

## WASHINGTON REPORT - MAY/JUNE ISSUE

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### **SGR Update**

The Congress continues to work towards a long-term solution to the SGR problem. As this Report was being finalized, the House enacted a Senate passed SGR “fix” that will be good for 6 months (November 30, 2010). But finding a long-term solution is proving to be more challenging than many expected. The biggest challenge appears to be finding a consensus on how to pay for the fix.

Many physicians and billing companies continue to ask why Congress has not permanently fixed the SGR problem by now. A brief explanation follows.

Several different SGR “fix” options have been discussed over the past 6 months. There are permanent solutions, medium-term “fixes” and temporary “fixes” to the SGR problem being discussed in Congress. Unfortunately, none have been able to secure sufficient votes to pass either or both Houses of Congress. The issue is not whether the SGR problem needs fixing – everyone agrees that the SGR formula is seriously flawed and needs to be fixed or replaced. Rather, the issue is whether or not the fix (whatever form or shape it takes) is going to be “paid for.”

Many Members of Congress are now expressing grave concerns about the size of the deficits being incurred by the Federal government. Depending upon the particular method for fixing the SGR problem (e.g. short-term, long-term, permanent or temporary), the cost of the fix ranges from approximately \$80 Billion to \$250 Billion (over 10 years).

Early in this Congress, budgetary rules, called “pay-as-you-go” or “pay-go” for short, were adopted. These “pay-go” rules stipulate that for any “new” spending (spending not already included in the federal budget), Congress must either find new revenue or make cuts in other programs to offset the cost of the new spending. The purpose of these rules is to prevent additional deficit spending.

The current budget of the federal government assumes that the SGR formula, being the law, will be followed. Therefore, any change in the formula that results in higher Medicare payments than called for under SGR, represents “new” spending.

However, the “pay-go” rules also allow Congress to declare certain spending as “emergency” spending and waive the pay-go rules. In addition, Congress has also provided a specific pay-go budgetary exemption (approximately \$80 billion) for a short-term SGR fix. This means that Congress can enact a change in the SGR formula with a price tag of up to approximately \$80 Billion, without having to find new revenues or spending cuts to offset these new costs.

Many Members – Democrats and Republicans – are telling the Democratic Congressional leadership that just because the budget rules allow for increased deficit spending for an SGR fix, doesn’t mean that Congress should add more to an already historic deficit to fix the SGR formula.

There are any number of viable ideas on how to fix the SGR problem, the challenge confronting Congress in enacting one of those fixes is finding the money to pay for the fix or making a conscious decision to “pay for” the fix by additional deficit spending.

It appears increasingly likely that no long-term solution to the SGR problem will be adopted in 2010 and a permanent fix will have to wait for the next Congress.

## **CMS Announces Changes in Provider and Supplier Enrollment, Ordering, and Referring, and Documentation Requirements**

In early May, CMS issued an interim rule implementing provisions from the Patient Protection and Affordable Care Act (PPACA). The interim rules would provide that:

- All providers that qualify for an NPI must include their NPI on all applications to enroll in Medicare and Medicaid and on all claims submitted under these programs by January 1, 2011.
- Physicians and eligible professionals who order and refer covered items and services for Medicare beneficiaries must be enrolled in Medicare.
- Providers, physicians, and suppliers participating in the Medicare program must provide documentation on referrals to programs at high risk of waste and abuse (including durable medical equipment, prosthetics Orthotics, and supplies (DMEPOS), home health services, and other items or services specified by the Secretary.

### **These regulations become effective on July 6, 2010.**

On June 9th, members of the HBMA Board and Government Relations Committee met with Jim Bossenmeyer, Director of Provider and Supplier Enrollment at CMS to discuss this new policy. Based upon that meeting, it appears that CMS is investigating options for relaxing the enforcement of this policy until January, 2011. At press time, no new policy had been announced; however, CMS hoped to announce something prior to the July 6<sup>th</sup> effective date.

The motivation behind this new policy is an attempt to ensure only qualified individuals and/or organizations are permitted to enroll or maintain their billing privileges. CMS believes that including the provider's NPI on all claims and enrollment applications is an important step to controlling fraud and abuse of these programs.

Provider or suppliers, who are eligible for an NPI, must report the NPI on the Medicare enrollment application, and the provider or supplier must report the NPI to Medicare in an enrollment application if it was not previously enrolled. A provider or supplier enrolled in fee-for-service (FFS) Medicare must report the NPI on electronic or paper claims submitted to Medicare. The claim submitted by a Medicare beneficiary must contain the legal name and, if known, the NPI of any provider or supplier who is required to be identified in the claim. Medicare claims will be rejected if they do not contain the required NPI.

In regards to ordering and referring covered items and services for Medicare beneficiaries, Medicare requires the ordering supplier be identified by legal name and NPI in a claim submitted by the supplier of DMEPOS. PPACA requires that payment may only be made to eligible providers and only if the provider is enrolled in Medicare and that physicians must be identified by his or her NPI in claims for these services. Medicare requires the ordering or referring supplier be identified by legal name and NPI in the claims submitted by the supplier of laboratory, imaging, and specialist services effective on or after July 6, 2010.

To ensure the ordering or referring supplier is uniquely identified in Part B claims for covered services of laboratories, imaging suppliers, and specialists and to ensure those items are referred by qualified physicians or eligible professionals, the ordering or referring supplier must be a physician or eligible professional with an approved enrollment record in PECOS and be identified in this claim by legal name or NPI.

Medicare contractors may deny a claim submitted by Medicare beneficiaries if the ordering or referring supplier is not identified by his legal name.

HBMA, along with several other organizations representing physicians and practice managers submitted comments to CMS expressing concern about this proposal and urging great flexibility in the enforcement of this policy. A copy of HBMA's comments to CMS is available on the HBMA website.

### **Meet the New MedPAC Commissioners**

The Medicare Payment Advisory Commission (MedPAC) is a group of healthcare experts appointed by the Comptroller General of the United States to advise Congress on healthcare issues, in particular Medicare and Medicaid. Congress established MedPAC in 1997 to analyze access to care, cost and quality of care, and other key issues affecting Medicare.

On May 14, Gene L. Dodaro, Acting Comptroller General of the United States and head of the U.S. Government Accountability Office (GAO), announced the appointment of four new members and the reappointment of two existing members to the Medicare Payment Advisory Commission (MedPAC).

In making the appointments, Dodaro said, "Policymakers continue to rely on MedPAC's expert advice, and with the passage of health care reform, MedPAC's role will continue to be particularly important. I am pleased to report that, once again, we had many qualified applicants for MedPAC. The four new individuals selected will bring impressive credentials and valuable experience and insights to the commission,"

The newly appointed members are:

**Scott Armstrong**, President and Chief Executive Officer, Group Health Cooperative  
**Katherine Baicker**, PhD, Professor of Health Economics, Harvard School of Public Health

**Mary Naylor**, PhD, RN, FAAN, Professor of Gerontology, University of Pennsylvania, School of Nursing

**Cori Uccello**, FSA, MAAA, FCA, Senior Health Fellow of the American Academy of Actuaries

Their terms will expire in 2013.

The reappointed members, whose terms will expire in April 2013, are:

Thomas M. Dean, MD, a family physician in Wessington Springs, South Dakota and

Herb B. Kuhn, President and CEO of the Missouri Hospital Association.

Below are brief biographies of new commission members.

**Scott Armstrong** is the President and Chief Executive Officer of Group Health Cooperative, a consumer-governed health system serving 650,000 enrollees through coordinated care plans for groups and individuals and for Medicare, Medicaid, and SCHIP beneficiaries. He has worked at Group Health since 1986, serving in positions ranging from assistant hospital administrator to chief operating officer; Armstrong became President and CEO of Group Health Cooperative in 2005.

Before joining Group Health, Armstrong was the assistant vice president for hospital operations at Miami Valley Hospital in Dayton, Ohio. He received his bachelor's degree from Hamilton College in New York and a master's degree in business with a concentration in hospital administration from the University of Wisconsin-Madison.

**Katherine Baicker**, is Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health, where her research

focuses on health insurance finance and the effect of reforms on the distribution and quality of care. Dr. Baicker has served on the faculty of the Department of Public Policy in the School of Public Affairs at the University of California, Los Angeles, the Economics Department at Dartmouth College, and the Center for the Evaluative Clinical Sciences and the Department of Community and Family Medicine at Dartmouth Medical School.

**Mary Naylor**, is a Professor in Gerontology at the University of Pennsylvania School of Nursing. Since 1989, Dr. Naylor has led an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations, and reduce health care costs for vulnerable community-based elders. Dr. Naylor is also the National Program Director for the Robert Wood Johnson Foundation program, Interdisciplinary Nursing Quality Research Initiative, aimed at generating, disseminating, and translating research to understand how nurses contribute to quality patient care. Naylor co-chaired the National Quality Forum's Steering Committee on Nursing Care Performance Measures. She is a member of the National Academy of Sciences, Institute of Medicine. Dr. Naylor received her PhD from the University of Pennsylvania and her BS in Nursing from Villanova University.

**Cori Uccello**, is Senior Health Fellow of the American Academy of Actuaries, serving as the actuarial profession's chief public policy liaison on health issues. Before joining the Academy in 2001, Ms. Uccello was a senior research associate at the Urban Institute. She previously held positions at the Congressional Budget Office and the John Hancock Mutual Life Insurance Company. Ms. Uccello has written extensively on the health insurance market and the Medicare program, including pieces on Medicare's financial condition and the Medicare prescription drug program. Ms. Uccello is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. She received her BS from Boston College and her MPP from Georgetown University.

### **Discretionary Spending in the Final Health Care Reform**

The Congressional Budget Office (CBO) has provided some additional information about the potential effects of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, on discretionary spending. Discretionary spending is spending that is funded through the annual appropriation process.

This information updates and expands upon the analysis of potential discretionary spending under PPACA that CBO issued on March 15, 2010. By definition all discretionary spending is subject to future appropriation actions, which could result in greater or smaller costs than the sums authorized by the legislation.

Discretionary costs fall into three general categories:

- \* The costs that will be incurred by federal agencies to implement the new policies established by PPACA, such as administrative expenses for the Department of Health and Human Services and the Internal Revenue Service for carrying out key requirements of the legislation.
- \* Explicit authorizations for future appropriations for a variety of grant and other program spending for which the act identifies the specific funding levels it envisions for one or more years.
- \* Explicit authorizations for future appropriations for a variety of grant and other program spending for which no specific funding levels are identified in the

legislation.

CBO newly estimates that total authorized costs in the first two categories will likely exceed \$115 Billion over the 2010-2019 period. CBO does not have an estimate of the potential costs of authorizations in the third category. This money was not accounted for in the original CBO estimate.

When CBO originally evaluated the budgetary impact of the Patient Protection and Affordable Care Act, it concluded that enactment of the legislation would result in a net reduction in federal deficits of \$143 Billion over the 10 year period covered by their estimate. With the new estimate, the net reduction in federal deficits would be reduced to \$28 Billion.

### **Berwick Nomination Hits Speed Bump**

Since his nomination as the next Administrator of the Centers for Medicare and Medicaid Services, Don Berwick has been the subject of numerous floor speeches by Republican Senators questioning his fitness to assume the Administrator's position.

Opposition to Berwick's confirmation has focused largely on his comments in support of the British Health Care system and comments indicating his support for rationing health care. Although Berwick appears to have the support of a majority of U.S. Senators at this time, it is conceivable his opponents could mount a filibuster against his nomination. It would take 60 votes to end a filibuster.

Recently, rumors began circulating that there was a problem with Berwick's "paperwork" and that this was delaying the start of his confirmation hearings. In the past, this phrase has often been an unofficial sign that the nominee is encountering some unforeseen problems.

Berwick, a physician, is the president and CEO of the Institute for Healthcare Improvement, as well as a Harvard University professor. The CMS Administrator position has not had an Administration Appointee since Mark McClellan stepped down from the role during the Bush Administration (2006). A series of "Acting" Administrators have filled the position for nearly 4 years. The Senate Finance Committee will conduct the confirmation hearings on Berwick's nomination but no date has been set. Finance Chairman Max Baucus had hoped to complete the confirmation process by July 4<sup>th</sup>; however due to Berwick's "paperwork" problems, this does not seem likely at this time.

### **Health Care Reform Insurance Website up and Running**

The Patient Protection and Affordable Care Act (PPACA) requires an internet Website (Web portal) be established for individuals and small businesses to obtain information about the insurance coverage that is available in their State. The Department of Health and Human Services (HHS) is issuing an interim rule that adopts the categories of information that will be collected and displayed such as content, data from issuers, and requests from States, associations, and high risk pools.

According to the new law, the Web portal needs to be clear, salient, and easy to navigate. HHS is in the process of establishing a web portal that meets these criteria. Once operational, the Web Portal will include information about:

1. Health insurance coverage offered by health insurance issuers
2. Medicaid coverage
3. Children's Health Insurance Program (CHIP) coverage

4. State health benefits high risk pool coverage
5. Coverage under the high risk pool created by PPACA
6. Coverage within the small group market for small businesses and their employees

Although HHS expects to have the website up and running by July 1, 2010, it will be constantly evolving. HHS plans to initially provide summary information about health insurance products available to individuals and small business markets. Additionally, it will provide introductory information on eligibility and services for Medicaid and CHIP and coverage options for small businesses. Overall, according to HHS officials, the Website will include information “that is useful to consumers regarding their health care and insurance needs.”

Information on the site as of July 1, 2010, will include information HHS collected by May 21, 2010, along with customer education information and information for small business on the small group market. The October 1, 2010, update will include information collected by September 3, 2010. The portal will be interactive so customers will have the ability to select all available issuers and portal plans. Comments are invited on the sort and selection functionality of the Web portal and the order and layering of the portal plans displayed. Health plan pricing and benefit information will be updated at least monthly. HHS will also report medical loss ratios, health plan performance ratings, and standards and reporting obligations for insurance sold under the exchanges.

HHS should be announcing the web address for the site in the very near future.

#### **CMS updates report on RAC demo appeals**

The Centers for Medicare & Medicaid Services (CMS) has updated its 2008 report on Medicare's Recovery Audit Contractor (RAC) demonstration program to include information through March 9, 2010. According to the [report](#), providers appealed 12.7% of RAC determinations from the inception of the three-year demonstration through March 9, of which 8.2% were overturned on appeal.

There are several data differences between this update and the January 2009 report. Explanations for the data differences are as follows:

- The number of claims with overpayment determinations has increased from 525,133 in the January 2009 report to 598,238, as a result of additional claims being manually included that were not entered into the RAC data warehouse prior to the end of the demonstration.
- The number of claims where the provider appealed has significantly decreased from the 118,051 reported in January 2009 to 76,073, due to several factors. The previous method of generating this figure counted claims appealed to multiple levels at each level of appeal. The revised method counts an appealed claim once, regardless of the number of levels of appeal.
- Duplicate claims were identified in the previous data, and they have been removed.

#### **Provider Appeals of RAC-Initiated Overpayments: Cumulative through 3/9/10**

Number of claims with overpayment determinations	598,238
Number of claims where provider appealed	76,073
Number of claims with appeal decisions in provider's favor	48,993

**Percentage of appealed claims with a decision in provider's favor**     **64.4%**

Percentage of claims overturned on appeal 8.2%

As the above chart notes, nearly 65% of appealed claims were resolved with a decision in **FAVOR** of the provider.

### **Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months**

CMS has issued an announcement reminding providers (or individuals or businesses that submit claims on behalf of providers), that as a result of the Patient Protection and Affordable Care Act (PPACA), claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For more details, please read the article at

<http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf> on the CMS website.

### **HITECH Act Update**

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Department of Health and Human Services (HHS) to revise the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to require covered entities to account for disclosures of protected health information to carry out treatment, payment, and health care operations if the disclosures are through an electronic health record (EHR).

CMS is proposing that when an individual's protected health information (PHI) is disclosed via an EHR, the individual whose information has been disclosed is entitled to know the following:

1. The date of disclosure
2. The name (and address) of the entity or person who received the PHI
3. A brief description of the information disclosed
4. A brief statement of the purpose for the disclosure (or a copy of the written request for the disclosure)

For multiple disclosures to the same person for the same purpose, the accounting is only required to include:

1. For the first disclosure, a full accounting with the information above
2. The frequency, periodicity, or number of disclosures made during the accounting period
3. The date of the last disclosure made during the accounting period

The law currently exempts disclosure to carry out treatment, payment, and health care operations from these accounting requirements.

The HITECH Act provides that a covered entity that has acquired an electronic health record after January 1, 2009 must comply with the new accounting requirement beginning January 1, 2011 (or anytime after that date when it acquires an electronic health record), unless HHS extends this compliance deadline to no later than 2013.

HHS will likely issue final guidance on these new standards by the end of 2010.

To review the full proposed rule, go to: <http://edocket.access.gpo.gov/2010/pdf/2010-10054.pdf>

### **Work-at-Home Medical Billing Fraud Ring Busted!**

The Federal Trade Commission (FTC) is sending checks to 3,500 consumers nationwide who were defrauded by a group of marketers accused of hawking phony business

opportunities. Consumers who were victims of this scam will receive a total of \$95,000 in refunds.

According to a press release issued by the FTC, “The reimbursement stems from the February 2008 settlement of a case brought as part of Project Fal\$e Hope\$, a Commission-led law enforcement sweep that included more than 100 actions filed by the FTC, the Department of Justice, the U.S. Postal Inspection Service, and other agencies in 11 states.”

In this case, known as EDI Healthclaims, the FTC alleged that scammers used mass mailings to consumers offering a “work-at-home” business opportunity to earn easy money electronically processing health-care providers’ medical claims for insurance reimbursement. According to the FTC, the defendants misled consumers by stating they would help them find their first medical billing client and give them a list of providers in their area looking for billing help – after the consumers paid a “licensing fee” of between \$4,985 and \$5,985. Consumers, who were promised they would earn at least \$1,200 a month, often made nothing and lost their up-front fee. A copy the FTC’s complaint, can be found at:

<http://www.ftc.gov/os/caselist/0623033/061212cmp0623033.pdf>.

If you’ve heard about this scam or know someone who may have been a victim of this scam, have them call 1-877-678-0676 with any questions.

#### **House Announces Summer Break Schedule**

The House’s August “vacation” will begin by Friday, July 30, a week earlier than previously scheduled. When Members of Congress are home during the August break, this is an excellent time to try to arrange a visit with your elected representatives or attend a town-hall meeting.

Originally, the House had planned to be in session during the first week of August and reconvene on September 14<sup>th</sup>. The House will still reconvene on September 14<sup>th</sup> but it will begin the August recess a week earlier than originally planned.

The Senate is scheduled to be in session the first week of August and Senate Majority Leader Harry Reid, D-NV., has threatened to keep the Senate in session through the second week in August if sufficient progress is not made on so-called “must pass” legislation.

#### **CMS Transmittals**

<b>Transmittal Number</b>	<b>Subject:</b>	<b>Effective Date</b>
<a href="#">R720OTN</a>	Additional Healthcare Common Procedure Coding System (HCPCS) Codes Subject to Clinical Laboratory Improvement Amendments (CLIA) Edits	07/19/2010
<a href="#">R1989CP</a>	October Quarterly Update to 2010 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement	10/04/2010
<a href="#">R721OTN</a>	Durable Medical Equipment National Competitive Bidding Implementation -- Phase 10C: Exception for Medicare	10/04/2010

	Beneficiaries Previously Enrolled in a Medicare Advantage Plan	
<a href="#">R344PI</a>	Chapter 10 Manual Redesign	07/05/2010
<a href="#">R722OTN</a>	Requirement for Submission of Shared Systems Data to the Integrated Data Repository (IDR)	10/04/2010
<a href="#">R1990CP</a>	October 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	10/04/2010
<a href="#">R344PI</a>	Chapter 10 Manual Redesign	07/05/2010
<a href="#">R343PI</a>	Medical Review Resolutions in the Absence of a Plan of Care (POC) and the Outcome Assessment Information Set (OASIS)	07/19/2010
<a href="#">R1988CP</a>	Enhancements to Home Health (HH) Consolidated Billing	10/04/2010
<a href="#">R1987CP</a>	Correction to the Claims Processing Internet Only Manual (IOM) to Reinstate Previous Instructions Regarding Payment Jurisdiction for Reassigned Services	08/12/2010
<a href="#">R1QRI</a>	Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual	09/13/2010
<a href="#">R719OTN</a>	Reprocessing of Claims for Certain Replacement Parts, Accessories, or Supplies for Prosthetic Implants and Surgically Implanted Durable Medical Equipment (DME) with Dates of Service of October 27th, 2008 through December 31, 2009	10/04/2010
<a href="#">R1986CP</a>	Guidelines to Allow Contractors to Develop and Utilize Procedures for Accepting and Processing Appeals Via Facsimile and/or Via a Secure Internet Portal/Application	10/01/2010
<a href="#">R1983CP</a>	Clarification on Use of the SNFABN and Denial Letters	07/12/2010

<a href="#">R1984CP</a>	July 2010 Update to the Ambulatory Surgical Center (ASC) Payment System	07/06/2010
<a href="#">R1985CP</a>	Clarifications and Updates of Therapy Services Policies	07/11/2010
<a href="#">R63GI</a>	October 2010 Update to the CMS Standard File for Reason Codes for the Fiscal Intermediary Shared System (FISS)	10/04/2010
<a href="#">R718OTN</a>	Durable Medical Equipment National Competitive Bidding Implementation Phase 10G: Paying for Oxygen Equipment when Grandfathered	10/04/2010
<a href="#">R717OTN</a>	Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment After July 1, 2010	07/09/2010
<a href="#">R442PR1</a>	Prospective Payment System Hospital Input Price Index	N/A
<a href="#">R1981CP</a>	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2011	07/06/2010
<a href="#">R715OTN</a>	Analysis for FISS, CWF and NCH for Physician and Non-Physician Practitioner Specialty Codes	10/04/2010
<a href="#">R1982CP</a>	July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2	07/06/2010
<a href="#">R1980CP</a>	July 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/06/2010
<a href="#">R716OTN</a>	HIPAA 5010 Activity - Testing of 5010 CRs	N/A
<a href="#">R93MCM</a>	Chapter 3. Medicare Marketing Guidelines	06/04/2010
<a href="#">R713OTN</a>	Hospital Provider Enrollment Revalidation	07/04/2010
<a href="#">R1978CP</a>	Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)	07/06/2010
<a href="#">R122NCD</a>	Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)	07/06/2010

<a href="#">R1968CP</a>	New Waived Tests	07/06/2010
<a href="#">R712OTN</a>	One-Time Mailing of Solicitation Letter To All Physicians And Non-Physician Practitioners Who Are Currently Enrolled In Medicare But Who Do Not Have An Enrollment Record In The Provider Enrollment, Chain And Ownership System (PECOS)	06/28/2010
<a href="#">R711OTN</a>	Revised Payment Files for the 2010 Ambulatory Surgical Center Payment System	06/21/2010
<a href="#">R121NCD</a>	Collagen Meniscus Implant	07/06/2010
<a href="#">R1977CP</a>	Collagen Meniscus Implant	07/06/2010
<a href="#">R127BP</a>	Revisions and Re-issuance of Audiology Policies	07/28/2010
<a href="#">R1975CP</a>	Revisions and Re-issuance of Audiology Policies	07/28/2010
<a href="#">R128BP</a>	July 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/06/2010
<a href="#">R1976CP</a>	July 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/06/2010
<a href="#">R171FM</a>	Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD)	N/A
<a href="#">R709OTN</a>	Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIIPAA) Version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)	10/04/2010
<a href="#">R1974CP</a>	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010
<a href="#">R339PI</a>	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010
<a href="#">R126BP</a>	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010

<a href="#">R170FM</a>	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010
<a href="#">R1970CP</a>	Updated Form CMS-1500 Information	10/04/2010
<a href="#">R1973CP</a>	Internet Only Manual (IOM) Chapter 25 Revisions	09/01/2010
<a href="#">R706OTN</a>	Extension for the Two Percent and Three Percent Add-On for the Ground Ambulance, Air Ambulance in Rural Areas and "";Super Rural""; Add-On	07/06/2010
<a href="#">R710OTN</a>	Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	N/A
<a href="#">R1972CP</a>	Quarterly HCPCS Code Changes - July 2010 Update	07/06/2010
<a href="#">R1971CP</a>	Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.2, Effective July 1, 2010	07/06/2010
<a href="#">R59SOMA</a>	Clarification of the Interpretive Guidelines for the Anesthesia Services Condition of Participation	05/21/2010
<a href="#">R707OTN</a>	Health Insurance Portability and Accountability Act (HIPAA) 005010 837 Institutional (837I) Edits and 005010 837 Professional (837P) Edits - October 2010 Version	10/04/2010
<a href="#">R705OTN</a>	Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Medicare Secondary Payer (MSP) Claims Processing	10/04/2010
<a href="#">R338PI</a>	Clinical Review Judgment (CRJ)	06/15/2010
<a href="#">R125BP</a>	Ambulance Services - Joint Responses	06/15/2010
<a href="#">R1969CP</a>	July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2	07/06/2010
<a href="#">R704OTN</a>	Implementation of the HIPAA Version 5010 276/277 Claim Status Edit October 2010 Release	10/04/2010

<a href="#">R701OTN</a>	October Common Edits and Enhancements Module (CEM) Updates	10/04/2010
<a href="#">R702OTN</a>	Common Edits and Enhancements Module (CEM) October Release Update for Test/Production Indicator Activity and Outbound Data Scrubbing	N/A
<a href="#">R700OTN</a>	Revised Payment Files for the 2010 Medicare Physician Fee Schedule Database (MPFSDB) and Retroactive Provisions under the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the Affordable Care Act)	06/01/2010
<a href="#">R1966CP</a>	Pulmonary Rehabilitation (PR) Services	10/04/2010
<a href="#">R124BP</a>	Pulmonary Rehabilitation (PR) Services	10/04/2010
<a href="#">R1965CP</a>	Appeals Revisions - AIC Requirements	08/09/2010
<a href="#">R697OTN</a>	Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months	10/04/2010
<a href="#">R694OTN</a>	Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Certain Diagnostic Imaging Procedures	07/06/2010
<a href="#">R1967CP</a>	July Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers (DMEPOS) Fee Schedule	07/06/2010
<a href="#">R698OTN</a>	Phase 2 Base System Changes for Implementation of the Next Version of the Health Insurance Portability and Accountability Act (HIPAA)-Multi Carrier System (MCS) Only	N/A
<a href="#">R1964CP</a>	Instructions for Downloading the Medicare ZIP Code File for October 2010	10/04/2010
<a href="#">R120NCD</a>	FDG PET for Solid Tumors and Myeloma	10/30/2010
<a href="#">R696OTN</a>	Requirements for Hospital Attestation and Billing of Fiscal Year 2007 and 2008 Informational Only Inpatient Claims for	06/07/2010

	Medicare Advantage Beneficiaries	
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