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Healthcare Reform

Will Congress approve healthcare reform or won't it? If healthcare reform is approved, what will be in the reform package? These are perhaps the two most common questions we've been asked over the past 10 months. The reality is that no one knows for sure. In April, we were told that Congress could pass healthcare reform legislation by mid-summer and have it on the President's desk by the August Congressional recess. Later, we were told that definitely September. We could have healthcare reform on the President's desk by mid-September. Then it was Thanksgiving and now the goal is to have a bill on the President's desk by the State-of-the-Union address at the end of January. Even that deadline now appears to be in jeopardy.

It is hard to find anyone in Congress or outside of Congress who does not agree that our current healthcare system is broken and in need of reform. Unfortunately, that appears to be where consensus both begins and ends. The ideas for how to reform our nation's healthcare delivery system are almost as numerous as there are Members of Congress.

Despite the consensus that the system is in need of reform, getting a bill passed by the Congress has proven much more difficult than many had predicted. The issues have become more complicated and the American people appear more polarized on the issue than ever before.

A final Senate vote on healthcare reform was held Christmas Eve morning. The bill passed the Senate on a straight party-line vote 60 – 39 (one Republican was absent). Several Democrats who felt the reform legislation did not go far enough expressed their displeasure with the bill but in the end, voted for the bill. Similarly, some Democrats who felt the legislation went too far also expressed displeasure with the final package but they, too, voted for the bill.

There is one remaining hurdle to getting a healthcare reform bill to the President – resolving the differences between the House and Senate passed versions.

As we have seen over the past 10 months, talking about the need for reform is much easier than achieving consensus on healthcare reform. The challenges that slowed the reform effort in both the House and Senate will be even more evident as the House and Senate work to resolve their differences. As the Washington Post put it in a story published shortly after the Senate vote was completed, “Now that the Senate has passed landmark health-care legislation with a rare Christmas Eve vote, the hardest work of all will begin: reckoning with long-standing differences between the House and Senate versions of reform and uniting behind a single bill that can be sent to the president.”

Outlined below are some of those areas where there appears to be consensus, as well as the issues for which consensus has been elusive.

Insurance Market Reform

While there are many defenders of maintaining a private insurance market, there are few who will defend the practices of health insurance companies. For example, while most Americans want to be able to buy health insurance in the private market, the American people almost universally decry the practice of denying insurance coverage to people with a pre-existing condition. Similar numbers of respondents also believe that insurance companies should not be allowed to drop someone because of high medical expenses. Finally, most people believe there should be no upper limits on the amount of money an insurance company is obligated to pay in order to cover the health expenses of insured individuals.

Reflecting this consensus, every serious healthcare reform bill considered by Congress this year has included provisions to ban pre-existing condition clauses in insurance contracts, mandate guarantee issue of insurance and lift life-time limits in insurance policies. It is a virtual certainty that these issues will be addressed as part of any bill that goes to the President.

Reducing the Cost of Health Insurance

Most Americans believe that health insurance costs too much. Double digit increases in health insurance premiums in both the individual and employer sponsored insurance market have made health insurance unaffordable for many individuals and employers. As a result, increasing numbers of Americans are dropping insurance coverage or moving to high-deductible insurance policies which leave the individual/family financially exposed. Employers are limiting the amount of their contribution to the cost of insurance and shifting more and more costs to the employee either through greater cost-sharing on the premiums or higher co-pays or deductibles.

In response to this, Congress has been working on creating new insurance subsidies for “low-income” individuals to try to make insurance more affordable. In addition, subsidies for small businesses that must purchase insurance in the more expensive small group market have also been proposed. What constitutes a “low-income” individual and what is defined as a “small business” is still an open question but it appears likely that a healthcare reform proposal sent to the President for his signature will include subsidies for low-income individuals and small businesses.

It appears most likely that a low-income individual or family will be classified as individuals or families with incomes up to 400% of the federal poverty level. This would mean, for example, that a family of four with a household income of less than approximately \$88,000.00 per year would qualify for a health insurance subsidy.

The definition of a small business also varies and could be a business with anywhere from fewer than 10 employees to businesses with as many as 500 employees. Some proposals use the businesses payroll as a more appropriate marker rather than the number of employees. Regardless of how this is resolved, it appears likely that there will be some tax subsidy to help more small businesses provide health insurance for their employees.

Individual/Employer Mandates

This has become one of the more controversial issues in the healthcare reform debate. Again, it appears likely that any healthcare reform bill that makes its way to the President's desk will include some type of mandate – individual or employer or both. At this point, the most likely outcome would be some type of mandate for both individuals as well as employers. It should be noted that the mandate for insurance will likely not start until 2014.

It is important to understand that there must be some type of mandate included in the bill if Congress is going to outlaw pre-existing condition provisions from insurance policies. If Congress should fail to adopt some type of mandate yet enact a federal ban on pre-existing condition clauses from insurance policies, it could actually make the current situation even worse.

The original intent behind putting pre-existing condition clauses in health insurance contracts was to prevent people from “gaming” the system. If everyone knew that he/she could purchase low-cost insurance at any time, regardless of his or her health status, why would they buy insurance? Many would simply decide to forego health insurance and wait until they got sick before they purchased insurance.

So a mandate will be a part of the final healthcare reform package as long as the language banning pre-existing condition clauses remains in the legislation.

Administrative Simplification

One area where there has been strong bi-partisan consensus has been in the area of administrative simplification (AS). Although the HIPAA statute was enacted more than a decade ago, the provider community has yet to experience most of the administrative simplification benefits promised by HIPAA. Both the House and Senate healthcare reform bills will include a variety of provisions aimed at trying to achieve the savings and efficiencies promised by HIPAA.

Medicare

Changes in the Medicare program will be a part of any healthcare reform package that gets to the President's desk but unfortunately, the changes will not be the types of reforms that will bring smiles to the faces of many healthcare providers.

Cuts in future provider payments (hospitals, physicians, home health agencies, etc.) will be a part of any healthcare reform initiative presented to the President. Medicare expenditure cuts will likely total somewhere in the neighborhood of \$400 Billion over the next 10 years. In other words, as a result of enactment of the healthcare reform legislation, Medicare will spend \$400 Billion less than would have otherwise occurred, had the healthcare reform bill never been enacted.

The single largest share of reductions in Medicare spending over the next 10 years will come from future provider payments. Instead of providers receiving full market-basket increases reflecting changes in medical inflation, the amounts of these inflationary increases will be reduced. The future reductions in provider payments will likely be in the range of \$170 - \$190 Billion over 10 years.

The second largest share of Medicare payment reductions will come from the Medicare Advantage (MA) program. This will be in the form of lower payments to the private insurance companies that offer MA products. In all likelihood, the amount of the reduction in MA plan payments will be between \$120 and \$130 Billion over 10 years.

According to the Congressional Budget Office (CBO), tens of Billions in long-term savings to the Medicare program will also be the result of unspecified cuts that will be proposed by a new Medicare Commission. While the name of the Commission and the Commission's scope of authority still need to be worked out, this new Commission will have wide latitude to recommend payment changes for all types of Medicare providers. Unlike the current Medicare Payment Advisory Commission (MedPAC) whose recommendations are strictly advisory in nature, the new Commission would have far greater impact on future provider payments.

How to Cover the Uninsured

Although there is no clear consensus between the House and Senate on how to provide insurance coverage for Millions of uninsured Americans, the final bill will have some mechanism for covering the uninsured. This is likely where consensus will be most difficult to achieve and in the end, could prove to be what kills healthcare reform. If a compromise is reached, it is expected that by 2019, approximately 92 – 96% of all Americans will have some type of insurance coverage. This compares to the estimated 83% of Americans who would have insurance if we did nothing to change the current system. Of the estimated 54 Million people who would be uninsured in 2019 if we do nothing, 32 – 34 Million would have some type of insurance coverage. This would mean that in 2019, approximately 20 – 24 Million people would still be without health insurance.

The House healthcare reform proposal, the [Affordable Health Care for America Act](#), has a very robust “public option”. The Senate, by comparison, did not include a public option in its version of healthcare reform, the [Patient Protection and Affordable Care Act](#). Instead, the Senate relies

upon a system of vouchers or subsidies individuals could use to purchase health insurance (offering minimum benefit packages) through newly established healthcare exchanges. The House bill also calls for the establishment of state-based “Exchanges” but these Exchanges would offer a new public program to compete with commercial insurance products available through the Exchange. The government negotiated products contemplated in the Senate proposal would be overseen by the federal Office of Personnel Management, the same agency that oversees the Federal Employee Health Benefits program.

Both the House and the Senate include provisions in their respective bills expanding Medicaid eligibility. The House bill would extend Medicaid coverage to include any individual with an income below 150% of the federal poverty level. The Senate proposal also expands Medicaid to all low-income individuals but tops out at 133% of poverty. As with a number of other provisions, this Medicaid expansion will likely not go into effect until 2014. Both the House and Senate included language authorizing the federal government to pay the cost of covering these newly eligible individuals. However, how long the federal government will cover these costs and how much of the cost the federal government will cover will have to be negotiated between the House and Senate.

It is not clear whose position will prevail in the House-Senate negotiations. This will likely prove to be one of the more contentious issues.

Paying for Healthcare Reform

After the public option vs. no public option debate, the second most contentious issue for House-Senate negotiators will be how to pay for healthcare reform. Both the House and Senate raise significant amounts of new revenue (i.e. taxes) but through very different methods.

The House relies primarily upon a new excise tax that would be imposed on “high income” individuals. The new excise tax would raise approximately \$460 Billion in new federal revenue over the next 10 years. In addition, penalty payments by individuals and employers not adhering to the respective mandates would raise approximately \$165 Billion between 2014 and 2019 (the penalties would not take effect until 2014). Total new revenues raised by the House bill would be \$781 Billion over 10 years.

The Senate proposes to impose a new 40% federal excise tax on so-called “Cadillac” health plans. These would be plans for which the individual premiums exceeded \$8,500 per year for an individual policy or \$23,000 per year for a family policy. The “Cadillac” health plan excise tax is estimated to raise approximately \$149 Billion between 2013 and 2019. Additional revenue would be raised through the imposition of fees on certain manufacturers (medical device) and insurers. A new hospital tax would raise \$87 Billion and other revenue/fee increases would generate approximately \$76 Billion in new revenue to the federal treasury. In total, the Senate raises approximately \$498 Billion in new revenues compared to the \$798 Billion in the House bill.

In addition to the House bill relying much more heavily on new taxes to fund healthcare reform, there are major philosophical differences in where that money should come from that may prove difficult to bridge.

Abortion - The Great Unknown

There also remains a major dispute about how to deal with federal payments (or restrictions) on abortion.

It has been the long held policy that federal tax dollars should not be used to pay for abortions unless it was an abortion to protect the life of the mother. This issue comes up most commonly in the context of the Medicaid program and is often referred to as the “Hyde” amendment.

Because the federal government would, for the first time, be paying for or subsidizing payments for insurance products, opponents of abortion argued that there should be “Hyde-like” prohibitions on the use of federal tax dollars to purchase an insurance policy that might cover abortions. Supporters of abortion-rights argue that restrictions on abortion funding have never extended to private insurance policies and shouldn’t in this case either.

Given the close nature of the key votes in the House and Senate, and several Members indicating that their support or opposition to the 2,000+ page legislation hinges exclusively on how the abortion funding debate is resolved, it is conceivable that the ultimate success or failure of the healthcare reform initiative could hinge on the outcome of the abortion dispute.

Conclusion

While the prospects for getting a healthcare reform bill to the President have improved greatly over the past few weeks, the pathway is anything but clear. Major policy disputes loom on the horizon and it is not clear who will blink.

To date, the President has stayed largely on the sidelines and rarely offered an opinion on legislative specifics. Instead, the President has consistently pointed to the broad set of principles he outlined earlier this year. You may recall that those are:

1. Protect families’ financial health
2. Make health coverage affordable
3. Aim for universality
4. Provide portability of coverage
5. Guarantee choice
6. Invest in prevention and wellness
7. Improve patient safety and quality care
8. Maintain long-term fiscal sustainability

House and Senate Leaders will be able to point to each of their respective bills and argue that their bill best meets the goals outlined by the President. Ultimately, it will rest with the President to articulate which plan he prefers and which plan gets his blessing.

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Ms. Louie and Mr. Burleigh Go to Washington

Holly Louie, HBMA Board Member and Co-Chair of the HBMA ICD-10 Task Force and Bob Burleigh, Co-Chair of the ICD-10 Task Force, spent three fun-filled days in Washington DC recently talking about electronic transaction code set standards and the conversion from ICD-9 to ICD-10. In addition, Louie and Burleigh spent a day walking around Capitol Hill meeting with Congressional staff, Senate staff and a U.S. Senator to talk about these issues.

Holly and Bob were in Washington to represent HBMA at two very significant events.

On December 8th, Louie and Burleigh participated in an all-day “Listening Session” conducted by CMS to talk about the upcoming adoption of both the 5010 Transaction Code Set Standards and the subsequent conversion from the use of ICD-9 Codes to ICD-10 Codes. Participating with the Task Force Co-Chairs were representatives of the AMA, AHA, MGMA, the Blue Cross/Blue Shield Association, AHIP (the association of health insurance plans), AHIMA, AAPC and various staff from CMS. This listening session was an opportunity for informal discussion among the various entities involved in the creation, transmittal and payment of medical claims about the common problems, concerns and issues each segment of the health care delivery system was encountering as it prepared for both 5010 and ICD-10.



Holly Louie and Senator Jim Risch (R-ID)

On Wednesday, December 9th, Louie and Burleigh ventured to Capitol Hill to meet with 7 different Congressional offices to talk about both ICD-10 and 5010 as well as efforts to achieve the Administrative Simplification goals promised by HIPAA. Although neither Louie nor Burleigh appears ready to make Washington a full-time place of residence, their contributions to the policy making process almost guarantee a return visit.

Finally, on Thursday, December 10th, Holly testified before the National Committee on Vital and Health Statistics (NCVHS). NCVHS is the advisory committee charged with making recommendations to the Secretary of Health and Human Services on matters related to HIPAA transaction standards and enforcement. Similar to the “Listening Session” each witness was asked to testify about various issues surrounding both the 5010 implementation and the use of the ICD-10 codes.

HBMA was joined at the witness table by representatives from the AMA, AHA and AHIP. One of the more striking developments from the hearing was the near unanimous question each of the witnesses asked of the NCVHS Committee members: Why? Why are physicians, hospitals,

health plans and billing companies and others being asked to undertake such a massive change at a critical point in our nation's fiscal, economic and healthcare history?

As Louie noted in her testimony, *"...even in the best of times, the transition to 5010 and ICD-10 would be both a functional and economic challenge. Undertaking this transition at a time when the economy is in the worst shape in several decades, new federal incentives for EHR and mandates for "meaningful use" are pending, and the fact that Congress is considering major changes to our nation's healthcare delivery system could amount to the "perfect storm" in American healthcare."*

The NCVHS is expected to make several recommendations to the Secretary with regard to the transition to 5010 and ICD-10. If you would like to learn more about the testimony Holly presented to the NCVHS, look for her article in the January issue of **"Billing."**

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SGR Update

On Saturday December 19, the U.S. Senate approved the FY 2010 Appropriations bill for the Department of Defense. The House had approved this bill a few days earlier. Included in this legislation was language postponing for two months the 21% reduction in the Medicare fee schedule conversion factor, scheduled to take effect on January 1, 2010. While this is good news, it also means that Congress still must act to fix the SGR problem or physicians will be staring at the same major cut in Medicare payments in two months. HBMA continues to express its concern about the failure of Congress to permanently address the SGR problem and urge Congress to fix this – now.

While there is broad recognition within Congress that cuts in physician fee schedule payments of the magnitude called for under the SGR formula are unacceptable, little action has been taken to permanently fix the problem. Each year, for the past several years, Congress approves a temporary one-year fix that "solves" the problem for 12 months. However, because of the way Congress has "paid for" these temporary fixes, it simply shifts the cost to the next fiscal year resulting in an even bigger projected cut in SGR payments the next year.

As the cost of fixing the SGR problem escalates, the options for fixing the problem diminish. It is hoped that over the next two months, Congress will direct serious attention to permanently fixing the SGR problem. Unfortunately, with the healthcare reform issue still to be worked out, it is not clear how much time Congress will be able to devote to fixing the SGR problem.

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Consult Codes No Longer Available for Medicare

Effective January 1, 2010, Medicare will no longer recognize consult codes. Instead, Physicians are being told to use the appropriate E/M code when billing for services that historically were classified as consults.

Several organizations, including HBMA have questioned how this will work when Medicare is the secondary payer to a claim submitted to another insurer who does recognize consults. In response to a question on this point, CMS had this to say,

“We do not have the authority to determine which services will be recognized and paid by other third party payers. Some payers may choose to adopt this policy subsequent to this final rule. In cases where other payers do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment. In those cases where Medicare is the primary payer, physicians must submit claims with the appropriate visit code in order to receive payment from Medicare for these services. In these cases, physicians should consult with the secondary payers in order to determine how to bill those services in order to receive secondary payment. In those cases where Medicare is the secondary payer, physicians and billing personnel will first need to determine whether the primary payer continues to recognize the consultation codes. If the primary payer does continue to recognize those codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes.

Should CMS decide to change or modify its policy on consults, HBMA will notify the membership immediately. In the meantime, HBMA continues to express concern about this decision.

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Medicare Expands List of Covered Preventive Services

The Centers for Medicare & Medicaid Services (CMS) has announced its final decision to cover Human Immunodeficiency Virus (HIV) infection screening for Medicare beneficiaries who are at increased risk for the infection, including women who are pregnant and Medicare beneficiaries of any age who voluntarily request the service. The decision is effective immediately.

In 2008, CMS was given the flexibility of adding to Medicare's list of covered preventive services, if certain requirements are met. Historically, Medicare could only cover additional preventive screening tests when Congress authorized it to do so.

In announcing the decision, HHS Secretary Kathleen Sebelius said, "Today's decision marks an important milestone in the history of the Medicare program. Beginning with expanding coverage for HIV screening, we can now work proactively as a program to help keep Medicare beneficiaries healthy and take a more active role in evaluating the evidence for preventive services."

In order for CMS to expand the scope of preventive services covered by Medicare, the service in question must have been "strongly recommended" or "recommended" by the U.S. Preventive Services Task Force. For instance, the Task Force graded HIV screening as "strongly recommended" for certain groups.

CMS can now use its authority under the National Coverage Determination (NCD) process to make decisions of this type.

More information about Medicare's new HIV screening benefit is available in CMS' final decision memorandum. Read the final decision online at:

<http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=229>.

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Red Flag Rule Delay

The Federal Trade Commission (FTC) has delayed the compliance deadline of the Red Flag Rule until June 1, 2010. HBMA, the AMA and other physician organizations will take this delay as an opportunity to continue to lobby the FTC and Congress to rescind the current rule and issue a new rule that would exclude physician practices from the Red Flag Rules.

By way of background, in 2007 the Federal Trade Commission (FTC) issued a set of regulations, known as the "Red Flag Rules," that require certain entities to develop policies and procedures aimed at preventing identify theft. Entities required to develop and implement these standards were businesses that routinely extended credit to their customers. Because physicians do not routinely collect cash at the time of service delivery and instead, rely upon a third party to pay a claim, the agency concluded that medical practices "routinely extend credit" to their customers.

Since the Red Flag Rule was issued, HBMA, the AMA and other groups have objected to the FTC's interpretation that physician practices are "creditors" when they accept insurance and bill patients after services are provided. HBMA will continue to fight the FTC's misguided interpretation.

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Blog This

The National Coordinator for Health Information Technology has announced the creation of a Health IT Blog. The purpose of the Blog is to create a forum where individuals interested in Health IT can share information, discuss the latest technology and link to others who have a common interest in health IT.

In announcing the Blog, Health IT Coordinator David Blumenthal had this to say, "As we work to encourage the meaningful use of health information technology, we want to hear what you

have to say. That's why we started this Blog and it's why we have worked so hard to ensure our process for moving forward is open and transparent."

And speaking of "meaningful use" of Health IT, the Centers for Medicare and Medicaid is still expected to announce "soon" the proposed criteria for meaningful use of EHRs. This will be a proposed standard and the public is invited and encouraged to offer comments when the proposal is announced. HBMA will take the opportunity to comment on this when the proposed rule is released.

To sign up for the new Blog or to learn more about this initiative, go to:

<http://healthit.hhs.gov/blog/onc/>

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CMS Transmittals

The following transmittals were released by CMS within the past 60 days.

Transmittal	Subject	Effective Date
R614OTN	Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	N/A
R320PI	Consolidated and revised sections 6.2.1 and 12 into section 2 to ensure consistency and flow of information. Minor revisions were made to sections 1.3, 6.1.4, 7.1.2 and 11.8.	01/25/2010
R1886CP	Emergency Update to the 2010 Medicare Physician Fee Schedule Database	01/04/2010
R1885CP	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness	01/04/2010
R1883CP	Limitation on Home Health Prospective Payment System (HH PPS) Outlier Payments	01/25/2010
R612OTN	Jurisdiction 10 A/B MAC Merge of the Part B Alabama, Georgia, and Tennessee CICS Production and User Acceptance Test Regions	06/05/2010
R1882CP	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/04/2010
R1877CP	Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict	04/05/2010

R610OTN	Implementation of the HIPAA Version 5010 276/277 Claim Status Second Phase	N/A
R1879CP	Revisions in Timeliness Requirements for Forwarding Misfiled Appeal Requests	01/04/2010
R110NCD	Positron Emission Tomography (PET)(FDG) for Cervical Cancer	01/04/2010
R1879CP	Positron Emission Tomography (PET) (FDG) for Cervical Cancer	01/04/2010
R1878CP	Revisions in Timeliness Requirements for Forwarding Misfiled Appeal Requests	01/19/2010
R92MCM	Chapter 4, Benefits and Beneficiary Protections	12/18/2009
R1880CP	Pharmacogenomic Testing for Warfarin Response	04/05/2010
R111NCD	Pharmacogenomic Testing for Warfarin Response	04/05/2010
R1876CP	Coverage of Kidney Disease Patient Education Services	04/05/2010
R318PI	Implementation of Home Health Agency Program Safeguard Provisions	01/01/2010
R117BP	Coverage of Kidney Disease Patient Education Services	04/05/2010
R1875CP	Revisions to Consultation Services Payment Policy	01/04/2010
R1874CP	Claim Status Category Code and Claim Status Code Update	01/04/2010
R1873CP	Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests	N/A
R1870CP	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness	01/04/2010
R609OTN	Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 - MAC Jurisdiction 12 Only	03/01/2010
R116BP	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/04/2010
R1871CP	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/04/2010

R1869CP	New Place of Service (POS) Code for Walk-in Retail Health Clinic	03/11/2010
R1872CP	January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0	01/04/2010
R607OTN	Allow Zoned Program Integrity Contractors (ZPICs) to Access Medicare Administrative Contractors (MACs) by ZPIC Zone	N/A
R608OTN	Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Flat File Analysis and Design	04/05/2010
R606OTN	5010-D.0 Project Healthcare Claims Acknowledgement 277CA Generator Implementation (FISS and MCS ONLY)	04/05/2010
R1867CP	Requirements to Prevent the Misuse of Modifiers PA, PB, and PC on Incoming Claims	01/04/2010
R109NCD	Positron Emission Tomography (PET)(FDG) for Cervical Cancer	01/04/2010
R1866CP	Positron Emission Tomography (PET) (FDG) for Cervical Cancer	01/04/2010
R1864CP	Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year 2010	01/04/2010
R1865CP	January 2010 Update of the Ambulatory Surgical Center (ASC) Payment System	01/04/2010
R315PI	Provider Enrollment and Veterans Administration (VA) Hospitals	03/08/2010
R316PI	Administrative Appeals Process for Provider Enrollment	01/04/2010
R163FM	Add Physician Specialty Code 27 (Geriatric Psychiatry) to CROWD Form F (Participating Physicians/Supplier Report)	04/05/2010
R55SOMA	Revisions to Appendix PP-Interpretive Guidelines for Long-Term Care Facilities, Tag F441	09/30/2009
R54SOMA	Revisions to Appendix PP-Interpretive Guidelines for Long-Term Care Facilities, Tag F441	09/30/2009
R604OTN	Payment for Implantable Tissue Markers (HCPCS Code A4648)	02/26/2010
R1861CP	Ambulance Inflation Factor for CY 2010	01/04/2010

R1862CP	Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update	01/04/2010
R1863CP	Hospice Reporting Requirements for the Attending Physician and the Hospice Physician Certifying the Terminal Illness	01/04/2010
R605OTN	Implementation of the Updated Health Insurance Portability and Accountability Act (HIPAA) 005010 837 Institutional (837I) Edits and 005010 837 Professional (837P) Edits	04/05/2010
R601OTN	Creation of Receipt Date for Multi-Carrier System (MCS)	N/A
R603OTN	Remittance Advice (RA) Codes and Medicare Summary Notice (MSN) Messages Regarding Oxygen Equipment	12/28/2009
R314PI	Clarification of Deactivation Instructions	12/28/2009
R602OTN	HIPAA 5010 Activity - Medicare Administrative Contractor (MAC) Certification Test Package Development	09/29/2009
R1860CP	Therapy Cap Values for Calendar Year (CY) 2010	01/04/2010
R598OTN	Instructions on How Contractors Must Process Medicare Secondary Payer Claims When Negative Claim Adjustment Reason Code (CARC) Amounts are Received in the Claim Adjustment Segment (CAS) for Certain MSP Claims that are Suspended	12/21/2009
R1859CP	MIPPA Section 139 Teaching Anesthesiologists	01/04/2010
R1857CP	New Waived Tests	01/04/2010
R599OTN	Integrated Outpatient Code Editor (IOCE) PC (interactive and batch) Re-Write	04/05/2010
R1858CP	Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.0, Effective January 1, 2010	01/04/2010
R600OTN	Elimination of National Standard Format (NSF) Code from the VMS System	N/A
R312PI	Home Health Agency (HHA) Capitalization Requirements	12/21/2009
R313PI	Program Integrity Manual (PIM) Reorganization Chapters 1, 2, and 7	12/21/2009

R1850CP	2010 Annual Update to the Therapy Code List	01/04/2010
R1852CP	Claim Status Category Code and Claim Status Code Update	01/04/2010
R1853CP	CY 2010 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/04/2010
R115BP	Ambulance Services	01/04/2010
R61GI	Update to Medicare Deductible, Coinsurance and Premium Rates for 2010	01/04/2010
R1851CP	Therapy Cap Values for Calendar Year (CY) 2010	01/04/2010
R1854CP	January 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	01/04/2010
R1855CP	Instructions for Downloading the Medicare ZIP Code Files for April 2010	04/05/2010
R311PI	Recovery Audit Contractors (RACs)	12/14/2009
R593OTN	Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Round One Rebid Implementation--Phase 8B: Oxygen Modality	04/05/2010
R592OTN	Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Phase 8C of Implementation: Repairs and Replacements	04/05/2010
R590OTN	Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception	04/05/2010
R595OTN	Ensuring the Denial of Claims for Ambulance Services Rendered to Beneficiaries in Part A Skilled Nursing Facility Stays	04/05/2010
R1847CP	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2010	01/04/2010
R1845CP	Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases	01/04/2010
R596OTN	Phase 2 Base System Changes for Implementation of	N/A

	the Next Version of the Health Insurance Portability And Accountability Act (HIPAA) - Multi Carrier System (MCS) Only	
R441PR1	Medicare Swing-Bed-Rates, adds Table 21	N/A
R62DEMO	Payments to Practices Participating in the Electronic Health Records (EHR) Demonstration	04/05/2010
R591OTN	Incorporation of the National Provider Identifier (NPI) into the National Supplier Clearinghouse (NSC) Enrollment System and Related Instructions	04/05/2010
R1846CP	Implementation of Common Working File (CWF) Editing for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)	04/05/2010
R1844CP	Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process	01/05/2010
SE0928	Further Clarification of Instructions on Using 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims	N/A
R589OTN	Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008	01/04/2010
R113BP	Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2010	01/04/2010
R114BP	Outpatient Mental Health Treatment Limitation	01/04/2010
R60GI	Outpatient Mental Health Treatment Limitation	01/04/2010
R1843CP	Outpatient Mental Health Treatment Limitation	01/04/2010
R1842CP	Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the Form CMS-1500	04/05/2010
R586OTN	Validating the Billing of End Stage Renal Disease (ESRD) 50/50 Rule Modifier	04/05/2010
R308PI	Rural Air Ambulance	11/30/2009
R162FM	Recovery Audit Contractors (RACs)	12/15/2009

R59GI	The CMS Standard File for Reason Codes for the Fiscal Intermediary Shared System (FISS)	04/05/2010
R588OTN	Reflecting the Payment Ambulatory Payment Classification (APC) on the Remittance Advice (RA)	04/05/2010
R585OTN	The shared system maintainer shall not report services on the 1565C lines 5-7 when the Medicare allowed amount is greater than zero and the Medicare paid amount is zero	04/05/2010
R584OTN	Reporting Requirements for the Fiscal Intermediary Shared System (FISS) Medicare Fraud Edit Module	04/05/2010
R1840CP	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010
R1841CP	National Council for Prescription Drug Programs (NCPDP) Version D.0 Coordination of Benefits (COB) Requirements for the National Claims Crossover Process	04/05/2010
R72MSP	Claim Adjustment Reason Code (CARC) Update for Medicare Secondary Payer (MSP) Claims Processing	04/05/2010
R1839CP	Instructions regarding processing claims rejecting for gender/procedure conflict	04/05/2010
R1838CP	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure codes on Inpatient Hospital Claims	04/05/2010
R583OTN	Pilot to Transition a Segment of the WPS Legacy Workload (formerly processed by Mutual of Omaha) to the J1 A/B Medicare Administrative Contractor	04/05/2010
R582OTN	Update to the Common Working File (CWF) Edits to Recognize the "";RA""; and "";RB""; Modifiers for Durable Medical Equipment (DME) Repairs and Replacements	04/05/2010
R581OTN	For Analysis Only --Clarification on the Proper Billing of the Statement Covers From and Admission/Start of Care Dates on Institutional Claims	04/05/2010
R1837CP	2010 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder	01/04/2010
R1836CP	New Physician Specialty Code for Geriatric	04/05/2010

Psychiatry

[R1835CP](#)

Instructions for Downloading the Medicare ZIP Code
Files for January 2010

01/04/2010