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CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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The e-News for Tue Feb 28 includes...

NATIONAL PROVIDER CALLS

- Wed Feb 29 – [Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Last Chance to Register](#)
- Thu Mar 1 – [Medicare Shared Savings Program and Advance Payment Model Application Process – Last Chance to Register](#)
- Mon Mar 12 – [Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Save the Date](#)

OTHER CALLS, MEETINGS, AND EVENTS

- Wed May 2 – [Inpatient Rehabilitation Facility Patient Assessment Instrument Train-the-Trainer Conference – Register Thu Mar 1 through Fri Mar 16](#)

ANNOUNCEMENTS AND REMINDERS

- [One Day Until the Covered Document Review Date for DMEPOS Competitive Bidding Round 2 and National Mail-Order Competition](#)
- [HHS Secretary Sebelius Announces Next Stage for Providers Adopting EHRs](#)
- [Were You Sent a Request to Revalidate Your Medicare Enrollment?](#)
- [Save Time – Submit Your Medicare Enrollment Application through Internet-Based PECOS, Now with e-Signature](#)
- [ICD-10: It's Closer Than It Seems – WEDI's Survey on ICD-10 Industry Progress Now Open](#)
- [It's Not Too Late to Give and Get the Flu Vaccine](#)

CLAIMS, PRICER, AND CODE UPDATES

- [HIPAA 5010 Claims Translation Issues Affecting Medicare Crossover Claims – Error Codes H51108, H20203, and H45255](#)
- [Claims Rejecting Due to Unnecessary Billing of Discharge Date](#)
- [Important Information for Institutional Providers Regarding the Billing of Hospital Outpatient and Inpatient Ancillary Services](#)
- [January 2012 Quarterly Inpatient Provider-Specific File Updated](#)
- [Reprocessing Advanced Diagnostic Imaging Claims Denied in Error](#)

UPDATES FROM THE MEDICARE LEARNING NETWORK®

- [“Mass Immunizers and Roster Billing” Fact Sheet Available in Hardcopy](#)
- [February 2012 Version of Medicare Learning Network Products Catalog Now Available](#)
- [“Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders” MLN Matters Article Released](#)
- [“The Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors” MLN Matters Article Revised](#)

Special National Provider Call Series: Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Last Chance to Register [\[↑\]](#)

Wed Feb 29; 2:30-4pm ET

Section 3007 of the *Affordable Care Act* requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the Medicare Physician Fee Schedule starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

This National Provider Call is in support of the efforts of CMS to implement the Medicare Physician Feedback and Physician Value-Based Payment Modifier Programs. This call is one of a series of calls CMS will hold to engage the public in dialogue about physician level value-based purchasing and obtain stakeholder input on how best to implement the physician value modifier.

This National Provider Call will include presentations from a panel of three private sector experts who have had experiences in implementing physician-level pay-for-performance programs. The second call in the series, scheduled for Wed Mar 14, will feature three additional private sector experts.

Target Audience: Medicare Fee-for-Service physicians, specialty medical societies, and other interested parties.

Agenda:

- Opening Comments and Background – Sheila Roman, MD, MPH; CMS
 - Background on the Value-Based Payment Modifier
 - Introduction of Speakers
- Using Physician Pay-for-Performance to Improve Care – R. Adams Dudley, MD, MBA; University of California, San Francisco
- Quality Measurement: Physician & Practice Performance – Ted von Glahn, MPH; Pacific Business Group on Health
- Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field – Francois de Brantes, MS, MBA; Health Care Incentives Improvement Institute
- CMS Questions and Comment
- General Question and Answer Session
- Closing – Sheila Roman, MD, MPH; CMS

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.* For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process – Last Chance to Register [[↑](#)]

Thu Mar 1; 1:30-3pm ET

On Thu Oct 20, 2011, CMS issued a final rule under the *Affordable Care Act* to establish the Medicare Shared Savings Program, along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients.

On Thu Mar 1, CMS is hosting a National Provider Call, during which subject matter experts will provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes. A question and answer session will follow the presentations.

The Medicare [Shared Savings Program Application](#) and [Advance Payment Model](#) webpages have important information, dates, and materials on the application process. Call participants are encouraged to review the applications and materials prior to the call.

Target Audience: Medicare Fee-For-Service (FFS) providers

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.* For more details, including instructions on registering for the call, please visit <http://www.eventsvc.com/blhtechnologies>.

National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Save the Date [[↑](#)]

Mon Mar 12; 12:30-2pm ET

More than \$3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made since the program began last year; more than 191,000 eligible professionals, eligible hospitals, and critical access hospitals are actively registered. On Thu Feb 23, CMS announced a proposed rule for Stage 2 requirements and other changes to the program, which will be published on Wed Mar 7.

This National Provider Call will provide an overview of the proposed rule, so you can learn what you need to know to receive EHR incentive payments. (CMS plans to hold another National Provider Call on program basics for Eligible Professionals on Tue Mar 27; more information about this call will be available soon.)

The CMS proposed rule can be found at http://www.OFR.gov/OFRUpload/OFRData/2012-04443_PI.pdf. For more information on the EHR Incentive Programs, visit <http://www.CMS.gov/EHRIncentivePrograms>.

Target Audience: Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicare EHR Incentive Programs. For more details:

- [Eligibility Requirements for Professionals](#)
- [Eligibility Requirements for Hospitals](#)

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs (note that we cannot answer questions on the rule beyond what is proposed)

Registration Information: Registration for this call will be available soon at <http://www.eventsvc.com/blhtechnologies>.

Presentation: The presentation for this call will be posted at least one day before the call at <http://www.CMS.gov/NPC/Calls>.

- Additional material related to the EHR Incentive Programs in today's e-News... [\[next\]](#)

Inpatient Rehabilitation Facility Patient Assessment Instrument Train-the-Trainer Conference – Register Thu Mar 1 through Fri Mar 16 [\[↑\]](#)

Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201)

To support the implementation of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS will host an IRF Patient Assessment Instrument (PAI) Train-the-Trainer Conference on Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all Inpatient Rehabilitation Facility providers, associations, and organizations that support quality care in inpatient rehabilitation facilities. The goals of the conference are to:

- Introduce the Quality Indicator item set that has been added to the IRF-PAI
- Discuss assessment procedures and coding for the 2 quality measures:
 - Catheter Associated Urinary Tract Infections (CAUTI), and
 - Pressure Ulcers
- Discuss data submission specifications, including presentations by the Centers for Disease Control and Prevention on the CAUTI, and the use of the National Health Safety Network for submitting data associated with this measure

Registration for the conference will begin Thu Mar 1 and end Fri Mar 16. Hotel reservations will not be accepted until registration has closed, at which time reservations may be made by phone or online; each participant will be limited to one room reservation.

Additional information is available at the conference website at www.NationalConference.info, and questions can be submitted to conference2@totalsolutions-inc.com.

One Day Until the Covered Document Review Date for DMEPOS Competitive Bidding Round 2 and National Mail-Order Competition [\[↑\]](#)

Reminder: If you are a supplier bidding in Round 2 and/or the national mail-order competition of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, you must submit your hardcopy financial documents on or before Wed Feb 29, 2012, in order to be eligible to be notified if you have any missing financial documents. *Don't wait – send the required hardcopy documents TODAY!*

The covered document review process gives bidders the opportunity to be notified of missing required financial documents. The Centers for Medicare &

Medicaid Services (CMS) urges all bidders to take advantage of this process. Under the covered document review process, we will notify suppliers that submit their hardcopy financial documents by the Covered Document Review Date (CDRD) of any missing financial documents. *The CDRD for the Round 2 and national mail-order competitions is Wed Feb 29, 2012 – financial documents must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Wed Feb 29, 2012, to qualify for the covered document review process.*

The covered document review process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit only the indicated missing financial document(s) within 10 business days of the notification. *Only those suppliers that submit financial documents by the CDRD will receive notice from CMS of any missing financial documents.* Bidders that submit their hardcopy financial documents after the CDRD will not be notified of any missing financial documents. After the bid window closes, bidders may only submit the requested financial documents identified as part of the CDRD process and cannot submit corrections to any other required documents. We encourage bidders to review the [Covered Document Review Date](#) factsheet available on the CBIC website.

Here are some important things to remember when submitting your hardcopy documents:

- Review the Request for Bids (RFB) instructions carefully to be sure that your documents comply with all requirements. The RFB instructions contain complete instructions for compiling and submitting your documents.
- Put your bidder number on every page of every document. We need your bidder number to match your hardcopy documents with your electronic bid. You will get your bidder number when you complete the Business Organization Information screen in Form A in DBidS, the online bidding system.
- Submit all required hardcopy documents in one package.
- The Round 2 and national mail-order competitive bidding areas (CBAs), product categories, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the [CBIC website](#). Suppliers should review this information prior to submitting their bid(s). CMS will send important information via email during the bidding and contracting periods, so it is very important that you keep the email address registered in IACS current. To update an email address, go to the registration page on the CBIC website.

If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9am and 9pm Eastern Time during the bidding period.

HHS Secretary Sebelius Announces Next Stage for Providers Adopting EHRs [\[↑\]](#)

On Fri Feb 24, Health and Human Services Secretary Kathleen Sebelius announced the next steps for providers who are using electronic health record (EHR) technology and receiving incentive payments from Medicare and Medicaid. These proposed rules, from CMS and the Office of the National Coordinator for Health Information Technology (ONC), will govern stage 2 of the Medicare and Medicaid EHR Incentive Programs.

Under the *Health Information Technology for Economic and Clinical Health (HITECH) Act*, part of the *American Recovery and Reinvestment Act of 2009*, eligible

healthcare professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it in a meaningful way. What is considered “meaningful use” is evolving in three stages:

- *Stage 1 (which began in 2011 and remains the starting point for all providers):* “meaningful use” consists of transferring data to EHRs and being able to share information, including electronic copies and visit summaries for patients.
- *Stage 2 (to be implemented in 2014 under the proposed rule):* “meaningful use” includes new standards such as online access for patients to their health information, and electronic health information exchange between providers.
- *Stage 3 (expected to be implemented in 2016):* “meaningful use” includes demonstrating that the quality of healthcare has been improved.

The CMS proposed rule specifies the stage 2 criteria that eligible providers must meet in order to qualify for Medicare and/or Medicaid EHR incentive payments. It also specifies Medicare payment adjustments that, beginning in 2015, providers will face if they fail to demonstrate meaningful use of certified EHR technology and fail to meet other program participation requirements. Under the proposed rule, stage 1 has been extended an additional year, allowing providers to attest to stage 2 in 2014, instead of in 2013.

ONC’s rule proposes capabilities and related standards and implementation specifications that certified EHR technology (CEHRT) will need to include to support the achievement of “meaningful use” by eligible healthcare providers for the EHR reporting periods beginning in fiscal year / calendar year (FY/CY) 2014 and beyond. The rule proposes a redefinition of CEHRT and a revised certification processes to reduce burden and add flexibility, and requests public input to improve safety, data portability, and transparency.

The ONC and CMS proposed rules are available at <http://www.OFR.gov/inspection.aspx>. The comment period for both proposed rules will close on Mon May 7, 2012. Additional information on the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.CMS.gov/EHRIncentivePrograms>.

The full text of this excerpted HHS press release (issued Fri Feb 24), as well as links to relevant media factsheets, can be found at <http://www.HHS.gov/news/press/2012pres/02/20120224a.html>.

- Additional material related to the EHR Incentive Programs in today’s e-News... [\[previous\]](#)

Were You Sent a Request to Revalidate Your Medicare Enrollment? [\[↑\]](#)

Lists of providers sent notices to revalidate their Medicare enrollment may be found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp and in the links below. Information on revalidation letters sent in February will be posted in late March.

- [Revalidations Mailed September through October 2011](#)
- [Revalidations Mailed November through December 2011](#)

- [Revalidations Mailed January 2012](#)

CMS is working to make this information available in Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) in mid April.

- Additional material related to Provider Enrollment in today's e-News... [\[next\]](#)

Save Time – Submit Your Medicare Enrollment Application through Internet-Based PECOS, Now with e-Signature [\[↑\]](#)

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers and suppliers to *sign Medicare enrollment applications electronically*. Save time and expedite review of your application by using internet-based PECOS. (This feature does not change who is required to sign the application.)

In internet-based PECOS, all *Individual Provider applications* that do not include new reassignments may e-sign the application as part of the submission process. This applies to Physicians and Non-Physician Practitioners, including those enrolling just to order and refer.

Any *Organizational Provider applications* that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized official/delegated official (AO/DO) of the application as part of the submission process. The AO/DO can then follow the instructions in the email and electronically sign the application. This applies to Institutional Providers; Clinics, Group Practices, and Certain Other Suppliers; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the AO/DO for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to their appropriate contractor).

Learn more about PECOS at <https://PECOS.CMS.hhs.gov>, and be on the look-out for more enhancements in the coming months! Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSupport@cgi.com.

- Additional material related to Provider Enrollment in today's e-News... [\[previous\]](#)

ICD-10: It's Closer Than It Seems – WEDI's Survey on ICD-10 Industry Progress Now Open [[↑](#)]

The Workgroup for Electronic Data Interchange (WEDI) is conducting its latest [Industry Progress Survey](#) on ICD-10. Information from this survey will be used to inform WEDI, CMS, and other organizations on the progress of ICD-10 implementation, as well as assist in planning necessary programs and actions to assist the industry in transitioning to ICD-10.

To gather the most complete picture of progress within the industry, this survey is open to all organizations affected by ICD-10, such as vendors, health plans, providers, and payers. The survey is open to both WEDI members and non-members; WEDI asks that participants only submit one survey per organization.

The survey will close on *Wed Feb 29*. Please direct any questions to Ann Marie Railing at WEDI at 703-391-2718 or amrailing@wedi.org.

Keep Up to Date on Version 5010 and ICD-10. Visit [the ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today!

It's Not Too Late to Give and Get the Flu Vaccine [[↑](#)]

Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention also recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and <http://www.CMS.gov/immunizations>.

- Additional material related to Preventive Health Services in today's e-News... [[next](#)]

HIPAA 5010 Claims Translation Issues Affecting Medicare Crossover Claims – Error Codes H51108, H20203, and H45255 [[↑](#)]

Currently, after A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), fiscal intermediaries (FIs), and carriers have

finalized payment of incoming provider/physician/supplier claims, they transmit the adjudicated claims to the Coordination of Benefits Contractor (COBC) for Medicare claims crossover purposes. The COBC translates the claims into the required *HIPAA* ANSI 837 claim formats for claims crossover purposes, then subjects them to *HIPAA* compliance validation; normally, it is within this module that *HIPAA* compliance problems are identified.

When the COBC identifies *HIPAA* compliance problems, it notifies the A/B MAC, DME MAC, FI, or carrier that its processed claims could not be crossed over. This entity, in turn, mails the affected provider/physician/or supplier a special letter that indicates “The claim(s) could not be crossed over due to claim data errors...” and includes the specific error code (eg. H51000) with accompanying error description. The assumption is that once providers/physicians/suppliers receive these letters from Medicare, they will then take steps to bill their patients’ supplemental payer for the balances owed after Medicare.

In recent weeks, three issues have arisen that were caused by defects in the COBC compliance validation process:

- *H51108*: ‘237’ is not a valid ‘Line Level Adjustment Reason Code’
 - Issue: COBC was incorrectly rejecting claims that contained a claim adjustment reason code (CARC) 237. The rejection occurred because COBC’s vendor inadvertently did not have reason code 237 loaded to its CARC table.
 - Fix date: Mon Jan 16
- *H20203*: Element CLM16 is present though marked ‘Not Used’
 - Issue: COBC’s vendor’s translation routine was copying the value from 2300 CLM20 and incorrectly creating that value within 2300 CLM16 (‘Not Used’)
 - Projected fix date: Mon Feb 27
 - Steps taken: As of the week of Mon Feb 13, CMS asked its A/B MACs, DME MACs, FIs, and carriers to hold the letters they would normally generate that contain error code H20203. Effective Mon Feb 27, our Medicare contractors will be able to resend the affected claims to the COBC so that they may be successfully crossed over.
- *H45255*: The Other Subscriber Primary Identifier (2330A NM109) cannot be the same as the group or policy number (2320 SBR03)
 - Resolution: COBC scrubs the duplication that is present in 2320 SBR03
 - Project fix date: TBD, but hopefully not later than early April 2012
 - *NOTE: Currently, error H45255 is prohibiting the sending of Medicare crossover claims to North Dakota Medicaid in certain instances.*
 - Steps taken: CMS is requesting that Medicare contractors hold the letters that would normally be generated for error code H45255. Once a fix date is identified for this issue, CMS will notify the Medicare contractors to resend the affected claims to the COBC so that they may be successfully crossed over.

CMS sincerely regrets that the above error conditions have arisen. We are actively partnering with the COBC to address these problems as quickly as possible.

- Additional material related to 5010 claims in today’s e-News... [\[next\]](#)

Crossover Claims Rejecting Due to Unnecessary Billing of Discharge Date [\[↑\]](#)

According to the Technical Report Version 3 (TR-3) for 5010A1 837 claims, a discharge date is required for inpatient claims when the patient was discharged from the facility and the discharge date is known. A discharge date is *not* to be sent unless required. For Part B physicians/practitioners and suppliers, the key to this requirement is being able to determine if the services were ‘inpatient’ by making reference to the Place of Service (POS) code, available at http://www.CMS.gov/place-of-service-codes/20_Place_of_Service_Code_Set.asp. Only POS codes 21, 31, 51, and 61 contain either ‘inpatient’ or ‘inpatient services’ in their description.

Currently, Medicare *does not* maintain an edit for inbound 837 professional claims to check that 2300 DTP03 (Discharge Date) is only billed when POS 21, 31, 51, and 61 are billed. However, the Coordination of Benefits Contractor (COBC), which administers the Medicare claims crossover process on behalf of CMS, does have *HIPAA* 5010 editing that will activate when physician or practitioner billing offices include POS codes such as 11 (office), 22 (outpatient), 23 (emergency room), or 81 (independent lab) on Medicare Part B claims, as these POS codes are clearly not ‘inpatient’ by definition. Consequently, many physician/practitioner offices and DME suppliers are receiving provider notification letters from their servicing A/B MAC, DME MAC, or carrier that include an H40142 error code and the following description: “Discharge Date (DTP-01=096) was not expected because this claim is not for Inpatient Services.”

For physician and practitioner offices, including those that bill Medicare via hardcopy claims, the key to avoiding receipt of the above *HIPAA* compliance error, which prevents crossing over of the affected claims, is to *only* include a discharge date, when known, if you are billing a Part B claim for services with POS codes 21, 31, 51, or 61.

DME suppliers are instructed to include a discharge date on incoming claims when billing *HCPCS E0935 (continuous passive motion [CPM] device)*. For such claims, the POS is most often 12 (home). To ensure that your DME claims for a CPM device will properly cross over, DME suppliers should include discharge date reporting within the 2400 NTE (“notes segment”), not in 2300 DTP03 on incoming version 5010A1 837 professional claims, when billing their DME MAC electronically.

CMS continues to pursue opportunities to ensure that front-end and back-end Medicare *HIPAA* 5010 compliance editing becomes more closely aligned.

- Additional material related to 5010 claims in today’s e-News... [\[previous\]](#)

Important Information for Institutional Providers Regarding the Billing of Hospital Outpatient and Inpatient Ancillary Services [\[↑\]](#)

CMS has identified a Medicare claims processing issue that is causing certain hospital outpatient services rendered in an institutional setting to be processed incorrectly.

Medicare contractors have been instructed to not reject claims with Reason Codes 38038, 38074, 38151, 38033, and 38154 when the discharge date of the outpatient claim (13X) is the same as the admission date of the inpatient ancillary claim (12X). If your claims have rejected with the above reason codes in error, you can now begin resubmitting claims.

January 2012 Quarterly Inpatient Provider-Specific File Updated [[↑](#)]

The January 2012 quarterly Inpatient Provider-Specific File (PSF) SAS data has been corrected and is now available on the CMS website. The Inpatient SAS data file is available at http://www.CMS.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp, in the “Downloads” section of the page.

Reprocessing Advanced Diagnostic Imaging Claims Denied in Error [[↑](#)]

CMS has received reports that providers are receiving denials for advanced diagnostic imaging (ADI) services they are accredited to perform. We have taken action to correct the situation. CMS has instructed all contractors to review each ADI claim denial, and reprocess those claims that were deemed to be incorrectly denied in a timely manner. Providers do not need to take any action in this situation.

From the MLN: “Mass Immunizers and Roster Billing” Fact Sheet Available in Hardcopy [[↑](#)]

The “[Mass Immunizers and Roster Billing](#)” fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on mass immunizers and roster billing, and includes information on simplified billing procedures for the influenza and pneumococcal vaccinations. To place your order for any of Medicare Learning Network® products available in print, visit <http://www.CMS.gov/MLNProducts> and click on ‘MLN Product Ordering Page’ under ‘Related Links Inside CMS’ at the bottom of the webpage.

- Additional material related to Preventive Health Services in today’s e-News... [[previous](#)]

From the MLN: February 2012 Version of Medicare Learning Network Products Catalog Now Available [[↑](#)]

The February 2012 version of the MLN Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on “Formats Available.” The catalog can be found at <http://www.CMS.gov/MLNProducts/downloads/MLNCatalog.pdf>.

From the MLN: “Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders” MLN Matters Article Released [[↑](#)]

MLN Matters Special Edition Article #SE1210, “[Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders](#),” has been released and is available in downloadable format. This article is designed to provide education on Recovery Audit review findings related to renal and urinary tract disorders, and includes a description of the problems found and guidance on how providers can avoid them in the future.

From the MLN: “The Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors” MLN Matters Article Revised [[↑](#)]

MLN Matters Special Edition Article #SE1204, “[The Role of the Zone Program Integrity Contractors \(ZPICs\), Formerly the Program Safeguard Contractors \(PSCs\)](#),” has been revised is now available in downloadable format. This article is designed to provide education on the roles and responsibilities of Zone Program Integrity Contractors (ZPICs), and includes an overview of the various program integrity functions that ZPICs perform and each of their seven designated zones. The article was revised to change information cited in the table on page 2; all other information remains the same.

More Helpful Links...

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

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