 2430 loop, shown in the CAS segment with an AAE qualifier. | 118 |
| 375 | **PAID AMOUNT CANNOT BE GREATER THAN ALLOWED AMOUNT**<br>For a Medicare Secondary Payer (MSP) claim, the amount the primary payer paid in the 2320 loop, AMT segment, D qualifier, cannot be greater than the amount the primary payer allowed, shown in the 2320 loop, AMT segment, B6 qualifier. | 97 |
| 421 | **DIAG CODE (XXXXX) INVALID FOR DATE SVC**<br>The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis. | 82 |
| 207 | **INVALID HIC NUMBER SUFFIX**<br>The suffix submitted for the beneficiary's HIC number is invalid. For a list of valid suffixes and their meanings visit this article on our website: https://www.cahabagba.com/part_b/education_and_outreach/general_billing_info/hic_suffixes.htm. | 38 |

# Tennessee Medicare Part B
## Top Five Reasons for EDI Claim Rejections for April 2012

Audit trails show which of your claims were accepted by the Cahaba GBA processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA EDI Services is providing you with the top five reasons for claim rejections. For the month of **April 2012**, these are:

| Claim Rejection | Description | Number of Claims |
|---|---|---|
| 421 | **DIAG CODE (XXXXX) INVALID FOR DATE SVC**<br>The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis. | 430 |
| 302 | **INVALID BILLING (NO CHARGES BILLED)**<br>Claim did not contain any items with an associated billed amount. | 357 |
| 434 | **PROC CODE REQUIRES REFERRING NPI**<br>Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim. | 68 |
| 888 | **INSTREAM REJECTION**<br>There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred | 61 |
| 207 | **INVALID HIC NUMBER SUFFIX**<br>The suffix in the Health Insurance Claim (HIC) number submitted for the beneficiary is invalid. For an explanation of HIC numbers and suffixes please visit https://www.cahabagba.com/part_b/education_and_outreach/general_billing_info/hic_suffixes.htm | 60 |

# Alabama Medicare Part B
## Top Ten EDI 277CA Edits for April 2012 for Version 5010

For claim submissions in the 5010 format that pass high-level edits a 277CA transaction is created. This transaction will indicate file, batch, claim, and line level edits.

For spreadsheets that list the 277CA edits and give more detailed information about them please visit the CMS website at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp. Visit the Washington Publishing Company's website at http://www.wpc-edi.com for more information about 277CA transactions and the codes used in them.

In order to increase the number of claims that successfully pass through front-end editing and into processing Cahaba GBA EDI Services is providing you with the top ten 277CA edits. For the month of **April 2012**, these are:

| Edit Number | Number of Edit Occurrences | Business Edit Message | Explanation of Edit |
|---|---|---|---|
| X222.087.2010AA.NM109.050 | 6,867 | This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider. | 2010AA.NM109 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109. |
| X222.196.2300.REF.010 | 2,935 | This Claim is rejected for Invalid Information within the Payer Assigned Claim Control Number Information submitted inconsistent with billing guidelines. | 2300.REF with REF01 = "F8" must not be present. |
| X222.121.2010BA.NM109.020 | 2,632 | This Claim is rejected for Invalid Information for a Subscriber's | 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNNA |

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|---|---|---|---|
| | | contract/member number. | or NNNNNNNNNAA or NNNNNNNNNAN where “A” represents an alpha character and “N” represents a numeric digit. |
| X222.094.2010AA.REF02.050 | 2,365 | This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID. | 2010AA.REF must be associated with the provider identified in 2010AA.NM109. |
| X222.351.2400.SV101-7.020 | 2,117 | This Claim is rejected for relational field Information within the Detailed description of service. | 2400.SV101-7 must be present. when 2400.SV101-2 is present on the table of procedure codes that require a description. |
| X222.351.2400.SV101-2.020 | 1,822 | This Claim is rejected for relational field Information within the HCPCS. | When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472". |
| X222.295.2320.SBR03.006 | 1,804 | This Claim is rejected for relational field Information submitted inconsistent with billing guidelines for the Other Insured's Policy Number. | Beneficiary’s group number in SBR03 is identical to beneficiary’s policy number in the accompanying NM109. |
| X222.087.2010AA.NM109.030 | 1,711 | This Claim is rejected for Invalid Information in | 2010AA.NM109 must be a valid NPI on the Crosswalk when |

| | | | |
|---|---|---|---|
| | | the Billing Provider's NPI (National Provider ID). | evaluated with 1000B.NM109. |
| X222.351.2400.SV102.060 | 1,598 | This Claim is rejected for Invalid Information within the Line Item Charge Amount and Service Line Paid Amount Claim is out of balance. | SV102 must = the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts. |
| X222.157.2300.CLM05-3.020 | 1,115 | This Claim is rejected for Invalid Information within the Claim Frequency Code. | 2300.CLM05-3 must be "1". |

# Georgia Medicare Part B
## Top Ten EDI 277CA Edits for April 2012 for Version 5010

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In order to increase the number of claims that successfully pass through front-end editing and into processing Cahaba GBA EDI Services is providing you with the top ten 277CA edits. For the month of **April 2012**, these are:

| Edit Number | Number of Edit Occurrences | Business Edit Message | Explanation of Edit |
|---|---|---|---|
| X222.087.2010AA.NM109.050 | 19,210 | This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider. | 2010AA.NM109 billing provider must be "associated" to the submitter (from a trading partner management perspective) in 1000A.NM109. |
| X222.121.2010BA.NM109.020 | 4,651 | This Claim is rejected for Invalid Information for a Subscriber's contract/member number | 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit. |
| X222.094.2010AA.REF02.050 | 3,833 | This Claim is rejected for relational field Billing Provider's | 2010AA.REF must be associated with the provider identified in |

| | | | |
|---|---|---|---|
| | | NPI (National Provider ID) and Tax ID. | 2010AA.NM109. |
| X222.351.2400.SV101-7.020 | 2,328 | This Claim is rejected for relational field Information within the Detailed description of service. | 2400.SV101-7 must be present. when 2400.SV101-2 is present on the table of procedure codes that require a description. |
| X222.087.2010AA.NM109.030 | 2,187 | This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID) | 2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. |
| X222.116.2000B.SBR09.010 | 2,120 | This Claim is rejected for Invalid Information in the Payer's claim filing indicator; Length invalid for receiver's application system | 2000B.SBR09 must be "MB". |
| X222.351.2400.SV101-2.020 | 2,095 | This Claim is rejected for relational field Information within the HCPCS. | When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472". |
| X222.262.2310B.NM109.030 | 1,706 | This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI). | 2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. |
| X222.257.2310A.NM108.020 | 1,641 | This Claim is rejected for Missing Information for the Identifier Qualifier within the Referring Provider's National Provider Identifier (NPI) | 2310A.NM108 must be present. |
| X222.273.2310C.N403.020 | 1,377 | This Claim is | 2310C.N403 must |

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|---|---|---|---|
| | | rejected for Invalid Information for a Service Location's Postal/Zip | be a valid 9 digit Zip Code. |

# Mississippi Medicare Part B
## Top Ten EDI 277CA Edits for April 2012 for Version 5010

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In order to increase the number of claims that successfully pass through front-end editing and into processing Cahaba GBA EDI Services is providing you with the top ten 277CA edits. For the month of **April 2012**, these are:

| Edit Number | Number of Edit Occurrences | Disposition/Error Code | Explanation of Edit |
|---|---|---|---|
| X222.087.2010AA.NM109.050 | 3,175 | This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider. | CSCC A8: "Acknowledgement / Rejected for relational field in error"<br>CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity."<br>EIC: 85 "Billing Provider" |
| X222.121.2010BA.NM109.020 | 1,361 | This Claim is rejected for Invalid Information for a Subscriber's contract/member number | 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNA or NNNNNNNNAA or NNNNNNNNAN where "A" represents an alpha character and "N" represents a |

| | | | |
|---|---|---|---|
| | | | numeric digit. |
| X222.351.2400.SV101-7.020 | 1,066 | This Claim is rejected for relational field Information within the Detailed description of service | 2400.SV101-7 must be present. when 2400.SV101-2 is present on the table of procedure codes that require a description. |
| X222.116.2000B.SBR09.010 | 1,017 | This Claim is rejected for Invalid Information in the Payer's claim filing indicator; Length invalid for receiver's application system | 2000B.SBR09 must be "MB". |
| X222.092.2010AA.N403.020 | 923 | This Claim is rejected for Invalid Information in the Billing Provider's Postal/Zip Code | 2010AA.N403 must be a valid 9 digit Zip Code. |
| X222.094.2010AA.REF02.050 | 844 | This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID. | 2010AA.REF must be associated with the provider identified in 2010AA.NM109 |
| X222.351.2400.SV101-2.020 | 779 | This Claim is rejected for relational field Information within the HCPCS | When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472". |
| X222.262.2310B.NM109.030 | 629 | This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI). | 2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. |
| X222.196.2300.REF.010 | 618 | This Claim is rejected for Invalid Information within the Payer Assigned Claim Control Number Information submitted inconsistent | 2300.REF with REF01 = "F8" must not be present. |

| | | | |
|---|---|---|---|
| | | with billing guidelines. | |
| X222.226.2300.HI01-2.030 | 507 | This Claim is rejected for Invalid Information within the Primary diagnosis code | If 2400.SV107-1, SV107-2, SV107-3, or SV107-4 is "1" and 2300.HI01-1 is "BK" then 2300.HI01-2 must be a valid ICD-9-CM Diagnosis code on the date in 2400.DTP03 when DTP01 = "472", based on the ICD-9-CM Diagnosis Code list. |

# Tennessee Medicare Part B
## Top Ten EDI 277CA Edits for April 2012 for Version 5010

For claim submissions in the 5010 format that pass high-level edits a 277CA transaction is created. This transaction will indicate file, batch, claim, and line level edits.

For spreadsheets that list the 277CA edits and give more detailed information about them please visit the CMS website at http://www.cms.gov/MFFS5010D0/20_TechnicalDocumentation.asp. Visit the Washington Publishing Company's website at http://www.wpc-edi.com for more information about 277CA transactions and the codes used in them.

In order to increase the number of claims that successfully pass through front-end editing and into processing Cahaba GBA EDI Services is providing you with the top ten 277CA edits. For the month of **April 2012**, these are:

| Edit Number | Number of Edit Occurrences | Business Edit Message | Explanation of Edit |
|---|---|---|---|
| X222.087.2010AA.NM109.050 | 7,946 | This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider. | CSCC A8: "Acknowledgement / Rejected for relational field in error"<br>CSC 496 "Submitter not approved for electronic claim submissions on behalf of this entity."<br>EIC: 85 "Billing Provider" |
| X222.094.2010AA.REF02.050 | 4,694 | This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID. | 2010AA.REF must be associated with the provider identified in 2010AA.NM109. |
| X222.121.2010BA.NM109.020 | 3,764 | This Claim is rejected for Invalid Information for a Subscriber's contract/member number. | 2010BA.NM109 must be 10 - 11 positions in the format of NNNNNNNNNA or NNNNNNNNNA |

| | | | |
|---|---|---|---|
| | | | A or NNNNNNNNNA N where “A” represents an alpha character and “N” represents a numeric digit. |
| X222.351.2400.SV101-7.020 | 3,087 | This Claim is rejected for relational field Information within the Detailed description of service. | 2400.SV101-7 must be present. when 2400.SV101-2 is present on the table of procedure codes that require a description. |
| X222.087.2010AA.NM109.030 | 2,321 | This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID). | 2010AA.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. |
| X222.351.2400.SV101-2.020 | 1,862 | This Claim is rejected for relational field Information within the HCPCS. | When 2400.SV101-1 = "HC", 2400.SV101-2 must be a valid HCPCS Code on the date in 2400.DTP03 when DTP01 = "472". |
| X222.196.2300.REF.010 | 1,530 | This Claim is rejected for Invalid Information within the Payer Assigned Claim Control Number Information submitted inconsistent with billing guidelines. | 2300.REF with REF01 = "F8" must not be present. |
| X222.262.2310B.NM109.030 | 1,165 | This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI). | 2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109. |

| | | | |
|---|---|---|---|
| X222.275.2310C.REF.010 | 1,043 | This Claim is rejected for Invalid Information submitted inconsistent with billing guidelines for the Service Location's Additional/Secondary Identifier. | 2310C.REF must not be present. |
| X222.157.2300.CLM05-3.020 | 986 | This Claim is rejected for Invalid Information within the Claim Frequency Code | 2300.CLM05-3 must be "1". |

# LCD- Finalized Draft Local Coverage Determinations (LCDs)

- **J10 MAC B (Alabama, Georgia, Tennessee)**

**Notice Period: June 15, 2012 through July 31, 2012**
**Effective Date: August 1, 2012**

The Notice Period for the Draft Local Coverage Determinations (LCDs) listed below will begin June 15, 2012. Following a forty-five day Notice Period, these finalized Draft LCDs will become effective August 1, 2012.

**Medicine: Noninvasive Peripheral Arterial and Venous Studies (DL30040)**

- The Cahaba GBA Part B LCD was revised and adopted for Part B after being presented for Comment. The LCD provides coverage guidance for noninvasive peripheral arterial and venous evaluations, and evaluation of dialysis access.

**Transportation Services: Ambulance (DL30022)**

- The Cahaba GBA Part B LCD was revised and adopted for Part B after being presented for Comment. As part of this process, this revision reflects coverage for ambulance providers and suppliers. The LCD provides coverage guidance for emergency and non emergency ground ambulance services, and emergency air ambulance transportation.

A 'Comment and Response' document is located at the end of each LCD under the *Related Documents* field.

When the Notice Period begins, the finalized Draft LCDs can be accessed from the Local Coverage Determinations (LCDs) and Articles page of our website (select 'Status of Draft LCDs' for your state).

A printed version of the LCDs is available upon request by contacting the Provider Contact Center.

# LCD- Draft Local Coverage Determination (LCD) Open Meetings- 2012

- **J10 MAC B (Alabama, Georgia, Tennessee)**

The Cahaba GBA Draft Local Coverage Determination (LCD) Open Meetings for the remainder of 2012 for J10 MAC are tentatively scheduled for:

- July 17, 2012
- November 6, 2012

The Meetings begin at 10:00 AM (CT) and are held at Cahaba GBA in Birmingham, Alabama. Attendees may participate onsite or telephonically.

The Draft LCD Open Meeting is held to allow the submission of scientific evidence and other information from providers and members of the general public relating to draft LCDs.

Detailed information, including instructions for registration, will be posted on *What's New* approximately four weeks prior to the Meeting date.

# LCD- Draft Local Coverage Determination (LCD) Open Meeting

- **Carrier 00512 (Mississippi)**

The next Cahaba GBA Draft LCD Open Meeting for Mississippi is scheduled for **July 17, 2012**. Due to the transition of Mississippi Part B to the JH MAC this fall, future meetings will be determined by Novitas Solutions, Inc. (Novitas).

Mississippi Part B providers are welcome to attend; however, no draft LCDs applicable to Mississippi will be presented.

Detailed information, including instructions for registration, will be posted on *What's New* approximately four weeks prior to the Meeting date.

Please check the Novitas website at https://www.novitas-solutions.com/transition/jh/index.html for future meetings and additional information.

# LCD- Radiology: Magnetic Resonance Imaging of the Spine- Retired

**J10 MAC B (Alabama, Georgia, Tennessee)**

**Effective May 31, 2012,** the Local Coverage Determination (LCD) for **Radiology: Magnetic Resonance Imaging of the Spine (L30052)** is retired.

**Carrier 00512 (Mississippi)**

**Effective May 31, 2012**, the Local Coverage Determination (LCD) for **Radiology: Magnetic Resonance Imaging of the Spine (L30633)** is retired.

# Major Improvements to Medicare Online Enrollment System

Over the last year, CMS has listened to your feedback about the Medicare online enrollment system (PECOS) and made improvements to:

- Incorporate search capabilities on the My Enrollments page
- Increase access to information, and
- Allow electronic signature of the Certification Statement and Electronic Funds Transfer Agreement.

The following upgrades are now available:

**Overall Usability**
Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments Page. Users will be able to filter the enrollments shown on the My Enrollments Page based on: Medicare ID, National Provider Identifier (NPI), or by selecting an Enrollment Type, Enrollment Status, or State. Additional data has been added to the enrollment data on the My Enrollments Page, i.e. Enrollment Type, Medicare ID, and Practice Location.

**Access to More Information**
Users will also be able to see if a request for revalidation has been sent by the Medicare Administrative Contractor (MAC). A "Revalidation Notice Sent" date will be displayed on the My Enrollments page. This will reflect the date in which the Revalidation Letter was mailed by the MAC to the provider/supplier. The date will be displayed on the My Enrollments page for 120 days.

In addition, users will be able to identify those enrollments that are accredited for Advanced Diagnostic Imaging (ADI) Services. An ADI Services indicator will be visible on the My Enrollments page as either a "Yes" or "No".

**Electronic Submission and Signature of Electronic Funds Transfer (EFT) Agreement**
Users can now complete and submit EFT Agreements electronically with the option to e-sign the document. If the provider/supplier submits the EFT agreement electronically and chooses not to e-sign, they shall include a hardcopy form of the completed and signed EFT agreement with its supporting documentation to the contractor. Providers/suppliers are still required to physically mail confirmation of account information on bank letterhead, or a voided check whether the EFT is submitted electronically or via the paper version. Along with the documentation, it is also important that the provider/supplier print and mail the enrollment submission confirmation page containing the web tracking ID. This will ensure that the supporting documents mailed to your MAC get associated with your electronic application submission.

**Did you know?**
All FFS providers, including Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs) can take advantage of Internet-Based PECOS to check and update Medicare enrollment information.

To access internet-based PECOS, go to the PECOS website.

## Updated Part B 855 Enrollment Form Guide

Our Provider Enrollment department has updated the 855 Enrollment Form Guide on the Cahaba GBA website. Part B providers and suppliers will find this tool helpful when deciding which application is appropriate as they credential new and established members into the Medicare program. As a bonus feature to the guide, you have the capability to download the most current CMS 855 application(s). The tool is located on the Enrollment page at https://www.cahabagba.com/part_b/enroll_update_your_records/apply_formguide.htm.

## Signing Your Medicare Enrollment Application Electronically

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers to sign Medicare enrollment applications electronically. You can save time and expedite review of your application by utilizing the electronic signature process. *This feature does not change who is required to sign the application.*

Authorized officials of the Organization will receive an email providing the steps they need to take to electronically sign the enrollment application. This email will be automatically sent when the enrollment application is submitted. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list and check your spam or junk mail folders to ensure you receive the electronic signature email notifications.

An example of the beginning of the email to the authorized official is shown below:

> From: customerservice-donotreply@cms.hhs.gov
> Subject: Pending Medicare E-Signature Request (Tracking ID: XXXXXX0047)
> An application on behalf of Lexa Hospital was recently submitted by:
> Submitters Name: Lexa Smith
> Submitters Phone: 5555555555
> Submitters Email: lexa.smith@lexahospital.com

For more information about signing your Medicare enrollment electronically, see "Sign Your Medicare Enrollment Application Electronically" in the March 29 edition of the e-News.

# New Interactive Medicare Part B Financial Forms

There are two primary ways of recouping money: voluntary refunds and solicited refunds. Voluntary refunds come from providers who return overpayments without any notices from Medicare. Solicited refunds are refunds requested from providers by Medicare via Overpayment Demand Letters.

**Providers are currently able to request voluntary offsets by fax**, mail, or by contacting the Provider Contact Center (PCC). Beginning July 1, 2012, providers will be able to request offsets to the Overpayment Demand Letter by mail or fax, published in *CR7688- Immediate Recoupment for Fee for Service Claims Overpayments.*

Requesting an offset or overpayment notification just became easier with Cahaba's new Medicare Part B interactive **Overpayment Refund/Notification Form** and the **Overpayment Offset Form**. You just key the information onto the form, then print, sign, and fax.

The new interactive forms can be found on our website:

Overpayment Refund/Notification Direct Link:
https://www.cahabagba.com/part_b/forms/overpayment_refund.pdf

Overpayment Offset Form Direct Link:
https://www.cahabagba.com/part_b/forms/offset_request_form.pdf

The forms include the options of direct faxing or mailing in your offset request. The fax and mailing information is included on the form.

No matter which option you choose to use please be sure to include:

1. The overpayment refund form – SIGNED
2. A copy of the first page of the demand letter
3. A copy of the claim detail page located in the demand letter

This information is vital to the processing of the immediate offset request.

# Claim Specific CERT Errors- April 2012

- **J10 MAC B (Alabama, Georgia, Tennessee)**
- **Carrier 00512 (Mississippi)**

The Comprehensive Error Rate Testing (CERT) Program was implemented by the Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claims processing by Medicare contractors, like Cahaba. Contractors are then notified by CERT of the errors and findings.

We would like to remind you that should you receive an Additional Documentation Request (ADR) such as a request for records to support services that are involved in a CERT review, you should submit the appropriate documentation to support the services billed, including but not limited to progress note(s) to match the DOS billed, lab results, operative reports, diagnostic tests, physician orders, etc. Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

Providers may appeal unfavorable decisions with additional supporting documentation. For detailed information regarding the Appeals Process, refer to the following link: www.cahabagba.com/part_b/claims/appeals_process.htm.

Please contact the Provider Contact Center for individual questions concerning CERT errors:

- Alabama, Georgia and Tennessee Providers – 1-877-567-7271
- Mississippi Providers – 1-866-419-9454

This summary provides examples of Cahaba's errors identified by CERT. We encourage all providers to review this listing to educate you on common errors. This information will be updated periodically. The intent in providing this information is to prompt you to conduct an internal analysis of Medicare billing and reduce future denials by Medicare.

# Cahaba GBA's Website Enhancement- Coming Soon!

Cahaba Government Benefit Administrators®, LLC's website will soon have a new look! The enhancement is scheduled to be launched in late June, 2012 and will present information in a more comprehensive, logical, and easy to navigate manner.

Please note that the content information is not changing, just the layout and design of the site. You will continue to access the website at www.cahabagba.com.

Our Provider Outreach and Education Department will provide educational webinars to assist providers in navigating information on the new website. Look for the most current news concerning our new website in upcoming issues of the monthly *Medicare B Newsline* and via the Cahaba GBA e-mail notification service. If you are not currently enrolled, we encourage you to subscribe to Cahaba GBA, LLC e-mail listserv. To subscribe, go to https://www.cahabagba.com/forms/subscribeForm.htm.

# Extension of Enforcement Discretion Period for Updated *HIPAA 5010* Transaction Standards through June 30, 2012

The Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) is announcing that it **WILL NOT INITIATE** enforcement action for an additional **THREE (3) months, through June 30, 2012,** against any covered entity that is required to comply with the updated transactions standards adopted under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions.

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

## HHS Announces Intent to Delay ICD-10 Compliance Date

As part of President Obama's commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius announced that HHS will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013 – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

"ICD-10 codes are important to many positive improvements in our health care system," said HHS Secretary Kathleen Sebelius. "We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system."

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

## MLN Matters® Electronic Mailing List

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf and start receiving updates immediately!

## Medicare Secondary Payer Billing

Medicare is denying an increasing number of claims, because providers are not identifying the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the "Medicare Secondary Payer (MSP) Manual," Chapter 3, and MLN Matters® Article SE1217 for additional guidance.

## Highmark Medicare Services Changed Its Name to Novitas Solutions, Inc

Effective January 1, 2012, Diversified Service Options, Inc., a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida Inc., acquired Highmark Medicare Services from its parent company, Highmark Inc. As a result, Highmark Medicare Services changed its name to Novitas Solutions, Inc. Novitas will continue to be the Medicare Administrative Contractor (MAC) for the J12 jurisdiction and will also continue as the Section 1011 Administrative Contractor. In the near future, the Highmark website will be changing to http://www.Novitas-Solutions.com on the Internet.

## The Medicare Billing Certificate Programs for Part A and Part B Providers

Now Available!! **The Medicare Billing Certificate Programs for Part A and Part B Providers**. Learn about the Medicare Program and the specifics for your provider type with a special focus on Medicare billing, and receive a certificate in Medicare billing from CMS for successful completion of the program. Successful completion consists of completion of all required web-based training courses, required readings, and a 75-percent or higher score on the post-assessment. To participate in either the Part A or Part B provider type program, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.htm and click on 'Web-Based Training Modules' under 'Related Links Inside CMS.'

## Enrolling In the Medicare Program Fact Sheets (PECOS)

Several fact sheets that provide education to specific provider types on how to enroll in the Medicare Program and maintain their enrollment information using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) have been recently updated and are available in downloadable format from the Medicare Learning Network® (MLN). Please visit http://www.CMS.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf for a complete list of all MLN products related to Medicare provider-supplier enrollment.

## Primary Care Incentive Payment (PCIP) program

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

## Electronic Funds Transfer (EFT)

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article SE1126 titled, "Further Details on the Revalidation of Provider Enrollment Information" at http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf.

# Implementation of the Award for the Jurisdiction H Part A and Part B Medicare Administrative Contractor (JH A/B MAC) Including New Workload Numbers for Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas as well as for the J4 WPS Legacy Part A Workload

## I. GENERAL INFORMATION

A. Background:

The purpose of this Change Request (CR) is to notify all interested parties that the Centers for Medicare and Medicaid Services (CMS) shall change the contractor workload numbers for the Part A and Part B Arkansas (AR), Colorado (CO), Louisiana (LA), Mississippi (MS), New Mexico (NM), Oklahoma (OK), and Texas (TX) workloads as well as the J4 WPS Legacy Part A workload when those workloads are transitioned to the JH A/B MAC. These changes are being made because CMS needs to identify each workload by state using a standardized numbering system and change the existing MAC workload number in those cases where workload is moving to a new entity. These workloads shall be transitioned to the JH A/B MAC as indicated below.

| PART A | JH MAC Number | Effective Date | Current Workload Number |
|---|---|---|---|
| Arkansas | 07101 | 08/20/2012 | 00020 |
| Louisiana | 07201 | 08/20/2012 | 00233 |
| Mississippi | 07301 | 08/20/2012 | 00233 |
| Colorado | 04111 | 10/29/2012 | 04101 |
| New Mexico | 04211 | 10/29/2012 | 04201 |
| Oklahoma | 04311 | 10/29/2012 | 04301 |
| Texas | 04411 | 10/29/2012 | 04401 |
| J4 WPS Legacy | 04911 | 10/29/2012 | 04901 |

| PART B | MAC Number | Effective Date | Current Contractor Number |
|---|---|---|---|
| Arkansas | 07102 | 08/11/2012 | 00520 |
| Louisiana | 07202 | 08/11/2012 | 00528 |
| **Mississippi** | **07302** | **10/20/2012** | **00512** |
| Colorado | 04112 | 11/17/2012 | 04102 |
| New Mexico | 04212 | 11/17/2012 | 04202 |
| Oklahoma | 04312 | 11/17/2012 | 04302 |
| Texas | 04412 | 11/17/2012 | 04402 |

These effective dates occur on either a Monday (for the Part A workloads) or a Saturday (for the Part B workloads). The Saturday date for the Part B workloads was established to enable the JH A/B MAC to run one or more clean out cycles if necessary. However, the first post transition full production cycle for all of these workloads will be run no earlier than the Monday following the cutover weekend.

Some shared systems, such as HIGLAS, utilize the Friday prior to the effective date to refer to the transition effective date.

The Part A AR, LA and MS workloads are currently processed in a single Customer Information Control System (CICS) region utilizing FISS rollup number 00234. The Part A CO, NM and TX workloads are currently processed in a single CICS region utilizing FISS rollup number 04001.

The following applications or entities will need to accommodate the new MAC workload numbers for both testing and production:

- CMS Analysis, Reporting and Tracking System (CMS ARTS)
- Contractor Administrative-Budget and Cost Reporting System (CAFM),
- Comprehensive Error Rate Testing System (CERT),
- Contractor Management Information System (CMIS),
- CMS Baltimore Data Center,
- Coordination of Benefits Agreement Program (COBA),
- Contractor Reporting of Operational Workload Data System (CROWD),
- Common Working File (CWF),
- CWF ELGE
- Customer Service Assessment and Management System (CSAMS)
- Debt Collection System (DCS),
- Expert Claims Processing System (ECPS),
- Electronic Correspondence Referral System (ECRS),
- Electronic Health Records Incentive Program (EHR),
- Enterprise Data Centers (EDCs);
- Fiscal Intermediary Shared System (FISS),
- Health Care Information System (HCIS),
- Healthcare Integrated General Ledger Accounting System (HIGLAS),
- Health Insurance Master Record (HIMR),
- Intern and Resident Information System (IRIS),
- Limited On-Line Access System (LOLA),
- Medicare Coverage Database (MCD),
- Medicare Secondary Payer Recovery Contractor (MSPRC),
- Multi-Carrier System (MCS)
- National Level Repository (NLR),
- National Part B Pricing Files,
- National Provider Identifier (NPI) crosswalk,
- Next Generation Desktop System (NGD),
- Quality Improvement Evaluation System (QIES, formerly known as OSCAR),
- Part B Analytics Reporting System (PBAR - formerly known as BESS),
- Physician/Supplier Overpayment Report (PSOR),
- Production Performance Monitoring System (PULSE),

- Provider Enrollment, Chain and Ownership System (PECOS),
- Provider Customer Service Program Contractor Information Database (PCID),
- Provider Inquiry Evaluation System (PIES),
- Program Integrity Management Reporting System (PIMR),
- Program Safeguard Contractor (PSC) or Zoned Program Integrity Contractors (ZPICs),
- Provider Overpayment Reporting System (PORS),
- Provider Statistical and Reimbursement System (PS&R),
- Recovery Auditors (RA – formerly known as the RACs),
- Recovery Management and Accounting System (REMAS),
- Renal Management Information System (REMIS),
- System Tracking for Audit and Reimbursement (STAR), and
- Zip Code File.

The JH workload was awarded to Novitas Solutions Inc. Its address is:

Novitas Solutions, Inc.
P. O. Box 890413
Camp Hill, PA 17089

The Part A Arkansas, Louisiana, and Mississippi and the Part B Arkansas and Louisiana workloads are currently processed by Pinnacle Business Solutions Incorporated. Its address is:

Pinnacle Business Solutions Inc.
515 West Pershing Boulevard
North Little Rock, AR.72114

The Part B Mississippi workload is currently processed by Cahaba Government Benefit Administrators. Its address is:

Cahaba GBA
500 Corporate Parkway
Birmingham, AL 35242

The Part A and Part B Colorado, New Mexico, Oklahoma, and Texas workloads as well as the MAC Jurisdiction 4 Part A WPS Legacy workload are currently processed by TrailBlazer Health Enterprises, LLC. Its address is:

TrailBlazer Health Enterprises, LLC.
Executive Center III
8330 LBJ Freeway
Dallas, TX 75243

***Change Request (CR) 7812***

# Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch

## Provider Types Affected

This MLN Matters® Article is intended all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries.

## Provider Action Needed

If Medicare systems reject a claim when the beneficiary name does not match the Health Insurance Claim Number (HICN), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use Reason Code 140 (Patient/Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

**All providers should ensure that their billing staffs are aware of these changes.**

## Additional Information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2449CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

***MLN Matters® MM7260***

# New Physician Specialty Code for Sleep Medicine and Sports Medicine

## Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, and suppliers who bill Medicare Carriers, Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment (DME) MACs for sleep medicine service and/or sports medicine services provided to Medicare beneficiaries.

## Provider Action Needed

Effective April 2, 2012, you will need to use physician specialty code (C0) for sleep medicine services. In addition, claims submitted to DME MACs for sports medicine service should use the sleep medicine specialty code of 23.

You should make sure that your billing staffs are aware of this new specialty code for sleep medicine services.

## Background

Medicare physician and non-physician practitioner specialty codes describe the specific or unique types of medical services that physicians and non-physician practitioners provide. While physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by physicians or non-physician practitioners. Medicare contractors also use specialty code data to develop claims processing edits.

## New Specialty Code

Change Request (CR) 7600 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Sleep Medicine. This new physician specialty code, which will be effective April 2, 2012, is C0. PECOS and your carrier or A/B MAC will recognize and use this new code as a valid primary and/or secondary specialty code for Sleep Medicine. Also, a new specialty code is established for sports medicine and that code is 23.

## Additional Information

You can find more information about the new sleep medicine specialty code by going to CR7600, located at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2462CP.pdf on the CMS website. A related transmittal that updates the "Medicare Financial Management Manual" is at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R209FM.pdf on the CMS website.

***MLN Matters® MM7600***

# Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012

## Provider Types Affected

This MLN Matters® article is intended for physicians, other suppliers and providers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

## Provider Action Needed

This article is based on Change Request (CR) 7785, which extends the therapy cap exceptions process through December 31, 2012, adds therapy services provided in outpatient hospital settings other than Critical Access Hospitals (CAHs) to the therapy cap effective October 1, 2012, requires the National Provider Identifier (NPI) of the physician certifying therapy plan of care on the claim, and addresses new thresholds for mandatory medical review.

## What You Need To Know

The therapy cap amounts for 2012 are $1880.00 for occupational therapy services, and $1880.00 for the combined services for physical therapy and speech-language pathology. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy caps on claims that are over these amounts. The use of the KX modifier indicates that the services are reasonable and necessary, and there is documentation of medical necessity in the patient's medical record. For services provided on or after October 1, 2012 and before January 1, 2013, there will be two new therapy services thresholds of $3700.00 per year: one annual threshold each for 1) Occupational Therapy (OT) services, and 2) Physical Therapy (PT) services and Speech-Language Pathology (SLP) services combined. Per-beneficiary services above these thresholds will require mandatory medical review.

See the 'Background' and 'Additional Information' sections of this article for further details regarding these changes

## Background

The Balanced Budget Act of 1997 (see http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf on the Internet) enacted financial limitations on outpatient PT, OT, and SLP services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act (see http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf on the Internet), and have been extended by legislation several times.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf on the Internet) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

The therapy cap amounts for 2012 are:

- $1880.00 for OT services, and
- $1880.00 for the combined services for PT and SL P.

Change Request (CR) 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:

1. The services are reasonable and necessary, and
2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals.

In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

- The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the National Provider Identifier (NPI) of the physician (or Non-Physician Practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.
- The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:
    - One for OT services, and
    - One for PT and SLP services combined.

    Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

Claims with the KX modifier requesting exceptions for services above either threshold are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1, 2012. Absent Congressional action, manual medical review expires when the exceptions process expires on December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Although Medicare suppliers and providers are not required to issue an Advance Beneficiary Notice (ABN) for these benefit category denials, they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.

## Key Billing Points

Remember the caps will apply to outpatient hospitals as detected via:

- Types of Bill (TOB) 12X (excluding CAHs with CMS Certification Numbers (CCNs) in the range of 1300-1399) or 13X;
- A revenue code of 042X, 043X, or 044X;
- Modifier GN, GO, or GP; and
- Date of service on or after October 1, 2012.

Other important points are as follows:

- The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.
- Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the Attending Physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.
- In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the Referring Physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.
- On professional claims, providers are to report the physician/NPP certifying the therapy plan of care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.
- For claims processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the "Medicare Benefit Policy Manual" (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf) for reporting the referring provider on a claim.
- On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 Technical Report 3 (TR3).
- For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the "Medicare Claims Processing Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the Centers for Medicare & Medicaid services (CMS) website.

Claims without at least one referring provider, including his/her NPI, will be returned as unprocessable with the following codes:

- Claim Adjustment Reason Code 165 (Referral absent or exceeded).

- Remittance Advice Remark Code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

## Additional Information

The official instruction, CR7785, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2457CP.pdf on the CMS website.

***MLN Matters® MM7785***

# Contractor and Common Working File (CWF) Additional Instructions Related to Change Request (CR) 7633 - Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

## Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Fiscal Intermediaries (FI), carriers and A/B Medicare Administrative Contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

## What You Need to Know

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

## Background

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

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

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

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442

(Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12 month period. It requires contractors to deny such claims with the following specific messages:

- Claim Adjustment Reason Code (CARC) B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- Remittance Advice Remark Code (RARC) M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

- Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed Advanced Beneficiary Notice (ABN) is on file.

- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

Also, remember that Medicare will only pay for up to four G0443 services within a 12 month period. Claims for G0443 that exceed that four session limit in a 12 month period will be rejected.

## Additional Information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2454CP.pdf on the CMS website.

The MLN Matters® Article MM7663, entitled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.pdf on the CMS website.

# Claim Status Category and Claim Status Codes Update - Revised

## Provider Types Affected

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

## What You Need to Know

This article is based on Change Request (CR) 7793 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ on the Internet. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012.

## Background

HIPAA requires all health care benefit payers to use Claim Status Category Codes and Claim Status Codes to report the status of submitted claim(s). Only codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ or http://www.wpc-edi.com/codes on the Internet. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by July 2, 2012.

## Additional Information

The official instruction, CR7793, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2436CP.pdf on the CMS website.

***MLN Matters® MM7793***

# New Influenza Virus Vaccine Code

## Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC) and Regional Home Health Intermediaries (RHHI) for providing influenza virus vaccines to Medicare beneficiaries.

## Provider Action Needed

Effective for claims with dates of service on or after July 1, 2012, Medicare will pay for influenza virus vaccine code Q2034. CR 7794, from which this article is taken, provides instructions for the payment of influenza virus vaccine code Q2034 for claims with dates of service on or after July 1, 2012, processed on or after October 1, 2012. Annual Part B deductible and coinsurance amounts do not apply. You should make sure that your billing staffs are aware of this new code for influenza virus vaccine.

## Background

Effective July 1, 2012, your Medicare carrier, FI, A/B MAC, or RHHI will begin accepting influenza virus vaccine code Q2034 (for dates of service on or after that date); and will add it to existing influenza virus vaccine CWF edits. For professional claims, for dates of service of July 1, 2012 through September 30, 2012, your contractor will use local pricing guidelines to determine payment rates for Q2034. After September 30, 2012, professional claims will be paid using the Medicare Part B payment limit for Q2034 according to the established payment rate in the October 2012 Part B drug pricing file.

### Processing Institutional Claims

Your contractor will pay for influenza virus vaccine code Q2034 **based on reasonable cost** to:

- Hospitals using type of bill (TOB) 12X and 13X;
- Skilled nursing facilities (SNF) using TOB 22X and 23X:
- Home health agencies (HHA) using TOB 34X;
- Hospital-based Renal Dialysis Facilities (RDF) using TOB 72X; and
- Critical access hospitals (CAH) using TOB 85X.

Your contractor will pay for influenza virus vaccine code Q2034 **based on the lower of the actual charge or 95% of the Average Wholesale Price (AWP)** to:

- Indian Health Service (IHS) hospitals using TOB 12X and 13X; and to:
- IHS CAHs using TOB 85X.
- Comprehensive Outpatient Rehabilitation Facilities (CORF) using TOB 75X; and
- Independent RDFs using TOB 72X.

Until systems are implemented, your contractor will hold institutional claims, containing code Q2034, with dates of service on or after July 1, 2012; and that are received before October 1, 2012. Upon implementation of CR7794 on October 1, contractors will begin to process the held claims.

## Additional Information

You can find more information about the new code for influenza virus vaccine (Q2034) by going to CR 7794, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2446CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

***MLN Matters® MM7794***

# General Update to Chapter 15 of the Program Integrity Manual (PIM) Part V

## Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers that submit claims to Medicare Carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs) and Home Health & Hospice Medicare Administrative Contractors (HHH MACs) for services provided to Medicare beneficiaries.

## What You Need to Know

This article is based on Change Request (CR) 7797, which implements changes to Chapter 15 of the Program Integrity Manual (PIM)—Medicare Enrollment. CR7797 focuses on the reasons for returning CMS-855 applications in Section 15.8.1 and the policies for rejecting CMS-855 applications in Section 15.8.2 of the PIM. Please make sure your staff is familiar with these changes.

## Key Points

Providers and suppliers who bill Medicare Carriers, FIs, A/B MACs and HHH MACs should take note of the following:

- Your Medicare contractor may return a Form CMS-855 submission only in the following instances:
    - The applicant sent its paper Form CMS-855 to the wrong contractor;
    - The contractor received the application more than 60 days prior to the effective date listed on the application (though this does not apply to: (a) providers and suppliers submitting a Form CMS-855A application, (b) Ambulatory Surgical Centers (ASCs), or (c) Portable X-ray Suppliers (PXRSs);
    - The contractor received an initial application from (a) a provider or supplier submitting a Form CMS-855A application, (b) an ASC, or (c) a PXRS, more than 180 days prior to the effective date listed on the application;
    - An old owner or new owner in a Change of Ownership (CHOW) submitted its application more than 90 days prior to the anticipated date of the sale (though this only applies to Form CMS-855A applications);
    - The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application;
    - The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar; and/or
    - The application is not needed for the transaction in question.

Providers and suppliers who bill Medicare Carriers and A/B MACs take note of the following:

- If, under Section 15.8.2 of Chapter 15, a physician, non-physician practitioner, or physician or non-physician practitioner group fails to provide requested information regarding its Form CMS-855

submission within the designated timeframe, the contractor will reject (rather than deny) the application.

## Additional Information

The official instruction, CR7797, issued to your Medicare Carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R415PI.pdf on the CMS website. Attached to CR7997 is the revised PIM Chapter, which further details the reasons for return/rejection.

***MLN Matters® MM7797***

# Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2012 Update

## Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for services provided to Medicare beneficiaries.

## Provider Action Needed

CR7831 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2012. You should make sure that your billing staffs are aware of these HCPCS code changes.

## Background

The HCPCS code set is updated on a quarterly basis. CR7831 describes the Centers for Medicare & Medicaid Services (CMS) process for updating specific HCPCS codes.

## Key Points of CR7831

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will no longer be payable for Medicare:

| HCPCS Code | Short Description | Long Description | MPFSDB* Status Indicator |
|---|---|---|---|
| J1680 | Human fibrinogen conc inj | INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 100 MG | I |
| J9001 | Doxorubicin hcl liposome inj | INJECTION, DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG | I |

* Medicare Physician Fee Schedule Data Base (MPFSDB)

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will be payable for Medicare:

| HCPCS Code | Short Description | Long Description | Type of Service (TOS) Code | MPFSDB Status Indicator |
|---|---|---|---|---|
| Q2034 | Agriflu vaccine | INFLUENZA VIRUS VACCINE, SPLIT VIRUS, FOR INTRAMUSCULAR USE (AGRIFLU) | V | X |
| Q2045 | Human fibrinogen conc inj | INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 1 MG | 1,9 | E |
| Q2046 | Aflibercept injection | INJECTION, AFLIBERCEPT, 1 MG | 1,9 | E |
| Q2047 | Peginesatide injection | INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS) | L | E |
| Q2048 | Doxil injection | INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, DOXIL, 10 MG | 1,9 | E |
| Q2049 | Imported Lipodox inj | INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, IMPORTED LIPODOX, 10 MG | 1,9 | E |

## Additional Information

The official instruction, CR 7831, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2450CP.pdf on the CMS website.

***MLN Matters® MM7831***

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