



CMS Medicare FFS Provider e-News

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

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

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Colleagues—

We're moving! In the very near future, we'll begin releasing the weekly e-News on Tuesdays instead of Fridays. The e-News will continue to be just as reliable and valuable as ever – you'll just have your CMS news to share earlier in the week.

You've hopefully noticed that we've done some work over the last few months to refine the look and feel of the e-News, and this is just the latest step we're taking to make sure the Agency's communications are as consistently useful as possible for the FFS provider community.

It's my hope that this change will continue to make it easier for you to share the Agency's news and announcements with your members and other constituents.

My very best—

Robin

The e-News for the week of Fri Apr 8 includes...

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Special Open-Door Forum: Physician Quality Reporting System and E-Prescribing (eRx) Incentive Program Success Stories [[↑](#)]

Thu Apr 14, 2:30-3:30pm ET

The Centers for Medicare & Medicaid Services will host a Special Open-Door Forum on the 2011 Physician Quality Reporting System (previously known as the Physician Quality Reporting Initiative or PQRI) and E-Prescribing (eRx) Incentive programs. This Special Open-Door Forum will include:

- Physician Reporting and E-Prescribing Success Stories, with presentations from:
 - Dr Sobel, Physician with Crossroads Internal Medicine, Owings Mills, MD
 - Dr O’Dell, Physician with Truman Medical Centers, Kansas City, MO
 - Jud Neal, President and CEO of Physician’s Business Network, Kansas City, MO
- Success stories on:
 - Practice Description
 - Years of Experience
 - Implementation of the Physician Quality Reporting and E-Prescribing Incentive Programs
 - Lessons Learned
- Q&A with CMS subject matter experts

Remember: Be sure to use the correct 2011 Physician Quality Reporting Measure Specifications, as these documents are updated from year to year:

- 2011 Physician Quality Reporting Measure Specifications for Claims and Registry Reporting of Individual Measures
- 2011 Physician Quality Reporting Measures Groups Specifications
- 2011 Physician Quality Reporting EHR Measure Specifications
- 2011 Physician Quality Reporting GPRO I Narrative Measure Specifications

Special Open-Door Forum Participation Instructions:

- Dial 800-837-1935 and use conference ID #44767416
- Note: TTY Communications Relay Services are available for the Hearing-Impaired. For TTY services, dial 7-1-1 or 800-855-2880 and a Relay Communications Assistant will help.
- An audio recording and transcript of this call will be posted to the Special Open-Door Forum website at http://www.CMS.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around Fri May 13

National Provider Call on 2011 Physician Quality Reporting System & eRx Incentive Program [[↑](#)]

Tue Apr 19, 1:30-3pm EDT

The Centers for Medicare & Medicaid Services' Provider Communications Group will host a national provider conference call on the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. The Physician Quality Reporting System is voluntary quality reporting program that provides an incentive payment to identified individual eligible professionals (EPs) and group practices that satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part-B Fee-For-Service beneficiaries; the Physician Quality Reporting System (formerly known as PQRI) was first implemented in 2007 as a result of section 101 of the *Tax Relief and Health Care Act of 2006 (TRHCA)* and further expanded as a result of the *Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)*, and the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*. The eRx Incentive Program is an incentive program for eligible professionals initially implemented in 2009 as a result of section 132(b) of *MIPPA*; the eRx Incentive Program promotes the adoption and use of eRx systems by individual eligible professionals and group practices.

Agenda:

- Electronic Prescribing (eRx) Incentive Program Payment Adjustment; and
- Q & A with CMS Physician Quality Reporting System and eRx subject matter experts

A PowerPoint slide presentation will be posted to the Physician Quality Reporting System webpage at http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp for you to download prior to the call so that you can follow along with the presenter. Educational products are available on the Physician Quality Reporting System and the eRx Incentive Program at <http://www.CMS.gov/PQRS> and <http://www.CMS.gov/eRxIncentive>, respectively; feel free to download the resources prior to the call so that you may ask questions of the CMS presenters.

In order to receive the call-in information, you must register for the call. Note that if you are planning to sit in with a group, only one person needs to register to receive the call-in information. Also note that, if you plan to request continuing education credit from your professional organization and if this organization requires proof of registration, you will need to personally register so that you receive a confirmatory email.

Registration will close at 1:30pm EDT on Mon Apr 18 or when available space has been filled; no exceptions will be made, so please register early. To register for the call:

- Visit <http://www.eventsvc.com/palmettogba/041911>.
- Fill in all required information and click "Register."
- You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Please save this page, in the event that your server blocks the confirmation emails. (If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.)

- If assistance for hearing impaired services is needed, the request must be sent to medicare.ttt@palmettogba.com no later than 3 business days before the event.

For those of who will be unable to attend, a written and audio transcript of the call will be available at least one week after the call at <http://www.CMS.gov/PQRS>.

CMS Launches Dedicated Webpage for the Medicare Shared Savings Program [\[↑\]](#)

On Thu Mar 31 CMS published in the *Federal Register* proposed rule CMS-1345-P, “Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations,” which implements the Medicare Shared Savings Program and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated webpage at www.CMS.gov/SharedSavingsProgram for Medicare FFS providers and other providers of services and suppliers. Bookmark the webpage and check back often, as CMS continues to add information on the program.

Alabama and Missouri Launched Their Medicaid EHR Programs in April [\[↑\]](#)

In the last week, Alabama and Missouri began participating in the Medicaid Electronic Health Record (EHR) Incentive Program. This means that eligible professionals (EPs) and eligible hospitals in Alabama and Missouri will be able to receive incentive payments through the Medicaid EHR Incentive Program. More information about the Medicaid EHR Incentive Program can be found on the [Medicare and Medicaid EHR Incentive Program Basics page](#) of the CMS EHR website.

If you are a resident of Alabama or Missouri, and are eligible to participate in the Medicaid EHR Incentive Program, visit your State Medicaid Agency website for more information on your state's participation in the Medicaid EHR Incentive Program: [Alabama](#) and [Missouri](#).

As of Mon Apr 4, 13 states have launched their Medicaid EHR Incentive Programs, and six states have issued incentive payments to Medicaid EPs who have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months. For a complete list of states that have already begun participation in the Medicaid EHR Incentive Program, see the [State Medicaid Information](#) document on the CMS EHR website.

Want more information about the EHR Incentive Programs? Visit the [CMS EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs; also sign up for the [EHR Incentive Programs email update listserv](#).

Reminder: Attestation for the Medicare EHR Incentive Program is only a few weeks away. On Mon Apr 18, Medicare EPs and eligible hospitals will be able to use the CMS web-based attestation system to attest to meeting meaningful use criteria. Prepare now for this important milestone.

PEPPER Training for Critical Access Hospitals, Preparation to Receive Free Comparative Data Reports [\[↑\]](#)

Beginning in April 2011, the Centers for Medicare & Medicaid Services will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating

Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments, which hospitals can use to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction, and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to CAH QualityNet Administrators and those who have basic user accounts with the PEPPER Recipient role on or about Mon Apr 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at www.QualityNet.org (see "Getting Started With QualityNet" and "Test Your System"). Additional information about downloading PEPPER from My QualityNet can be found at <http://www.PEPPERresources.org/PEPPER/DownloadingPEPPER.aspx> (includes System Set-up and Test Guide, Troubleshooting Tips, and a guide for Configuration Changes for Compatibility with QualityNet). CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting www.QualityNet.org and clicking on the "Hospitals – Inpatient" link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

TMF will conduct a web-based training session for CAH staff providing information on PEPPER and how to use it on Thu Apr 28 at 1 pm CT. To register for the training, CAH staff should visit <https://TMFevents.webex.com>; the training will be recorded and posted on <http://www.PEPPERresources.org>.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the [PEPPER website](#). CAH staff are encouraged to join the email list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Final Reminder! Time Is Running Out – Have You Responded to the MCPSS? [[↑](#)]

Do you have any thoughts on your interactions with the services you experience with your Medicare contractors? Have any feedback, positive or constructive, to give CMS about your experiences with your contractors?

Don't miss your chance to tell! Your opportunity to participate in the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly coming to an end and CMS still needs your feedback. If you have already responded to the 2011 MCPSS, thank you; if you haven't, don't pass up this golden opportunity to let your voice be heard.

If you or your office received notification from CMS that you were randomly selected to participate in the 2011 MCPSS, this is your last chance to respond before the survey closes. Your feedback is very important. The MCPSS is your opportunity to tell CMS about your satisfaction with the processing and payment services you receive from us.

Completion of the survey should only take a few minutes, and can be done by yourself or your designee; just follow the instructions in your survey invitation. (If you do not have your invitation letter, contact the MCPSS Provider Helpline today at 800-654-1431 or mcps@scimetrika.com for assistance.) CMS will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law. (Note that only providers and suppliers who have been randomly selected and notified can

participate in the 2011 MCPSS.)

For more information about the MCPSS, please visit <http://www.CMS.gov/MCPSS>.

New Information to Improve Patient Safety at America's Hospitals [[↑](#)]

The *Hospital Compare* website now offers new data about hospital-acquired conditions at more than 4700 hospitals across the nation. For the first time, Medicare patients can see how often hospitals report serious conditions that develop during an inpatient hospital stay and possibly harm patients with important new data about the safety of care available in America's hospitals added today to CMS's *Hospital Compare* website (<http://www.HealthCare.gov/compare>).

"Any potentially preventable complication of care is unacceptable," said CMS Administrator Donald Berwick, MD. "We at CMS are working together with the hospital and consumer community to bring hospital-acquired conditions into the forefront and do all we can to eliminate harm from the very healthcare system intended to heal us."

These serious conditions, also known as hospital-acquired conditions (or HACs), often result from improper procedures followed during inpatient care. This data release shows the number of times a HAC occurred for Medicare fee-for-service patients between October 2008 and June 2010. The numbers are reported as number of HACs per 1000 discharges, and are not adjusted for hospitals' patient populations or case-mix. Independent data from the Institute of Medicine estimates that as many as 98,000 people die in hospitals each year from medical errors that could have been prevented through proper care. Although not every HAC represents a medical error, the HAC rates provide important clues about the state of patient safety in America's hospitals. In particular, HACs show how often the following potentially life-threatening events take place:

- Blood infections from a catheter placed in the hospital;
- Urinary tract infections from a catheter placed in the hospital;
- Falls, burns, electric shock, broken bones, and other injuries during a hospital stay;
- Blood transfusions with incompatible blood;
- Pressure ulcers (also known as bed sores) that develop after a patient enters the hospital;
- Injuries and complications from air or gas bubbles entering a blood vessel;
- Objects left in patients after surgery (such as sponges or surgical instruments);
- Poor control of blood sugar for patients with diabetes.

In total, CMS reports HAC rates for 8 measures, which were selected because they incur high costs to the Medicare program or because they occur frequently during inpatient stays for Medicare patients. Furthermore, HACs usually result in higher reimbursement rates for hospitals when they occur as complications for an inpatient stay because they require more resources to care for the patient with the complication. Lastly, CMS considers HACs to be conditions that could have reasonably been prevented through the use of evidence-based guidelines for appropriate hospital inpatient care. CMS has gathered HAC rates from hospitals since 2007. Since 2008, Medicare has not provided additional reimbursement for cases in which one of the HACs was reported as having developed through the course of a patient's hospital stay.

CMS is working with the members of the Hospital Quality Alliance – a national private-public partnership of hospital, consumer, provider, employer, payer, and government agencies – to make HAC data

accessible to the public in meaningful, relevant, and easily-understood ways that encourage healthcare quality improvement. Later this year, CMS will work with the Alliance and directly with consumers about how to fold HAC data directly into the *Hospital Compare* framework. For now, HAC data is available through a downloadable file linked to the *Hospital Compare* website.

CMS is also working with its Quality Improvement Organization (QIO) contractors and to give hospitals the resources they need to eliminate HACs as much as possible. For instance, QIOs have been working since 2008 with providers across the country to reduce rates of hospital-associated infections, slow rates of pressure ulcers in nursing homes and hospitals, and improve safety and reduce infection for surgery patients. More information about QIOs' efforts is online at <http://www.CMS.gov/QualityImprovementOrgs>.

In addition to information about HACs, *Hospital Compare* reports 25 inpatient and 5 outpatient process-of-care measures, readmission and mortality rates for certain conditions, three children's asthma care measures, and 10 measures that capture patient satisfaction with hospital care. The site also features information about the volume of certain hospital procedures performed and conditions treated for Medicare patients and what Medicare pays for those services.

Consumers have relied on *Hospital Compare* since 2005 to provide information about the quality of care provided in over 4700 of America's acute-care, critical access, and children's hospitals. *Hospital Compare* is one of CMS's most popular websites, receiving about 1 million page-views each month.

To review the HAC data CMS released today, please visit the "Hospital Spotlight" section of *Hospital Compare* online at <http://www.HealthCare.gov/compare>.

Electronic Prescribing (eRx) Incentive Program Update – Avoiding the Adjustment [[↑](#)]

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part-B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part-B PFS-covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part-B PFS-covered professional services. (The payment adjustment does not apply if less than 10% of an eligible professional's or group practice's allowed charges for the Sat Jan 1, 2011 through Thu June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx measure.) Also note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment if (s)he:
 - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Thu June 30, 2011, based on primary taxonomy code in NPPES;
 - Does not have prescribing privileges. Note that (s)he must report G8644 at least one time on an eligible claim prior to Thu June 30, 2011;
 - Does not have at least 100 cases containing an encounter code in the measure denominator;
 - Becomes a successful e-prescriber; and
 - Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.
- Group Practices – For group practices that are participating in eRx GPRO-I or GPRO-II during 2011, the group practice MUST become a successful e-prescriber.
 - Depending on the group’s size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the “Getting Started” webpage at <http://www.CMS.gov/ERXincentive>, or download the “Medicare’s Practical Guide to the Electronic Prescribing (eRx) Incentive Program” under “Educational Resources” on the same website.

Information on Requests for Anticipated Payment Incorrectly Rejected as Untimely for Home Health PPS Episodes of Care [\[↑\]](#)

CMS Change Request #7080 established the policy that for institutional claims that include span dates of service (ie. a “From” and “Through” date span on the claim), the “Through” date on the claim is used to determine the date of service for claims filing timeliness. This policy had an unintended impact on billing home health prospective payment system (HH PPS) episodes of care.

Medicare instructions require the “From” and “Through” dates to be the same date on the Request for Anticipated Payment (RAP) for a HH PPS episode. This means the RAP will have an earlier “Through” date than the associated final claim for the same episode. Since CR #7080 was implemented, RAPs have been rejected as untimely when the associated final claim was still timely. CMS has determined that this is an error and has instructed Medicare contractors to bypass the enforcement of timely filing on RAPs.

Cases have already occurred in which a RAP was incorrectly rejected as untimely and a timely-submitted final claim for the same episode was returned to the provider due to the lack of a corresponding RAP on file. In some cases, these final claims are now past the timely filing deadline. CMS has determined that an administrative error exception to the timely filing requirement applies in these cases. Home health agencies affected by these cases should bring them to the attention of their Medicare contractors, who will bypass timely filing for these claims so they may be processed.

Reprocessing of Federally Qualified Health Centers (FQHCs) Claims [\[↑\]](#)

Effective Sat Jan 1, 2011, Federally Qualified Health Centers (FQHCs) began reporting detailed Healthcare Common Procedure Coding System (HCPCS) codes for all services rendered during the encounter/visit. CMS instructed FQHC providers to submit charges associated with the encounter/visit on a 052X revenue line with an evaluation and management (E&M) HCPCS code.

CMS became aware that coinsurance may not be calculated correctly when claims are submitted with multiple 052X revenue lines on 77x bill types. The FISS has been updated to ensure coinsurance is applied to the 052x revenue line containing the E&M HCPCS code.

Please contact your Medicare contractor and identify any claims that have been processed incorrectly as outlined above. Your contractor will adjust all claims brought to their attention.

Updates to Test Codes in Clinical Laboratory Fee Schedule [\[↑\]](#)

CMS is updating the status of two codes on the Clinical Laboratory Fee Schedule (CLFS), both effective Fri Apr 1, 2011:

- Code G0431QW is deleted from the CLFS. Code G0431 describes a high-complexity test, and should not be reported with a QW modifier; the QW modifier indicates a CLIA-waived test.
- Code G0434QW is added to the CLFS. Code G0434 can describe a CLIA-waived test. The use of the QW modifier to indicate a CLIA-waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

Information for Institutional Providers Regarding the Billing of Codes for Preventive Services [\[↑\]](#)

CMS has identified a Medicare claims processing system issue that is causing certain preventive services rendered in an institutional setting to be processed incorrectly. The following describes the action that will be taken by Medicare claims administration contractors:

- Preventive service codes listed in Change Request #7012 and surgical procedure codes 10000-69999 furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services with dates of service on and after Sat Jan 1, 2011, were suspended due to deductible and coinsurance being erroneously applied. A partial correction for this problem was implemented on Mon April 4, 2011.
- Outpatient claims containing Hepatitis B vaccines codes 90740-90747 submitted on type of bill 13X with dates of service on or after Sat Jan 1, 2011, are suspending if they are the only service on the claim. Also, claims containing Hepatitis B vaccine services are not being paid when other services are billed on the same claim. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. Medicare providers will be notified of this correction via listserv message.
- Outpatient Prospective Payment System (OPPS) claims containing codes G0402, G0389, Q0091, G0101, G0130, 77078, 77079, 77080, 77081, 77083, 76977, G0104, G0105, G0106, G0120, G0121, G0008, G9141, G0009, G0436, and G0437 submitted on type of bill 13X with dates of service on or after Sat Jan 1, 2011, are erroneously applying deductible and coinsurance. Medicare contractors have been instructed to hold claims impacted by this problem. A software correction is scheduled for Mon May 9, 2011.

As these software corrections are made, Medicare contractors will release any suspended claims and automatically reprocess claims for preventive services and claims for surgical services billed with a PT modifier (bullet #1, above) that have been paid incorrectly or erroneously applied deductible or coinsurance. Most reprocessing will be completed by Tue May 31, 2011; however, claims being suspended for surgical services billed with a PT modifier (bullet #1) reimbursed under OPPS will be released with the implementation of the

IOCE software in July 2011. Reprocessing of claims that have been paid incorrectly for this issue will be completed by Sun July 31, 2011. For further information, please review [MLN Matters Article #MM7012](#), issued on Wed Mar 2.

Updated October 2010 and January 2011 Average Sales Price Files Now Available [\[↑\]](#)

CMS has posted revised October 2010 and January 2011 Average Sales Price (ASP) pricing files online, which are available for download at <http://www.CMS.gov/McrPartBDrugAvgSalesPrice>.

Implementation of Errata for Version 5010 of HIPAA Transactions and Updates in 837I, 837P, and 835 Flat Files – Priority (Type) of Admission or Visit Code and Reason Code 11701 [\[↑\]](#)

CMS does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The Priority (Type) of Admission or Visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (Information not Available). Additional Priority (Type) of Admission or Visit code values and descriptions are available from the National Uniform Billing Committee (www.NUBC.org) or from your servicing MAC. The Priority (Type) of Admission or Visit code is not required on 4010A1 institutional claims submitted or corrected via an 837.

For more information on Version 5010, please visit <http://www.CMS.gov/Versions5010andD0>.

From the MLN: “Mental Health Services” Booklet – New [\[↑\]](#)

A new publication titled “Mental Health Services” is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

From the MLN: “Ambulance Fee Schedule” Fact Sheet Revised [\[↑\]](#)

The revised publication titled “Ambulance Fee Schedule” (revised March 2011) is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf. This fact sheet is designed to provide education about the Ambulance Fee Schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

From the MLN: “Health Professional Shortage Area” Fact Sheet Revised [\[↑\]](#)

The revised publication titled “Health Professional Shortage Area” (revised March 2011) is now available in downloadable format from the **Medicare Learning Network**® at

<http://www.CMS.gov/MLNProducts/downloads/HPSAfactsht.pdf>. This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

From the MLN: “Medicare Disproportionate Share Hospital” Fact Sheet Revised [↑]

The revised publication titled “Medicare Disproportionate Share Hospital” (revised March 2011) is now available in downloadable format at

http://www.CMS.gov/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH) including background; methods to qualify for the Medicare DSH adjustment; *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and *Deficit Reduction Act of 2005* provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

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