

# Washington Report –January 2010

## An HBMA Government Relations Publication

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### **What Can Brown Do for You?**

In an election heard “round the world” Scott Brown (R-MA), a little known state Senator, captured the seat formerly held by Senator Ted Kennedy (D-MA) in a special election. Beyond the immediate symbolism of electing a Republican to a seat held by a Kennedy for more than 60 years; the election of Brown dramatically changed the voting dynamics of the United States Senate and sent a chill down the spines of those advocating for major changes in our nation’s healthcare system.

With the seating of Senator Brown, the political alignment in the U.S. Senate will be as follows:

Democrats – 57

Independents – 2

Republicans – 41

The two Independents – Lieberman of Connecticut and Sanders of Vermont – caucus with the Democrats.

Under the rules of the Senate, it takes 60 votes to end debate on most bills or amendments. Prior to Brown’s election, the Democrats enjoyed a “filibuster proof” majority. Ironically, while the White House and the popular media have often characterized the Healthcare Reform debate in the Senate as being stymied due to Republican filibusters, the fact is that until now, Republicans alone could not sustain a filibuster on any legislation. To the extent there was a filibuster and the Senate rejected an attempt to end a filibuster, it would take at least one Democrat to vote with the Republicans to sustain a filibuster.

Discerning the meaning of the Brown election will be the subject of months of debate. Was Brown just the beneficiary of a poorly run campaign by Massachusetts Attorney General Martha

Coakley (D-MA)? Or, were the people of Massachusetts collectively sending a message to the rest of the nation regarding one-party rule in Washington, DC? Was the election about healthcare reform or something else altogether?

Like most elections, there were a multitude of issues that ultimately led to the outcome. For some, it was healthcare for others, it was the quality of the candidate.

Opponents of healthcare reform point to the clear distinction between the two candidates regarding HCR – Brown opposed the plan before the Congress, Coakley supported it. Similarly, supporters of HCR note that as a state Senator, Brown voted for comprehensive healthcare reform and that because the voters of Massachusetts already have near “universal coverage” the Massachusetts election had little to do with healthcare reform.

We know that Scott Brown is the new Senator from Massachusetts and that is all we know. Whether his election has any effect on the ultimate success or failure of Healthcare Reform or whether his presence in the Senate changes the type of healthcare reform being considered remains to be seen.

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### **Is Healthcare Reform dead?**

In the immediate aftermath of the Brown election, many national commentators suggested that healthcare reform was dead. Even many leading proponents of HCR made dire predictions about the future of HCR in the wake of Brown’s election.

However to paraphrase Mark Twain, “rumors of the demise of Healthcare Reform are greatly exaggerated.”

In his State-of-the Union address to a joint session of Congress and the American people, President Obama urged Congress to continue to work for comprehensive healthcare reform. Although his comments about HCR were not extensive (about 5 minutes in a speech lasting 70 minutes), they were still an important part of the vision the President has put before the American people. Various public opinion polls continue to say that the American people support reforming our nation’s healthcare delivery system. What is not clear – and what is taking time to work out – is just what types of reforms it is the American people want.

President Obama continues to advocate for major reforms of our nation’s healthcare delivery system and many Congressional leaders have echoed that call. They maintain that Congressional and White House negotiators were very close to working out a deal on HCR before the Brown election and that with some minor tweaking, that deal should be concluded.

According to an article in the New York Times, President Obama said that after lawmakers work out the differences between the House and Senate reform bills (HR 3962, HR 3590), he wants to meet publicly with Democrats, Republicans and independent experts to consider the measures and clarify particular reform provisions for U.S. residents. Obama said lawmakers and the

independent experts would then hold a debate on the overhaul proposals before Congress decides whether to pass a reform bill.

Also according to the Times, President Obama said he wants to work through the proposals "in a methodical way, so that the American people can see and compare what makes most sense." The President and supporters of his healthcare reform plan believe that there has been misinformation about his plan and that if the American people only better understood what it was he was proposing, they would support his plan. The President, "pledged to refute false statements and misunderstandings about reform proposals."

However, more moderate Democratic members along with those Democrats in more politically marginal districts have been urging their leaders to "go slow". They are urging the President and Democratic Leaders in the House and the Senate to talk with Republicans before trying to finalize a plan. These Representatives and Senators believe it is still possible to produce a healthcare reform plan that is bi-partisan.

Many Democrats appear fearful that a misreading of the American electorate just 9 months before the next national election when all 435 House seats and 33 Senate seats are up for election, could lead to a major shift in the political fortunes of the Democratic party. Advocates for "going slow" believe that the American people have grown tired of the healthcare reform debate and the conflicting messages and there needs to be a "cooling off" period. These Members appear to believe, unlike the President, that the American people heard and read enough about the plan - they just didn't like what they heard or saw. It wasn't a matter of explaining it better, they suggest, but rather a need to perhaps go back to the drawing board.

Although there has been tremendous speculation on just what Congress and the President might do on healthcare, the fact is that no consensus has yet emerged. Some are suggesting that the Democrats use their majorities (albeit no longer filibuster proof) to push healthcare reform through Congress using the budget reconciliation process which, under the rules of the Senate, is not subject to a filibuster.

Recent announcements by several vulnerable Democrats suggest that even this strategy could be in jeopardy as several Senate Democrats have indicated they would not support this initiative. It is not clear that as many as 10 Democratic Senators would oppose using reconciliation but the fact that it wasn't used in the past suggests that at least initially, there may be trouble securing the 50 votes (the VP could break a tie) to use reconciliation as a vehicle.

Finally, President Obama has invited leaders from both Parties to participate in a Healthcare Reform Summit where Republican and Democratic leaders can meet and talk with the President and his advisors and share their ideas for reforming the healthcare system. While the immediate reaction to the summit idea was positive, some are questioning whether the President's new-found desire for bi-partisanship is "too little, too late." It was not clear whether this "summit" would occur before or after House and Senate Democratic leaders had achieved consensus on their HCR proposal.

Healthcare reform is not dead. It is on life-support but it is not dead. Strong bi-partisan majorities in Congress still believe our healthcare delivery system is broken and need of reform. If the consensus for reform can be sustained, then it is still possible for Congress to pass and the President to sign a healthcare reform proposal.

Unfortunately, the way things are going, it may that the only thing folks from both sides of the aisle can agree upon is that the current system is broken. It would be unfortunate if that is where consensus both begins and ends.

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### **SGR and Therapy Caps – Where Is Congress?**

In late December, Congress passed legislation that **temporarily** prevented a 21.2% cut in Medicare physician fee schedule payments on January 1. This is what has become known as the SGR (Sustainable Growth Rate) problem. Unfortunately for recipients of physical therapy or occupational therapy, Congress did not include an extension of the waiver of the therapy cap.

The SGR “fix” effectively extended the 2009 Medicare fee schedule for 2 additional months until March 1. Unless Congress intervenes the projected 21.2% SGR cut will take place on March 1.

Part of the problem in coming up with a solution to the SGR problem has been one of cost. It is now estimated that fixing the SGR problem could cost the Medicare program in excess of \$300 Billion in additional expenditures over the next 10 years. This is the amount necessary to fix the problem by instituting a 10 year freeze in payments. Given the pending insolvency of the Medicare program in just a few short years, adding this level of debt to the program would only hasten the day when the program went bankrupt.

While one would be hard-pressed to find anyone in Washington who believes the SGR cut will actually take place on March 1, it is also unclear what exactly will be done to replace this cut and whether this will be another short-term solution or whether Congress will opt for a more long-term answer.

Congress has taken steps to overcome one major hurdle in coming up with even a temporary fix – waiving the pay-go requirement for an SGR fix for up to five years.

Under the recently approved Debt Limit legislation, Congress voted to reinstate the “pay-as-you-go” (aka pay-go) rules mandating that any changes resulting in higher than projected expenditures had to be offset with either spending cuts elsewhere in the budget or new taxes to prevent the additional spending from adding to the deficit. In reinstating these “pay-go” rules, Congress exempted an SGR fix from those rules for up to 5 years allowing approximately \$80 Billion in spending for an SGR fix without subjecting that new spending to the pay-go rules.

Congress is expected to try to approve a longer term (although not a permanent fix) to the SGR problem to give physicians greater certainty on future spending for physician services under Medicare.

In addition, it is expected that Congress will also approve a reinstatement of the therapy cap waiver process. Under the waiver process, many patients can exceed the cap on Medicare expenditures for therapy services. This exception process expired on January 1 and unless Congress moves to reinstate the exception process, many Medicare beneficiaries will see new limits placed on their benefit.

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### **EHR Incentive Payments and Meaningful Use**

In early 2009, the Congress passed, and the President signed, an economic recovery bill that included incentive payments for the meaningful use of Electronic Health Records (EHRs) beginning in 2011. The goal of increased use of EHR is to increase the quality and efficiency of healthcare in this country. Proponents of greater use of HER also say that EHRs will make the system more efficient and be able to enhance the performance of healthcare providers.

Under the incentive payment program, eligible health care professionals (EPs) can receive up to \$44,000 in incentive payments from the Medicare program between 2011 and 2015 if they become “meaningful users” of a “certified” Electronic Health Record system. For Medicaid, EPs can receive incentive payments up to \$63,750 between 2011 and 2021 for the adoption, implementation or meaningful use of a certified EHR.

On January 13, the Centers for Medicare and Medicaid Services (CMS) published proposed rules outlining the criteria a provider must meet to demonstrate “meaningful use” of a certified EHR. On the same day, the Office of the National Coordinator (ONC) published an “interim-final” rule outlining the criteria an EHR system must meet in order to be certified. At some subsequent point, ONC will announce the organizations that will be recognized by the federal government for purposes of determining whether an EHR system meets the certification criteria.

The comment period for these proposals runs until March 15, 2010. HBMA is in the process of developing comments and will share those comments with the members once they have been finalized.

### **Meaningful Use**

The conceptual approach that the CMS employed in developing the Meaningful Use (MU) regulation was to create a framework for data capture and sharing which would advance clinical processes to improve patient outcomes. To achieve this goal, it divided the definition of MU into three stages: a basic definition that will go into effect in 2011 and then two subsequent stages which will start in 2013 and 2015 which will be defined by future proposed rules.

This article will address the State 1 criteria.

## Stage 1

The Stage 1 criterion focuses on:

- electronically capturing health information in a coded format, including lab results;
- using that information to track key clinical conditions and communicating that information for care coordination purposes to other providers and the patient;
- implement clinical decision support tools to facilitate disease and medication management consistent with Medicare and Medicaid rules;
- utilize e-Prescribing;
- report clinical quality measures and public health information.

In order to be eligible to receive the payments from CMS during Stage 1, the Eligible Provider (EP) must meet the following 25 Objectives and Measures.

- 1     **Objective:** Use computer physician order entry (CPOE)  
      **Measure:** CPOE is used for at least 80 percent of all orders
- 2     **Objective:** Implement drug-drug, drug-allergy, drug- formulary checks  
      **Measure:** The EP has enabled this functionality
- 3     **Objective:** Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®  
      **Measure:** At least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data
- 4     **Objective:** Generate and transmit permissible prescriptions electronically (eRx)  
      **Measure:** At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
- 5     **Objective:** Maintain active medication list  
      **Measure:** At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data
- 6     **Objective:** Maintain active medication allergy list  
      **Measure:** At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient has no medication allergies) recorded as structured data
- 7     **Objective:** Record demographics.  
      **Measure:** At least 80 percent of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
- 8     **Objective:** Record and chart changes in vital signs  
      **Measure:** For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20
- 9     **Objective:** Record smoking status for patients 13-years-old or older  
      **Measure:** At least 80 percent of all unique patients 13-years-old or older seen by the EP “smoking status” recorded
- 10    **Objective:** Incorporate clinical lab-test results into EHR as structured data  
      **Measure:** At least 50 percent of all clinical lab tests results ordered by the EP or by an

authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data

- 11 **Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach  
**Measure:** Generate at least one report listing patients of the EP with a specific condition
- 12 **Objective:** Report ambulatory quality measures to CMS or the States.  
**Measure:** For 2011, an EP would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.
- 13 **Objective:** Send reminders to patients per patient preference for preventive/ follow-up care  
**Measure:** Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over
- 14 **Objective:** Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules  
**Measure:** Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II.A.3
- 15 **Objective:** Check insurance eligibility electronically from public and private payers  
**Measure:** Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP
- 16 **Objective:** Submit claims electronically to public and private payers.  
**Measure:** At least 80 percent of all claims filed electronically by the EP
- 17 **Objective:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request  
**Measure:** At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours
- 18 **Objective:** Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)  
**Measure:** At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information
- 19 **Objective:** Provide clinical summaries to patients for each office visit  
**Measure:** Clinical summaries provided to patients for at least 80 percent of all office visits
- 20 **Objective:** Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically  
**Measure:** Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
- 21 **Objective:** Perform medication reconciliation at relevant encounters and each transition of care  
**Measure:** Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care

- 22     **Objective:** Provide summary care record for each transition of care and referral  
       **Measure:** Provide summary of care record for at least 80 percent of transitions of care and referrals
- 23     **Objective:** Capability to submit electronic data to immunization registries and actual submission where required and accepted  
       **Measure:** Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries
- 24     **Objective:** Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice  
       **Measure:** Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)
- 25     **Objective:** Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities  
       **Measure:** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a) (1) and implement security updates as necessary

CMS is soliciting feedback from the public on these measures. Are they reasonable and are they appropriate? Is the bar too high or too low? As mentioned above, HBMA is in the process of reviewing the proposed rule and will be submitting comments to CMS on these objectives and measures.

If you would like to review this one hundred sixty-nine (169) page proposed rule, you may access it at <http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>.

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## **Growth In National Health Expenditures Over The Next Several Years**

The Chief Actuary for the Medicare and Medicaid program has released the latest information on projected spending on healthcare over the next decade.

According to a report prepared by CMS’s Office of the Actuary and published by the journal Health Affairs, growth in national health expenditures (NHE) increased faster than the growth in the Gross Domestic Product (GDP) last year. In 2009, NHE grew 5.7 percent when compared to the previous year, while GDP declined 1.1 percent.

The figures reported by the Office of the Actuary (OA) are estimates as actual numbers for 2009 are not yet available.

Looking behind the aggregate numbers shows an alarming trend.

The OA believes that the projected growth for 2009 was largely due to faster spending in the Medicaid program. The rate of growth in Medicaid spending in 2009 was more than double the

rate of growth experienced in Medicaid in 2008 (9.9 percent growth in 2009 compared to 4.7 percent in 2008).

Also contributing to the acceleration was faster growth in the use of a variety of health care services, for example, treatment for the H1N1 virus.

According to the report, “As a result of NHE growth outpacing GDP growth in 2009, the health share of GDP is expected to have increased from 16.2 percent of GDP in 2008 to 17.3 percent in 2009, which would represent the largest one-year increase in history.”

The OA is currently projecting that health expenditures will decelerate by 3.9 percent in 2010; however, this projection is based upon the assumption that the 21.2% SGR reduction currently mandated, will actually occur. Should, as has been the case in the past, Congress intervene to prevent the SGR cut from taking place, the OA projects that health expenditures will go up in 2010.

The impact of the SGR cut on our healthcare system is rather dramatic. As noted above, if the SGR cut were allowed to take place, National Health Expenditures would DECREASE by a rate of 3.9 percent in 2010. However, if Congress authorizes a freeze in the physician fee schedule so that doctors get paid in 2010 at 2009 levels, National Health Expenditures in 2010 would INCREASE by 4.7 percent.

Over the ten year period (2009-2019) covered by the OA’s analysis, “average annual health spending growth (6.1 percent) is anticipated to outpace average annual growth in the overall economy (4.4 percent). By 2019, national health spending is expected to reach \$4.5 trillion and comprise 19.3 percent of GDP.”

Looking at the private insurance market, the OA projects a, “... steady rate of growth in premiums” along with a net reduction in the number of people with private health insurance coverage.

The OA projects that over the 10-year period 2009-2019, “average annual spending growth for hospital, physician and clinical services, and prescription drugs is projected to increase 6.1 percent, 5.9 percent, and 6.3 percent, respectively.”

The health care spending projection data can be found on the CMS web site at

[http://www.cms.hhs.gov/NationalHealthExpendData/03\\_NationalHealthAccountsProjected.asp](http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp)

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## **President Submits 2011 Budget – Affordable Health Care for All Americans**

On February 1, President Obama submitted his 2011 Budget to Congress. President Obama’s budget, like those of his predecessors, outlines his Administrations priorities and goals on all aspects the federal government from healthcare to national security.

It will now be up to Congress to actually adopt a budget. They can use the President's budget as a guide or come up with a budget completely different from the one suggested by the President. Unlike some previous Congresses which have declared the President's budget "dead on arrival" at least this Congress feigned some interest while making it clear; however, that the President's spending priorities were not necessarily shared by key Members of Congress.

Below are some of the highlights of the President's budget as it relates to healthcare.

### **Build on Health Information Technology (IT) Adoption Momentum.**

*The Budget includes \$110 million for continuing efforts to strengthen health IT policy, coordination, and research activities. Combined with the Recovery Act's Federal grant and incentive programs designed to assist providers with adoption and meaningful use of electronic health records, these efforts will improve the quality of health care while protecting privacy and security of personal health information.*

### **Increase Investment in Patient-Centered Health Research.**

*The Budget includes \$286 million within the Agency for Healthcare Research and Quality for research that compares the effectiveness of different treatment options, building on the expansion of this research begun under the Recovery Act.*

### **Bolster Prevention and Wellness Activities.**

*The Budget bolsters core prevention activities by expanding community health activities, strengthening the public health workforce, and enhancing surveillance and health statistics to improve detection and monitoring of chronic disease and health outcomes. The Budget funds a new effort in as many as 10 of the largest cities in the United States to reduce the rates of morbidity and disability due to chronic disease through effective policy and environmental change strategies.*

### **Fight Waste and Abuse**

*Reducing fraud, waste, and abuse is an important part of restraining spending growth and providing quality service delivery to beneficiaries. In November 2009, the President signed an Executive Order to reduce improper payments by boosting transparency, holding agencies accountable, and creating incentives for compliance. This Budget puts forward a robust set of proposals to strengthen Medicare, Medicaid, and CHIP program integrity efforts, including proposals aimed at preventing fraud and abuse before they occur, detecting it as early as possible when it does occur, and vigorously enforcing all penalties and recourses available when fraud is identified. It proposes \$250 million in additional resources that, among other things, will help expand the Health Care Fraud Prevention & Enforcement Action Team (HEAT) initiative, a joint effort by the Departments of Health and*

*Human Services and Justice. As a result, the Administration will be better able to minimize inappropriate payments, close loopholes, and provide greater value for beneficiaries and taxpayers.*

**Identify Ways to Improve Health Care Services for Seniors and People with Disabilities.**

*The Budget includes new Medicare and Medicaid demonstration projects that evaluate reforms to provide higher quality care at lower costs, improve beneficiary education and understanding of benefits offered, and better align provider payments with costs and outcomes. Special emphasis will be placed on demonstrations that improve care coordination for beneficiaries with chronic conditions, that better integrate Medicare and Medicaid benefits for beneficiaries in both programs, and that provide higher value for dollars spent.*

**Increase the Number of Primary Health Care Providers.**

*The Budget invests \$169 million in the National Health Service Corps (NHSC) to place providers in medically underserved areas to improve access to needed health care services.*

Congress, over the next several months, will debate these proposals and eventually, adopt a Budget Resolution reflecting Congressional priorities. This Congressionally adopted Budget Resolution does not go to the President but instead, becomes the guide for Congress in determining where to spend money during Fiscal Year 2011.

During his State-of-the-Union address, President Obama spoke about his desire to see a freeze in discretionary domestic spending. Domestic discretionary spending accounts for a very small percentage of total federal spending each year. Medicare, Medicaid, Social Security are classified as “entitlement” spending and would not be part of the President’s budget freeze proposal. Furthermore, the President’s proposal will not be put forward officially until next year.

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CMS Program Transmittals

The following transmittals were released by CMS between January 1, 2010 and January 29, 2010.

<b>Transmittal #</b>	<b>Subject</b>	<b>Effective Date</b>
<a href="#"><u>SE1001</u></a>	Additional Information Regarding the Calendar Year (CY) 2010 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	N/A
<a href="#"><u>SE1005</u></a>	Providers Randomly Selected to Participate in the Medicare Contractor Provider Satisfaction Survey	N/A

	(MCPSS) Urged to Respond	
<a href="#">R1888CP</a>	Positron Emission Tomography (PET) (FDG) for Cervical Cancer	01/04/2010
<a href="#">R1887CP</a>	Emergency Update to the 2010 Medicare Physician Fee Schedule Database	01/04/2010
<a href="#">R617OTN</a>	Medically Unlikely Edits (MUEs).	04/05/2010
<a href="#">R618OTN</a>	Institutional Online Screens Changes for Version 005010 Related to ICD-10, Institutional Online Screens Changes for Additional Medical Codes, and Changes Needed to Process Additional Medical Codes - Analysis Only	04/05/2010
<a href="#">R616OTN</a>	Common Working File (CWF) Non-Base Jobs to Base Jobs	N/A
<a href="#">R619OTN</a>	Converting the BSIs for the Providers Transitioning from WPS Legacy Workload (formerly processed by Mutual of Omaha) to the J1 A/B Medicare Administrative Contractor (MAC)	04/19/2010
<a href="#">R1890CP</a>	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure codes on Inpatient Hospital Claims	04/05/2010
<a href="#">R1891CP</a>	Correction to CR 6728 on Correct Coding Initiative (CCI) Edits, Version 16.0, Effective January 1, 2010	01/15/2010
<a href="#">R1889CP</a>	Pharmacogenomic Testing for Warfarin Response	04/05/2010
<a href="#">R14P232</a>	transmittal updates Chapter 32, Home Health Agency Cost Report, (Form CMS-1728-94	N/A
<a href="#">R1895CP</a>	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims	04/05/2010
<a href="#">R620OTN</a>	Various OIG Reports that have Medical Review Implications	02/16/2010
<a href="#">R1893CP</a>	Paying Claims Without Common Working File (CWF) Approval	04/01/2010
<a href="#">R322PI</a>	Durable Medical Equipment (DME MAC) and the National Supplier Clearinghouse (NSC MAC) Procedures for Third Party Notification of Deceased Durable Medical Equipment, Prosthetic, Orthotic and	07/06/2010

	Supplies (DMEPOS) Supplier Associates	
<a href="#">R1894CP</a>	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010
<a href="#">R21P236</a>	This transmittal also reflects further clarification to existing instructions and incorporates select Federal Register provisions.	N/A
<a href="#">R622OTN</a>	Systematic Synchronization of Medicare Participating Physician or Supplier Agreement (PAR) Status Between the Multi Carrier System (MCS) Provider Enrollment, Chain and Ownership System (PECOS)	01/04/2010
<a href="#">R119BP</a>	Coverage of Inpatient Rehabilitation Services	01/04/2010
<a href="#">R164FM</a>	Chapter 7, Internal Control Requirements Update	11/23/2009
<a href="#">R165FM</a>	Notice of New Interest Rate for Medicare Overpayments and Underpayments 2nd Notification for FY 2010	01/25/2010
<a href="#">R623OTN</a>	Implementation of the HIPAA Version 5010 276/277 Claim Status Second Phase	N/A
<a href="#">R1892CP</a>	Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation	03/15/2010
<a href="#">R621OTN</a>	Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 - MAC Jurisdiction 9 Only	03/01/2010
<a href="#">R624OTN</a>	Incorporation of the National Provider Identifier (NPI) into the National Supplier Clearinghouse (NSC) Enrollment System and Related Instructions	N/A
<a href="#">R625OTN</a>	Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	N/A
<a href="#">R1896CP</a>	Healthcare Provider Taxonomy Codes (HPTC) Update April 2010	04/05/2010
<a href="#">R628OTN</a>	Integrated Outpatient Code Editor (IOCE) PC (interactive and batch) Re-Write	07/06/2010
<a href="#">R57SOMA</a>	Revised Chapter 2, The Certification Process, Section 2256H	01/29/2010
<a href="#">R1903CP</a>	Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the Form CMS-150	04/05/2010

<a href="#">R630OTN</a>	FISS Integrated Outpatient Code Editor (IOCE) Control Block Changes Related to ICD-10	07/06/2010
<a href="#">R629OTN</a>	MCS Changes Needed to Automate the Annual Update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	07/06/2010
<a href="#">R627OTN</a>	Carriers and Part A and Part B Medicare Administrative Contractors (A/B MACs) to Fully Populate the Provider Enrollment, Chain and Ownership System (PECOS)	03/15/2010
<a href="#">R632OTN</a>	Claim Adjustment Reason Code (CARC) Update for Medicare Secondary Payer (MSP) Claims Processing	07/06/2010
<a href="#">R8P229</a>	This transmittal also reflects further clarification to existing instructions and incorporates select legislative and other provisions. The effective date for instructional changes will vary due to various implementation dates.	N/A
<a href="#">R1899CP</a>	April 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	04/05/2010
<a href="#">R323PI</a>	MCS Changes Needed to Automate the Annual Update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	03/29/2010
<a href="#">R1898CP</a>	Dialysis Adequacy, Infection and Vascular Access Reporting	07/06/2010
<a href="#">R1900CP</a>	Correction to Processing of Non-Covered Revenue Codes	07/06/2010
<a href="#">R1897CP</a>	Associating Hospice Visits to the Level of Care	04/29/2010
<a href="#">R1901CP</a>	Billing and Processing for Healthy Control Group Volunteers in a Qualified Clinical Trial	07/06/2010
<a href="#">R120BP</a>	Revision of Definition of Compendia as Authoritative Source for Use in the Determination of a Medically- Accepted Indication of Drugs/Biologicals Used Off- label in Anti-Cancer Chemotherapeutic Regimens	03/01/2010