

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



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BENEFIT
ADMINISTRATORS.LLC

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com



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Disclaimer

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Medicare Advantage Plan Directory

If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the CMS Web site. CMS updates this site on a monthly basis.



National Provider Identifier (NPI) News

During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf. Additional information can be found at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS Web site.



National Provider Identifier (NPI) News – Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. Additional information can be found at the CMS NPI Web site at: <http://www.cms.hhs.gov/NationalProvIdentStand/>



Medicare Learning Network (MLN) products

News Flash - Want to know when the latest Medicare Learning Network (MLN) products are available? By subscribing to the MLN_EDUCATION_PRODUCTS-L listserv you will receive e-mail notifications of new and updated MLN products. To subscribe to the MLN_EDUCATION_PRODUCTS-L listserv or to any of the many other CMS listservs, go to the CMS Mailing Lists Web page at <http://www.cms.hhs.gov/apps/mailinglists/> and sign up today.



Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's Web site: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0667.pdf>



Educational Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals educational video program, provides information on Medicare-covered preventive services, risk factors associated with various preventable diseases, and highlights the importance of prevention, detection, and early treatment of disease. The program is an excellent resource to help physicians, providers, suppliers, and other health care professionals learn more about preventive benefits covered by Medicare. Running approximately 75 minutes in length, the program is suitable for individual viewing or for use in conjunction with a conference or training session. To order your copy today, go to the Medicare Learning Network Product Ordering page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site. Available in DVD or VHS format.



News Flash - Rejected Claims Reminder

Fee-for-Service Medicare claims can be rejected by Medicare contractors (carriers, intermediaries (FIs), and Medicare administrative contractors (MACs)) for a variety of reasons including: incorrect billing information, terminated provider, the beneficiary is not eligible for Medicare or the claim was sent to the wrong contractor. If a provider has questions about a claim rejected by an FI/carrier or MAC, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.



DMEPOS Bidding Submission Deadline Extended

News Flash - The Centers for Medicare & Medicaid Services (CMS) is extending the bid submission deadline for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. All bids are due by 9:00 p.m. prevailing Eastern Time on July 27, 2007. The contract period for mail order diabetic supplies is April 1, 2008 – December 31, 2009. The contract period for all other first round product categories is April 1, 2008 – March 31, 2011. Suppliers must be accredited or have pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. Suppliers interested in bidding must have first registered to receive a User ID and Password before they could access the internet-based bid submission system. Suppliers who did not register cannot submit bids. The registration deadline was June 30, 2007. For more information on the program as well as bidding and accreditation information, please visit <http://www.dmecompetitivebid.com> or <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS>.



Medicare Disproportionate Share Hospital Fact Sheet Available

The revised (March 2007) Medicare Disproportionate Share Hospital Fact Sheet, which provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment and Medicare DSH payment adjustment formulas, is now available on the CMS Medicare Learning Network at : <http://www.cms.hhs.gov/MLNProducts/downloads/2007mdsh.pdf>

News from CMS For All Providers



UPDATE! Dissemination of Data from the National Plan and Provider Enumeration System (NPPES) to Begin September 4, 2007

NPPES health care provider data that is disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI Registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.

We must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI Registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits no later than Monday, August 20, 2007. Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

Health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007 (found on the CMS NPI Web page at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf) for assistance in making their edits. Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, OR 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)

The delay in the dissemination of NPPES data does not alter the requirement that HIPAA covered entities must comply with the requirements of the NPI Final Rule no later than May 23, 2008. All NPI contingencies that may be in place must be lifted by that date.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS Web site. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI is free - not having one can be costly.



Timeliness Standards for Processing ‘Other-Than-Clean’ Claims

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5513

Related CR Release Date: July 20, 2007

Related CR Transmittal #: R1312CP

Related Change Request (CR) #: 5513

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), DME Medicare administrative contractors (DME MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on CR 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

CAUTION – What You Need to Know

CMS published instructions in a separate transmittal to implement requirements for all carriers and MACs for timeliness standards for processing other-than-clean claims, and CR 5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

GO – What You Need to Do

See the “Background” and “Additional Information” sections of this article for further details regarding these requirements.

Background

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that Medicare process all “other-than-clean” claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section

1869; http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) further defines the term “clean claim” as meaning “a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.” Claims that do not meet the definition of “clean” claims are “other-than-clean” claims, and they require investigation or development external to the contractor’s Medicare operation on a prepayment basis.

A Medicare contractor should process all “other-than-clean” claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See *Medicare Claims Processing Manual*, CMS Pub. 100-04, Ch. 1, §80.2.1 for the definition of “receipt date” and for timeliness standards for clean claims; <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>)

However, when the Medicare contractor develops the ‘other-than-clean’ claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

EXAMPLE:

A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier and/or beneficiary until June 5th. In this example, 5 of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and/or beneficiary does not respond.

This timeliness standard does not apply:

- Where the Social Security Administration blocks a beneficiary’s Health Insurance Claim Number (HICN);
- Where there is a problem with the beneficiary’s record in Medicare’s files are not subject to this instruction;
- Where the claim is rejected by the translator software;
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- To claims submitted by a hospice and these claims are to be processed per instructions in the *Medicare Claims Processing Manual* (CMS Pub 100-04, Ch. 1, §50.2.3; <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>)

Additional Information

The official instruction, CR 5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Medicare’s Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network (MLN) Special Edition* article entitled “Medicare’s Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities,” which was published in the November 1, 2005, *Medicare A Newslines*. This *MLN Matters Special Edition* article can be found on the CMS Web site at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf>

This article was revised on August 7, 2007, to delete a reference to the NPI viewlet, which is no longer available on the CMS Web site. Previously, the article was revised on May 18, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Web site.



The 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Positive Results for Medicare’s Fee-for-Service Contractors

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This *Special Edition MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0733

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs)), Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs)).

Background

CMS reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with “1” representing “not at all satisfied” and “6” representing “completely satisfied.” The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor’s handling of provider inquiries surpassed claims processing as the key predictor of a provider’s satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at <http://www.cms.hhs.gov/MCPSS> on the CMS Web site.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.



Clarification About the Medical Privacy of Protected Health Information

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This *Special Edition MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0726

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The purpose of this *Special Edition (SE)* article, SE0726, is to be sure that health care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance

HHS' educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at <http://www.hhs.gov/hipaafaq/> on the HHS Web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at <http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf> on the HHS Web site.
- Review the "Summary of the HIPAA Privacy Rule" at <http://www.hhs.gov/ocr/privacysummary.pdf> on the HHS Web site.

HIPAA does not require providers to eliminate all incidental disclosures:

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at <http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf> on the HHS Web site.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the HHS/OCR Web site FAQs <http://www.hhs.gov/hipaafaq/notice/488.html> in the sub-category "Disclosures to Family and Friends."

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at <http://www.hhs.gov/hipaafaq/administrative/> on the HHS Web site.

HIPAA does not prevent child abuse reporting:

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at <http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf> on the HHS Webs ite.

HIPAA is not anti-electronic:

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at <http://www.hhs.gov/hipaafaq/providers/smaller/482.html> on the HHS Web site.

Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available at <http://www.hhs.gov/ocr/hipaa/> on the HHS Web site.

For a full list of educational materials, visit <http://www.hhs.gov/ocr/hipaa/assist.html> on the HHS Web site.

Disclaimer

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Important Guidance on the New CMS-1500 and UB-04 Forms

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This *Special Edition MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0729

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This *MLN Matters* article, SE0729, provides you valuable information about the new CMS-1500 and UB-04 forms.

Background

CMS Form 1500 Version 08-05

In 2006, CMS introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the National Provider Identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however, formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at <http://www.nucc.org/>, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

Some important details in completing the new CMS-1500 form are as follow:

- If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading *MLN Matters* article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You can find that article at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>

UB-04 Information

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the NPI taxonomy, and additional codes; and is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007, (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.

- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your contractor will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.
- For the UB-04, the billing provider's NPI is entered in Form Locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading *MLN Matters* article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You can find that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf>. The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Ch. 25 (Completing and Processing the CMS 1450 Data Set), §§70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at: <http://www.nubc.org/>

Additional Information

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This *Special Edition MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0728

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Background

In *MLN Matters* article, MM3709, CMS describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM3709 may be referenced at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf> on the CMS Web site.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:

Dispute Reason Codes:

- 000100 – Duplicate Claim
- 000110 – Duplicate Claim (within the same ISA – IEA loop)
- 000120 – Duplicate claim (within the same ST-SE loop)
- 000200 – Claim for Provider ID/State should have been excluded
- 000300 – Beneficiary not on eligibility file
- 000400 – Reserved for future use
- 000500 – Incorrect claim count
- 000600 – Claim does not meet selection criteria
- 000700 – HIPAA Error
- 009999 – Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

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Institutional Value Code Changes—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Institutional Value Code Changes,” which was published in the March 1, 2007, *Medicare A Newslines*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5411

Related CR Release Date: January 19, 2007

Related CR Transmittal #: R261OTN

Related Change Request (CR) #: 5411

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Note: This article was revised on July 24, 2007, to add clarifying language regarding the use of value codes on adjustments. (See paragraph 3 of the Background section.) All other information remains the same.

Provider Types Affected

Providers who bill fiscal intermediaries (FI), Part A/B Medicare administrative contractors (A/B MACs), or regional home health intermediaries (RHHIs) for Medicare services.

What You Need to Know

Value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are now restricted to use only in paper claims, and are no longer available for use on X12N 837 institutional claim transactions.

Background

The National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims only. These value codes are no longer available for use on X12N 837 institutional claim transactions

Your Medicare FI, RHHI, or A/B MAC will create edits to restrict the use of these value codes to paper claims, and to not allow their use on direct data entry claims. Further, Medicare will ensure that any paper claim data from value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 are migrated to the appropriate X12N 837 2320

Claim Level Adjustment (CAS) segment (claim adjustment reason code “PR”) for coordination of benefits files.

Note that CR 5411 does not say that adjustments that might previously be reported on an electronic claim using the value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 must now all be reported in the claim level CAS. Requirements already in the 837-I Implementation Guide that apply to reporting of adjustments in either the claim or the service level CASs apply when submitting initial electronic claims that involve such adjustments.

Additional Information

You can find the official instruction, CR 5411, issued to your FI, A/B MAC, or RHHI by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R261OTN.pdf> on the CMS Web site

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Claim Status Category Code and Claim Status Code Update

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5687

Related CR Release Date: July 23, 2007

Related CR Transmittal #: R1314CP

Related Change Request (CR) #: 5687

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed

STOP – Impact to You

This article is based on CR 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

CAUTION – What You Need to Know

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the <http://www.wpc-edi.com/codes> Web site. Chapter 31 of the *Medicare Claims Processing Manual*, §20.7 –

“Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277” discusses these codes in more detail. You may review §20.7 at: <http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf> on the CMS Web site.

GO – What You Need to Do

See the “Background” section of this article for further details.

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim’s status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/content/view/180/223/>. This Web page <http://www.wpc-edi.com/codes> has previously been referenced. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least six months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008.**

Additional Information

For complete details regarding this CR please see the official instruction (CR 5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates—**Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates,” which was published in the August 1, 2007, *Medicare A Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5597 Revised

Related Change Request (CR) #: 5597

Related CR Release Date: July 13, 2007

Effective Date: May 23, 2007

Related CR Transmittal #: R20COM

Implementation Date: July 30, 2007

Note: This article was revised on July 16, 2007, to reflect changes that CMS made to CR 5597. The transmittal number, CR release date, and the Web address for accessing CR 5597 were changed. All other information remains the same.

Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs), DME Medicare administrative contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).]

Provider Action Needed

CR 5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the CMS requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR 5597, for complete details about these rules under the Medicare NPI contingency plan, see *MLN Matters* article SE0721, which you will find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf> on the CMS Web site.**

The remainder of this article provides information on the highlights of changes announced in CR 5597.

Background

CR 5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, CMS Pub. 100-09. These changes are summarized as follows:

Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.

- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare’s Common Working File (CWF) system, refer to the *Medicare Claims Processing Manual*, Ch. 27, §50 at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf> on the CMS Web site.

Information Available on the IVR

- **USE THE IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)

- **USE THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp on the CMS Web site.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, “Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers,” which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.
- Also available is a Web site that serves as a resource allowing providers to check the definitions of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. This information is available at <http://www.wpc-edi.com/products/codelists/alertservice> on the Washington Publishing Company Web site.
- The web-based training courses, “Understanding the Remittance Advice for Professional Providers,” and “Understanding the Remittance Advice for Institutional Providers,” are available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS Web site. The courses provide continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to Part B providers for viewing ERAs.

Authentication of Beneficiary Elements—additions to current rules.

CR 5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR 5597 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf> on the CMS Web site.

Additional Key Points of CR 5597

- Medicare’s CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

Additional Information

For complete details regarding this CR please see the official instruction (CR 5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf> on the CMS Web site.

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Rules of Behavior Governing Medicare Eligibility Inquiries

The Centers for Medicare & Medicaid Services (CMS) has been advised that hospitals may be violating the rules of behavior associated with using the Medicare 270/271 eligibility systems in their attempts to determine Medicare beneficiary eligibility for the purpose of calculating hospital patient days for Disproportionate Share Hospitals (DSH) adjustments. For that reason, the following *Medicare Learning Network* (MLN) article, which was previously, published in the February 1, 2007, *Medicare A Newslines* is being republished. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5431

Related CR Release Date: January 8, 2007

Related CR Transmittal #: R1149CP

Related Change Request (CR) #: 5431

Effective Date: January 1, 2007

Implementation Date: April 2, 2007

Provider Types Affected

All providers and suppliers, including their third party billing agents or clearinghouses, who submit eligibility inquiries to Medicare.

Provider Action Needed

STOP – Impact to You

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. If you, or your biller, do not adhere to these rules of behavior and/or other CMS data privacy and security rules, you could incur revocation of access to the data as well as other penalties.

CAUTION – What You Need to Know

CR 5431, from which this article is taken, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and also delineates CMS's expectations for provider and clearinghouse use of the HIPAA 270/271 extranet application.

GO – What You Need to Do

Read the key points from CR 5431 in the "Background" section, below, and make sure that your staffs read the manual section (*Medicare Claims Processing Manual* (CMS Pub. 100-04), Ch. 31 ("ANSI X12N Formats Other than Claims or Remittance"), §10.3 ("Eligibility Rules of Behavior")), attached to CR 5431. (See "Additional Information," below, for instructions in locating CR 5431.)

Background

Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CR 5431, upon which this article is based, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and outlines CMS's expectations for providers and clearinghouses that use the HIPAA 270/271 extranet application.

In October 2005, CMS began offering to Medicare providers and clearinghouses, the HIPAA 270/271 beneficiary eligibility transaction, real-time, via the CMS AT&T communication Extranet; and in June 2006, began to pilot an internet application for eligibility information. Over time, this application will be available to an increasing number of Medicare providers.

Please keep in mind that the Medicare Electronic Data Interchange (EDI) enrollment process (which collects the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners, and establishes the data exchange expectations for both), must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party (a billing agent or clearinghouse).

First, here are the key points, from the CR, that address your responsibilities in dealing with beneficiary eligibility data.

- The HIPAA Privacy Rule mandates the protection and privacy of all health information, and specifically defines the authorized uses and disclosures of "individually-identifiable" health information. CMS is committed to maintaining the integrity and security of health care data in accordance with the applicable laws and regulations.

- You should always remember that Medicare eligibility data is to be used for Medicare business only, and that providers and their staffs are expected to use, and disclose, this protected health information according to the CMS regulations.
- Authorized purposes for requesting beneficiary Medicare eligibility information include:
 - To verify eligibility, after screening the patient to determine Medicare Part A or Part B eligibility;
 - To determine beneficiary payment responsibility with regard to deductible/co-insurance;
 - To determine eligibility for services such as preventive services;
 - To determine if Medicare is the primary or secondary payer;
 - To determine if the beneficiary is in the original Medicare plan, Part C plan (Medicare Advantage) or Part D plan; and
 - To determine proper billing.

Conversely, examples of unauthorized purposes for requesting beneficiary Medicare eligibility information include:

- To determine eligibility for Medicare without screening the patient to determine if they are Medicare eligible; or
- To acquire the beneficiary's health insurance claim number.

In dealing with Medicare beneficiary eligibility information, you and your employees/staff must:

- Ensure sufficient security measures exist to associate a particular transaction with a particular staff member or employee before requesting the information;
- Cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry;
- Promptly inform CMS or one of CMS's contractors (e.g., your carrier, fiscal intermediary (FI), or Part A/B Medicare administrative contractor (A/B MAC)) if you identify misuse of "individually-identifiable" health information accessed from the CMS database; and
- Limit each inquiry for Medicare beneficiary eligibility data to that for a patient that you are currently treating/serving, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Penalties

- HHS may impose civil money penalties on a HIPAA-covered entity of \$100 per failure to comply with a privacy rule requirement (not to exceed \$25,000 per year for multiple violations of the identical privacy rule requirement in a calendar year).
- Further, a person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA or a trading partner agreement under 42 U.S.C 1320d-6 faces a fine of \$50,000 and up to one-year imprisonment (increasing to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm).
- Under the False Claims Act, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

CR 5431 also discusses CMS' expectations for providers and clearinghouses who use the HIPAA 270/271 extranet application. A synopsis of this discussion follows.

For Providers

In order to access and use this system, you will need to 1) Register, on line, in IACS (Individual Authorized Access to CMS Computer Services) and provide your social security number and e-mail address so that the system can identify you and communicate with you through email, if necessary; and 2) Adhere to basic desktop security measures and to the CMS computer systems security requirements in order to ensure the security of Medicare beneficiary personal health information.

You will also be required to adhere to the security requirements for users of CMS computer systems and to the basic desktop security measures to ensure the security of Medicare beneficiary personal health information. You must not:

- Disclose or lend your identification number and/or password to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Browse or use CMS data files for unauthorized or illegal purposes.
- Use CMS data files for private gain or to misrepresent yourself or CMS.
- Make any disclosure of CMS data that is not specifically authorized.

As mentioned earlier, violation of these security requirements could result in termination of system access privileges and/or disciplinary/adverse action up to and including legal prosecution.

For Clearinghouses

CMS allows the release of eligibility data to third parties (providers' authorized billing agents or clearinghouses) for the purpose of preparing an accurate Medicare claim or determining eligibility for specific services.

In order to receive such access on behalf of providers, billing agents/clearinghouses must adhere to the following rules:

- Such entities may not submit an eligibility inquiry except as a health care provider's authorized, and through a business associate contract with the provider;
- Each provider that contracts with a billing agent/clearinghouse must sign a valid EDI enrollment form and be approved by a Medicare contractor before eligibility data can be sent to the third party;
- Each billing agent/clearinghouse must sign appropriate agreement(s) (i.e. Rules of Behavior, Trading Partner Agreement and Attestation Form) directly with CMS and/or one of CMS's contractors; and
- The billing agent/clearinghouse must be able to associate each inquiry with the provider or billing service making the inquiry.

Additional Information

You can find more information about the rules of behavior with respect to obtaining, disseminating, and using beneficiary's Medicare eligibility data by going to CR 5431, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1149CP.pdf> on the CMS Web site; and reading the attached *Medicare Claims Processing Manual* (CMS Pub. 100-04), Ch. 31 ("ANSI X12N Formats Other than Claims or Remittance"), §10.3("Eligibility Rules of Behavior").

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Home Health & Hospice Medicare A Newsline*.

Disclaimers

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Processing Requirements for Claims for Medicare Beneficiaries in State or Local Custody Under a Penal Authority

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4(b), respectively.

Regulations at 42 CFR 411.4(b) state that “Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody; and
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.”

The Centers for Medicare & Medicaid Services (CMS) established claim level editing using data received from the Social Security Administration (SSA). Specifically, the data contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will provide the Medicare contractor with the date span covered.

Policy

As indicated above, Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute according to regulations at 42 CFR 411.4(b). Therefore, items and services furnished to beneficiaries in state or local government custody will be denied.

However, providers and suppliers that provide services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of a condition code 63.

For additional information, refer to the *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 1, §10.4. This manual is available on the CMS Web site at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>



Correct Reporting of Diagnosis Codes on Screening Mammography Claims—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Correct Reporting of Diagnosis Codes on Screening Mammography Claims,” which was published in the June 1, 2007, *Medicare A Newslines*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5050 Revised

Related Change Request (CR) #: 5050

Related CR Release Date: April 28, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R916CP

Implementation Date: October 2, 2006

This article was revised on July 27, 2007 to add a reference to CR 5377. MM5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACs as an appropriate bill type for such services.

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR 5050 updates Ch. 18, §20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It **removes 12X type of bill (TOB)** from the list of applicable TOBs for diagnostic mammography; (See **Note above**.)
- It **adds HCPCS code G0202** to the list of valid codes for the billing of screening mammography; and
- It **adds HCPCS codes G0204 and G0206** to the list of valid codes for the billing of diagnostic mammographies.

Background

CMS is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

Implementation

The implementation date for this instruction is October 2, 2006.

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf> on the CMS Web site. The revised §20.4 of Ch.18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

To view the instruction (CR 5377) that reversed the removal of TOB 12X, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf> on the CMS Web site. The related *MLN Matters* article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Revised Information on PET Scan Coding

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5665

Related CR Release Date: July 20, 2007

Related CR Transmittal #: R1301CP

Related Change Request (CR) #: 5665

Effective Date: January 28, 2005 and January 1, 2008 (per article)

Implementation Date: January 7, 2008

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MACs)) for Positron Emission Tomography (PET) Scan services for Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective for services on and after January 28, 2005, your carrier, FI, or A/B MAC will deny claims for PET Scan services that contain CPT code 78609 and they will deny claims for PET Scan services on or after January 1, 2008, that contain HCPCS code A4641.

CAUTION – What You Need to Know

CR 5665, from which this article is taken, corrects erroneous information that was originally issued in CR 3741, transmittal 527 (New Coding for FDG PET Scans and Billing Requirements for Specific Indications of Cervical Cancer), dated April 15, 2005. CR 5665 updates *Medicare Claims Processing Manual*, Ch. 13, §§60.30.1 and 60.30.2 by removing HCPCS code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans.

GO – What You Need to Do

Make sure that your billing staffs are aware of these code changes and submit only covered codes in your claims for PET Scan services.

Background

CMS recently learned that the *Medicare Claims Processing Manual*, Ch. 13 (Radiology Services), §60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and §60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding CPT code 78609 (PET for brain perfusion imaging) and HCPCS code A4641.

- In §60.3.1, CPT code 78609 is incorrectly listed as a covered service by Medicare, and in §60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, §60.30.2 incorrectly lists HCPCS code A4641 as an applicable tracer for PET Scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing HCPCS code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects the erroneous information that was originally issued in CR 3747.

Notes: 1) All Positron Emission Tomography (PET) Scans services (codes 78459, 78491, 78492, 78608, and 78811-78816) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.

2) The correct PET Scan CPT codes and tracer HCPCS codes are listed in Tables 1 and 2, below.

Key points in CR 5665

- Effective January 28, 2005, CPT 78609 became a noncovered service for Medicare;
- Carriers, FIs, and A/B MACs will deny claims submitted with CPT code 78609 (effective January 28, 2005);
- When denying these claims, they will use:
 - Medicare Summary Notice (MSN) 16.10 “Medicare does not pay for this item or service.”
 - Claim Adjustment Reason Code 96: “Non-covered charge.”
 - Remittance Advice Remark Codes N386: —“This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

- Effective January 1, 2008, HCPCS code A4641 is not an applicable tracer for PET Scans;
- You should not report HCPCS code A4641 when submitting claims for PET Scans for services on or after January 1, 2008. Instead, as of that time, when submitting claims for PET Scans containing CPT code 78491 or 78492 you should use only tracer code A9555 or A9526; and, when submitting claims for PET Scans containing CPT code 78459, 78608, or 78811-78816, you should use only tracer code A9552 (see table 2, below).
- Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

The following tables list the currently covered PET Scan CPT codes (on or after January 28, 2005), and tracer HCPCS codes as of January 1, 2008.

Table 1
Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005

CPT Code	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body
NOTE: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See Table 2, below, for applicable tracer codes.	

Table 2

Tracer Codes Required for PET Scans on or after January 1, 2008 (A4641 is allowed for services on or before December 31, 2007)

<i>The following tracer codes are applicable only to CPT 78491 and 78492. They can not be reported with any other code.</i>	
Institutional providers billing fiscal intermediaries or A/B MACs	
HCPCS Code	Description
*A9555	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries
* Q3000 (Deleted effective 12/31/05)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13
*NOTE: For claims with dates of service prior to 1/01/06, providers report Q3000 for supply of radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82. For claims with dates of service 1/01/06 and later, providers report A9555 for radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82 in place of Q3000.	
Physicians/practitioners billing carriers or A/B MACs	
*A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13
A9555	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries
*NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.	
The following tracer codes are applicable only to CPT 78459, 78608, 78811-78816. They cannot be reported with any other code:	
Institutional providers billing fiscal intermediaries or A/B MACs	
* A9552	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries
* C1775 (Deleted effective 12/31/05)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18
**A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
*NOTE: For claims with dates of service prior to 1/01/06, OPPS hospitals report C1775 for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18. For claims with dates of service 1/01/06 and later, providers report A9552 for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of C1775.	
**NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.	

Physicians/practitioners billing carriers or A/B MACs

A9552	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries
*A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified

***NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.**

Additional Information

You can find more information about PET Scan codes by going to CR 5665, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1301CP.pdf> on the CMS Web site. You will find the updated *Medicare Claims Processing Manual*, Ch. 13 (Radiology Services), §§60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans) as an attachment to that CR.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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News from CMS for Hospital/CAH and SNF/SB Providers



Limitation on Charges for Services Furnished by Medicare Participating Hospitals to Individuals Eligible for Care through Indian Health Service (IHS) Programs

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This *Special Edition MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0734

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Medicare participating hospitals and skilled nursing facilities servicing individuals eligible for care through Indian Health Service (IHS) health programs.

What You Need to Know

This article was developed from the *Federal Register*, Volume 72, No. 106, Monday, June 4, 2007, and provides you information about a new regulation that may impact your payments for providing services through Indian health programs.

Effective July 5, 2007, all Medicare-participating hospitals that furnish inpatient services authorized by IHS, Tribal, and urban Indian organization entities, must accept no more than the rates of payment, discussed below, plus the usual Medicare coinsurance amount, as payment in full.

Background

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires hospitals that furnish any Medicare-payable inpatient hospital medical care services, to participate in both:

- The contract health services (CHS) program of the IHS operated by the IHS, Tribes, and Tribal organizations; and
- IHS-funded programs operated by urban Indian organizations. All of these programs are collectively referred to as I/T/Us, for any care that these programs purchase.

For purposes of this program, a hospital is defined as all hospitals that participate in Medicare, including any hospital clinics located off-site and critical access hospitals (CAHs), to include:

- Acute care hospitals,
- Distinct parts of inpatient hospitals (rehabilitation facilities, psychiatric facilities),
- Hospital based clinics,
- Psychiatric hospitals,
- Rehabilitation hospitals,
- Long term care hospitals,
- Critical access hospitals (including rehabilitation and psychiatric units paid under a prospective payment system (PPS) located within),
- Children's hospitals,
- Cancer hospitals, and
- Skilled nursing facilities (SNFs) & swing beds.

Section 506 also requires such participation to be in accordance with the admission practices, payment methodology, and payment rates set forth in Department of Health and Human Services (DHHS) regulations, including accepting these payment rates as payment in full. Specifically, effective July 5, 2007, all Medicare-participating hospitals that furnish inpatient services must accept no more than the rates of payment under the calculation, described below, as payment in full for all items and services authorized by IHS, Tribal, and urban Indian organization entities.

Further, this payment methodology applies to all levels of care, furnished by a Medicare-participating hospital, that is authorized by a contract health service (CHS) program of the IHS; or authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, or that an urban Indian program authorizes for purchase. This includes care provided as inpatient, outpatient, or skilled nursing facility care; as well as other services of a department, subunit, distinct part, or other hospital component (including services the hospital furnishes directly or under arrangements)

Basic Payment Determination/Methodology

1. Prospective Payment System (PPS)

Under this new rule, the basic payment determination for hospital services that Medicare would pay for under a PPS is based on that particular PPS. For example, inpatient hospital services of acute care hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals will be paid based on the same PPS systems Medicare uses to pay for similar hospital services under 42 CFR, part 412.

Similarly, outpatient hospital services and SNF care will be paid based on the PPS systems that Medicare uses to pay for those services under 42 CFR part 419 and 42 CFR part 413, respectively.

2. Reasonable Costs

Medicare participating hospitals that furnish inpatient services but are exempt from inpatient PPS and receive reimbursement based on reasonable costs (for example, CAHs, children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements) will be paid per discharge based on the reasonable cost methods established under 42 CFR part 413 (except that the interim payment rate under 42 CFR part 413, subpart E constitutes payment in full for authorized charges).

3. Coinsurance

CHS programs will continue to pay the equivalent of Medicare coinsurance.

The I/T/Us' payment calculations will be based on these determinations consistent with the CMS instructions to FIs/MACs at the time the claim is processed. For inpatient services, I/T/Us will pay a providing hospital the full PPS based rate (or the interim reasonable cost rate) without reduction for any co-payments, coinsurance, and deductibles that the Medicare program requires patients to contribute. Similarly, for outpatient, or Part B services, IHS/CHS will pay both the Medicare and beneficiary's portion of the payment, so that, in either instance, the hospital will get 100 percent of whatever the Medicare rate is for the service provided.

Note that if the I/T/U has negotiated a payment amount with a hospital or its agent, the I/T/U will pay the lesser of the negotiated amount, or the amount determined from Basic Determination (above) (including, but not limited to, capitated contracts or contracts per Federal law requirements).

You should be aware that in addition to the amount payable for authorized inpatient services (described above), payments will also include an amount to cover (to the extent such costs would be payable if the services had been covered by Medicare):

- The organ acquisition costs that hospitals with approved transplantation centers incur;
- Direct medical education costs;
- Units of blood clotting factor furnished to an eligible hemophiliac patient; and
- The costs of qualified non-physician anesthetists.

These payments will be made on a per discharge basis and will be based on standard payments that CMS or its FIs/MACs establish.

There are other specific details about this program that you should know about, i.e.:

- If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payer, the I/T/U: 1) Will be the payer of last resort; 2) Will pay the amount that the patient is responsible for (after the provider of services has coordinated benefits and all other alternative resources have been considered and paid), including

applicable co-payments, deductibles, and coinsurance that the patient owes; 3) Will pay only that portion of the payment amount not covered by any other payer; 4) Payment will not exceed the rate calculated in the Payment Methodology section (above), or the contracted amount (plus applicable cost sharing), whichever is less; and 5) Will make no additional payment to that made by Medicaid, (except for applicable cost sharing), as Medicaid payment is considered payment in full.

Note: Payments made for these services are considered payment in full, and a hospital or its agent may not impose any additional charge on the patient for any I/T/U authorized items and services, or for information that the I/T/U, its agent, or the FI/MAC request to determine payment or for quality assurance use.

- If it is determined that a hospital has submitted inaccurate information for payment (such as admission, discharge, or billing data), an I/T/U may (as appropriate): 1) Deny payment for these services (in whole or in part), and; (2) Disallow costs previously paid. Further, if for cost-based payments previously issued, it is determined that actual costs fall significantly below the computed rate actually paid, the computed rate may be retrospectively adjusted. The recovery of overpayments made as a result of the adjusted rate, or of payments made in error, may be accomplished by any method authorized by law.
- For a hospital (or its agent) to be eligible for payment from Indian health programs, it must submit the claim for authorized services: 1) On a UB-04 paper claim form or the HIPAA 837 electronic claim format ANSI X12N, version 4010A1 and include the hospital's Medicare OSCAR number/National Provider Identifier; 2) To the I/T/U, agent, or fiscal intermediary the I/T/U identifies in the agreement with the hospital or in the authorization for services I/T/U provides; and 3) Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the *Medicare Claims Processing Manual* applicable to the type of item or service provided.
- Participating hospitals and CAHs must accept the payment methodology and no more than the rates of payment (explained above), as payment in full for the following programs: 1) A CHS program of the IHS; 2) A CHS program carried out by an Indian Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act.; and 3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization, under which items and services are purchased for an eligible urban Indian.

Hospitals and CAHs may not refuse service to an individual on the basis that the payment for such service is authorized under such CHS and IHS funded urban Indian programs.

The following facilities or services are not covered by this regulation.

- Free standing ambulatory surgery centers (ASCs);
- Surgical centers;
- Physician services;
- Services of Independent Practitioners (Nurse practitioners, Physician Assistants, Clinical Nurse Specialists, etc);
- Independent laboratories;
- Any service or supply not covered by the Medicare program;
- Services of a renal dialysis facility;
- Home health services; and
- Hospice services.

Remember:

- **Inpatient PPS hospitals are paid based on discharge date. Therefore, if a patient were discharged on July 5, 2007, the entire stay would be paid under the applicable PPS.**
- **CAHs' and Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA) Hospitals' inpatient services will be paid based on whether the actual date of service falls on or after July 5, 2007. Line item dates of service can apply to OPPTS and other Part B outpatient claims.**
- **Payment for outpatient services is based on the date of service.**

Treating Patients with Serious Health Issues

IHS payment under this rule will reflect serious health issues faced by its patient population, as patients who are more seriously ill tend to require a higher level of hospital resources than patients who are less seriously ill, even though they may be admitted to the hospital for the same reason. Recognizing this, Medicare payments can be higher for patients in certain diagnostic-related groups (DRGs) based on a secondary diagnosis that could indicate specific complications or co-morbidities.

While these rates are generally not available to non-Indians who are members of an eligible Indian's household, if the individual meets the requirements at 42 CFR Part 136 for CHS coverage (e.g., non-Indian woman pregnant with eligible Indian's child, public health emergency), and payment is authorized by the CHS program (or by an urban program), then the Medicare-like rates (MLR) do apply.

Additional Information

You can find more information about the limitation on charges for services furnished by Medicare participating inpatient hospitals to individuals eligible for care through Indian Health Programs by reading the *Federal Register* at <http://www.nrepp.samhsa.gov/pdfs/FRN060407.pdf> on the CMS Web site.

If you have any questions, please contact your CMS Regional Office. Contact information for those offices is available at <http://www.cms.hhs.gov/RegionalOffices/> on the CMS Web site.

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News from CMS for Hospital/CAH and RDF Providers**Modification to the National Monitoring Policy for Erythropoiesis Stimulating Agents (ESAs) for End-Stage Renal Disease (ESRD) Patients Treated in Renal Dialysis Facilities**

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5700
Related CR Release Date: July 20, 2007
Related CR Transmittal #: R1307CP

Related Change Request (CR) #: 5700
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Renal dialysis facilities billing Medicare fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs) for services related to erythropoietin (EPO) and darbepoetin (Aranesp) for Medicare ESRD beneficiaries.

Background

In 2003, CMS solicited input from the ESRD community in order to develop a national claims monitoring policy for erythropoiesis stimulating agents, also referred to as ESAs, administered to ESRD patients receiving dialysis in a renal dialysis facility. After considerable input from the ESRD community, CMS implemented the first iteration of the national ESA monitoring policy referred to as EMP, effective for dates of service on or after April 1, 2006. (See earlier articles related to the EMP at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4135.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5251.pdf> on the CMS Web site.)

Emerging scientific data on the use of ESAs has prompted CMS to again revise the EMP to further control over-utilization and inappropriately sustained high hematocrit or hemoglobin levels.

What You Need to Know

CR 5700 makes the following changes effective for dates of service on or after January 1, 2008.

- Requests for payments or claims for 72X TOBs for ESAs (HCPCS Q4081, Epogen[®], J0882 Aranesp[®]) for ESRD patients receiving dialysis in renal dialysis facilities and reporting a hematocrit level (value code 49) exceeding 39.0 percent (or hemoglobin (value code 48) exceeding 13.0g/dL) for three or more consecutive billing cycles immediately prior to and including the current billing cycle, will have the reported dosage reduced by 50 percent on which payment may be made.
- Such claims should report modifiers ED (Hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL for three or more consecutive billing cycles immediately prior to and including the current billing cycle) or EE (Hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL for less than three consecutive billing cycles immediately prior to and including the current billing cycle) with HCPCS Q4081/J0882 on the line.
- Providers may continue to report the GS modifier (Dosage of EPO or Darbepoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level) when the reported hematocrit or hemoglobin levels exceed the monitoring threshold and a dose reduction has occurred.
- When the GS modifier is included on claims reporting modifier EE and HCPCS J0882/Q4081 on the line, the claim will be paid in full. The GS modifier, however, will have no effect on the 50 percent reduction of the reported dose on which payment may be made on claims reporting modifier ED and HCPCS J0882/Q4081 line items.
- 72X claims reporting hematocrit greater than 39.0 percent or hemoglobin greater than 13.0g/dL with HCPCS Q4081/J0882 on the line will be returned to provider if neither modifier ED or EE are present on at least one of the line items, or if both modifiers ED and EE are present.
- When Medicare makes a reported dosage reduction, the remittance advice will contain reason code 153 (Payment adjusted because the payer deems the information submitted does not support this dosage.)

- The dosage reduction may be taken by reducing covered units on the claim or by reducing the total payment applicable to the line.
- Medicare systems shall continue to allow for medical review override of these payment reductions.
- The medically unlikely edit (MUE) threshold has been revised. The MUE for claims for Epogen[®] (Q4081) is reduced to 400,000 units from 500,000, and to 1200 units from 1500 units for Aranesp[®] (J0882). Claims reporting doses exceeding the new thresholds are assumed to have typographical errors and will be returned to providers for correction.
- ESA claims for ESRD patients who receive their dialysis at home and self-administer their ESAs are exempt from this policy as reported in the earlier *MLN Matters* articles referenced above.
- None of the above requirements are applicable to 72X claims containing condition code 70 or 76 and Method I or II is applicable to the billing cycle.

The following chart below illustrates the resultant claim actions under all possible reporting scenarios.

Hct Exceeds 39.0% or Hgb Exceeds 13.0g/dL	ED Modifier? (Hct >39.0% or Hgb >13.0g ≥3 cycles)	EE Modifier? (Hct >39.0% or Hgb >13.0g <3 cycles)	GS Modifier? (Dosage reduced and maintained)	Claim Action
No	N/A	N/A	N/A	Do not reduce reported dose.
Yes	No	No	No	Return to provider for correction. Claim must report either ED or EE.
Yes	No	No	Yes	Return to provider for correction. Claim must report either ED or EE.
Yes	No	Yes	Yes	Do not reduce reported dose.
Yes	No	Yes	No	Reduce reported dose 25%.
Yes	Yes	No	Yes	Reduce reported dose 50%.
Yes	Yes	No	No	Reduce reported dose 50%.

Additional Information

For complete details regarding these changes please see the official instruction (CR 5700) issued to your Medicare FI or A/B MAC. That instruction is at <http://www.cms.hhs.gov/Transmittals/downloads/R1307CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Line Item Billing Requirement for Epoetin Alfa (EPO) Submitted on End Stage Renal Disease (ESRD) Claims

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5545

Related Change Request (CR) #: 5545

Related CR Release Date: July 13, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1285CP

Implementation Date: January 7, 2008

Provider Types Affected

Renal dialysis facilities (RDFs) submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for EPO provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5545, which completes the implementation of ESRD line item billing for renal dialysis facilities (RDFs) by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008. Be sure your billing staff is aware of these requirements.

Background

The first stage of the ESRD line item billing requirement was implemented by CR 5039 beginning on April 1, 2007. Now, CR 5545 completes the implementation of ESRD line item billing by providing instructions required to submit line item billing for EPO on ESRD claims with dates of service on or after January 1, 2008.

You can find an *MLN Matters* article related to CR 5039 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf> on the CMS Web site.

Line item billing allows for EPO to be billed the same way as all other separately payable drugs. For claims with dates of service on or after January 1, 2008, RDFs will bill for each administration of EPO on a separate line of the 72X type of bill indicating the line item date of service for the administration. The units reported on the claim line for EPO are multiplied by the total units defined by the Healthcare Common Procedure Coding System (HCPCS) to reflect the dosage per administration. Medicare will then calculate the EPO payment based on the units reported on the line for 72X claims with dates of service on or after January 1, 2008.

RDFs are no longer required to report value code 68 with the total monthly dosage with dates of service on or after January 1, 2008.

The total number of administrations of EPO will be determined by the total number of lines on the claim billing for EPO.

When RDFs report the GS modifier, it is not required to be reported on every EPO line item. The GS modifier should be reported on the line item(s) that represent an administration of EPO at the reduced dosage following existing instructions in the *Medicare Claims Processing Manual* (Pub. 100-04) Ch. 8, §60.4; <http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf>). No payment reduction is made when the GS modifier is present on the claim.

Supplies of EPO and Aranesp for self-administration should be billed according to the pre-determined schedule in the plan-of-care provided to the beneficiary. RDFs should submit a separate line item for each date an administration is expected to be performed with the expected dosage. In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule. For patients beginning to self administer EPO or Aranesp at home who are receiving an extra month supply of the drug, RDFs should:

- Bill the one month reserve supply on one claim line and
- Include the EM modifier—Emergency Reserve Supply (for ESRD benefit only).

Note that Medicare will return claims to the provider containing more than one EPO or Aranesp line with the EM modifier for claims with dates of service on or after January 1, 2008.

RDFs should include condition code 70 on claims billing for home dialysis patients that self-administer anemia management drugs, including EPO and Aranesp.

Note that the electronic form required for billing ESRD claims is the ANSI X12 837 Institutional claim transaction. The data structure of that transaction is difficult to express in narrative form. In addition, small providers who are exempt from the requirement to submit electronic claims, CMS provides instructions in CR 5545 relative to the UB-04 (form CMS-1450) hardcopy form. Those instructions are in the form of a revision to the *Medicare Claims Processing Manual* and that revision is attached to CR 5545.

Additional Information

The official instruction, CR 5545, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1285CP.pdf> on the CMS Web site.

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Vagus Nerve Stimulation (VNS) for Resistant Depression

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5612

Related Change Request (CR) #: 5612

Related CR Release Date: June 22, 2007

Effective Date: May 4, 2007

Related CR Transmittal #: R1271CP and R70NCD

Implementation Date: July 23, 2007

Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MACs) for vagus nerve stimulation procedures.

Provider Action Needed

CR 5612, from which this article is taken, announces that CMS is issuing a national (non) coverage determination (NCD) stating that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression.

Therefore, effective May 4, 2007, CMS will deny VNS claims when resistant depression is the indication for the procedure.

Background

VNS utilizes a battery-powered pulse generator (similar to a pacemaker), that is surgically implanted under the skin of the left chest and an electrical lead (wire) connected from the generator to the left vagus nerve; through which electrical signals are sent to the brain.

In 1999, CMS issued a national coverage determination (NCD) that (effective for services performed on or after July 1, 1999) VNS is reasonable and necessary for patients with medically refractory partial onset seizures when surgery is not recommended or has failed.

On August 7, 2006, a formal request to reconsider resistant depression as an additional indication initiated a national coverage analysis, and CR 5612, from which this article is taken, communicates the findings of that analysis. Specifically in CR 5612, CMS announces that it has reviewed the evidence and has concluded that VNS is not reasonable and necessary for the treatment of resistant depression under §1862(a)(1)(A) of the Social Security Act, and has issued a national noncoverage determination for this indication.

Therefore, effective May 4, 2007, CMS will deny or reject, as appropriate, VNS claims for resistant depression, as specified in the *Medicare National Coverage Determinations Manual*, Ch. 1, Part 2 (§§90 – 160.25 (Coverage Determinations)), §160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications)).

CR 5612 contains some specifics about VNS coverage that you should be aware of:

- Carriers, FIs, and A/B MACs will continue to pay VNS claims for medically refractory partial onset seizures as specified in section 160.18.B of the *Medicare National Coverage Determination Manual*, identified when any of the following ICD-9-CM diagnosis codes appear on the claim:
 - 345.41 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy),
 - 345.51 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy), or
- Carriers, FIs, and A/B MACs will continue to deny/reject VNS claims for all other types of seizures as specified in section 160.18.C of the *Medicare National Coverage Determination Manual*.
- Physicians and hospitals will be liable for noncovered VNS procedures unless they issue an appropriate advance beneficiary notice (ABN), which should include the following language:
 - Items or Service Section: “Vagus Nerve Stimulation”.
 - Because Section: “As specified in section 160.18 of Pub.100-03, Medicare National Coverage Determination Manual, Medicare will not pay for this procedure as it is not a reasonable and necessary treatment for (select either “your type of seizure disorder” or “resistant depression.”)”
- When denying non-covered VNS services carriers, FIs, and A/B MACs will use the following messages:
 - Medicare Summary Notice (MSN) 16.10 “Medicare does not pay for this item or service;”
 - Claim Adjustment Reason Code (CARC) 50: “These are non-covered services because this is not deemed a “medical necessity” by the payer;” and
 - One of the following Remittance Advice Remark Code (RARC) messages, depending on liability:
 - M27 Alert: “The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office;” **or**

- M38 “The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.”
- Medicare carriers, FIs, and A/B MACs will also include group code CO (contractual obligation) or PR (patient responsibility) depending on liability.
- Carrier, FIs, and A/B MACs will not search their files to retract payment for claims already paid, but will adjust claims brought to their attention.

Finally, you should remember that this addition/revision of §160.18 of the *Medicare National Coverage Determination Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You can find the official instruction issued to your carrier, FI, or A/B MAC about the VNS NCD by looking at the two transmittals for CR 5612. The first transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R70NCD.pdf> on the CMS web site. That transmittal contains the amended *Medicare National Coverage Determinations Manual*, Ch. 1, Part 2 (§§90 – 160.25 – Coverage Determinations), §160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications)). The second transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1271CP.pdf> and it contains the amended *Medicare Claims Processing Manual*, Ch. 32 (Billing Requirements for Special Services), §200 (Billing Requirements for Vagus Nerve Stimulation (VNS)).

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Capturing Days on Which Medicare Beneficiaries are Entitled to Medicare Advantage (MA) in the Medicare/Supplemental Security Income (SSI) Fraction

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5647

Related CR Release Date: July 20, 2007

Related CR Transmittal #: R1311CP

Related Change Request (CR) #: 5647

Effective Date: October 1, 2006

Implementation Date: January 7, 2008

Provider Types Affected

Hospitals billing either a Medicare administrative contractor (A/B MAC) or fiscal intermediary (FI) for services provided to Medicare beneficiaries enrolled in a Medicare Advantage plan.

Provider Action Needed

This article is based on CR 5647, which states that, **as of January 7, 2008, hospitals (this includes acute care hospitals paid under the inpatient prospective payment system, inpatient rehabilitation facilities (IRF), and long term care hospitals (LTCH)) must begin to submit "no pay" bills to their Medicare contractor for stays by Medicare Advantage (MA) beneficiaries.** This will allow for the days of those stays to be eventually captured in the Disproportionate Share Hospital (DSH) (or low income patient (LIP) for IRF) calculations.

Background

CR 5647 states that part of the calculation used to determine whether or not a hospital is eligible for DSH payments is based on the percentage of Medicare days for which the beneficiary was entitled to Medicare Part A and received SSI payments from the Social Security Administration (SSA). The SSA provides the SSI information to CMS. CMS then pulls all of the Medicare days for each eligible hospital and determines the percentage of days for which the Medicare beneficiaries were simultaneously eligible for SSI and Medicare. **The Medicare beneficiary days should include MA days in addition to Medicare fee-for-service Part A days.**

- In the past, hospitals were required to submit this information for MA beneficiaries (through 1998) by submitting a no-pay bill.
- Later, managed care organizations (MCOs) (now MA companies) were responsible for submitting this information (through 2001) as part of encounter data submissions to CMS. **Since MCOs are no longer required to submit encounter data, hospitals must submit data on their MA days so that these days may be considered in the Medicare fraction of the DSH calculation.** The IPPS regulations on DSH are located in 42 CFR 412.106.
- The Inpatient Rehabilitation Facility (IRF) PPS regulations on the Low Income Payment (LIP) are located in 42 CFR 412.624(e)(2).

Key Points of CR 5647

- Hospitals may go back and submit claims with discharge dates on or after October 1, 2006, (fiscal year (FY) 2007), so that SSI data for FY 2007 and beyond will include MA patient days.
- Hospitals should bill claims on an 11X TOB, include condition code 04, and all other applicable claim information because patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit a no-pay bill (TOB 11X) which includes condition code 04 to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for FY 2007 and beyond.]
- Teaching hospitals are already submitting their claims with condition codes 04 and 69 in order to be reimbursed for their Indirect Medical Education payment. They will continue to submit their bills with condition codes 04 and 69.
- To ensure that hospitals' MA days are included in the FY 2007 Medicare/SSI file (due in the summer of 2008), hospitals should try to submit their FY 2007 claims to their Medicare contractor between the implementation date (January 7, 2008) of this CR through March 2008.
- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for IPPS hospitals is located at http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage on the CMS Web site.

Implementation Date

January 7, 2008

Additional Information

For complete details regarding this CR please see the official instruction (CR 5647) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1311CP.pdf> on the CMS Web site. The revised sections of the *Medicare Claims Processing Manual* related to this issue are attached to CR 5647.

If you have questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

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Present On Admission Indicator—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Present On Admission Indicator,” which was published in the June 1, 2007, *Medicare A Newslines*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5499 Revised

Related CR Release Date: May 11, 2007

Related CR Transmittal #: R1240CP

Related Change Request (CR) #: 5499

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Note: This article was revised on August 15, 2007, to show that psychiatric and inpatient rehabilitation hospitals are also exempt from reporting the Present on Admission Indicator as noted in CR 5679.

Provider Types Affected

Hospitals who submit claims to fiscal intermediaries (FI) or Part A/B Medicare Administrative Contractors (A/B MACs) for Medicare beneficiary inpatient services.

Provider Action Needed

STOP – Impact to You

Effective October 1, 2007, Medicare will begin to accept a Present on Admission (POA) Indicator for every diagnosis on your inpatient acute care hospital claims. **However, providers must submit the POA on hospital claims beginning with discharges on or after January 1, 2008.** Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, psychiatric hospitals, inpatient rehabilitation facilities, and children’s inpatient facilities are exempt from this requirement.

CAUTION – What You Need to Know

CR 5499, from which this article is taken, announces the requirement for completing a Present on Admission (POA) Indicator for every diagnosis on an inpatient acute care hospital claim beginning with discharges on or after January 1, 2008, and provides your fiscal intermediaries (FI) and A/B MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator. (Providers can begin to submit POAs as of October 1, 2007.)

GO – What You Need to Do

You should make sure that your billing staffs are aware of this requirement, and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment and reporting of diagnoses and procedures. Please refer to the “Background” section for more details.

Background

Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) of patients effective for discharges on or after October 1, 2007. Effective for acute care inpatient prospective payment system (PPS) discharges on or after October 1, 2007, CMS will have selected at least 2 high cost or high volume (or both) diagnosis codes that:

- Represent conditions (including certain hospital acquired infections) that could reasonably have been prevented through the application of evidence-based guidelines; and
- When present on a claim along with other (secondary) diagnoses, have a DRG assignment with a higher payment weight.

Then, for acute care inpatient PPS discharges on or after October 1, 2008, while the presence of these diagnosis codes on claims could allow the assignment of a higher paying DRG, when they are present at the time of discharge, but not at the time of admission, the DRG that must be assigned to the claim will be the one that does not result in the higher payment.

Beginning for discharges on or after October 1, 2007, hospitals should begin reporting the POA code for acute care inpatient PPS discharges. There is one exception, i.e., claims submitted via direct data entry (DDE) should not report the POA codes until January 1, 2008, as the DDE screens will not be able to accommodate the codes until that date.

Hospitals that fail to provide the POA code for discharges on or after January 1, 2008, will receive a remittance advice remark code informing them that they failed to report a valid POA code. However, beginning with discharges on or after April 1, 2008, Medicare will return claims to the hospital if the POA code is not reported and the hospital will have to supply the correct POA code and resubmit the claim. In order to be able to group these diagnoses into the proper DRG, CMS needs to capture a POA indicator for all claims involving inpatient admissions to general acute care hospitals. CR 5499, from which this article is taken, announces this requirement (effective January 1, 2008); and provides your FI and A/B MACs with the coding and editing requirements, and software modifications needed to successfully implement this indicator.

Note: Adjustments to the relative weight that occur because of this action are not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of these adjustments.

These POA guidelines are not intended to replace any found in the *ICD-9-CM Official Guidelines for Coding and Reporting*, nor are they intended to provide guidance on when a condition should be coded. Rather, you should use them in conjunction with the *UB-04 Data Specifications Manual* and the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each “principal” diagnosis and “other” diagnoses codes reported on claim forms (UB-04 and 837 Institutional). Information regarding the UB-04 Data Specifications may be found at: <http://www.nubc.org/become.html>

Note: Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children’s inpatient facilities are exempt from this requirement. Also, as noted in CR5679 (<http://www.cms.hhs.gov/Transmittals/downloads/R289OTN.pdf>), hospitals paid under a PPS other than the acute care hospital PPS are exempt. Thus psychiatric and rehabilitation hospitals are exempt.

The following information, from the *UB-04 Data Specifications Manual*, is provided to help you understand how and when to code POA indicators:

1. General Reporting Requirements

- Pertain to all claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.
- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.
- Issues related to inconsistent, missing, conflicting, or unclear documentation must still be resolved by the provider.
- If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.
- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an “other diagnosis.”

2. Reporting Options and Definitions

- Y – Yes (present at the time of inpatient admission)
- N – No (not present at the time of inpatient admission)
- U – Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
- W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- 1 – Unreported/Not used – Exempt from POA reporting (This code is the equivalent of a blank on the UB-04, but blanks are not desirable when submitting data via the 4010A1).

The POA data element on your electronic claims must contain the letters “POA”, followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after “POA,” and (when applicable) the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter “Z” to indicate the end of the data element (or FIs and A/B MACs will allow the letter “X” which CMS may use to identify special data processing situations in the future).

Note that on paper claims the POA is the eighth digit of the Principal Diagnosis field (FL 67), and the eighth digit of each of the secondary diagnosis fields (FL 67 A-Q); and on claims submitted electronically via 837, 4010 format, you must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim:

If segment K3 read as follows: “POAYNUWIYZ,” it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).

As of January 1, 2008, all direct data entry (DDE) screens will allow for the entry of POA data and POA data will also be included with any secondary claims sent by Medicare for coordination of benefits purposes.

See the complete instructions in the UB-04 Data Specifications Manual for more specific instructions and examples.

Note: CMS, in consultation with the Centers for Disease Control and Prevention and other appropriate entities, may revise the list of selected diagnoses from time to time, but there will always be at least two conditions selected for discharges occurring during any fiscal year. Further, this list of diagnosis codes and DRGs is not subject to judicial review.

Finally, you should keep in mind that achieving complete and accurate documentation, code assignment, and reporting of diagnoses and procedures requires a joint effort between the healthcare provider and the coder. Medical record documentation from any provider (a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis) involved in the patient's care and treatment may be used to support the determination of whether a condition was present on admission or not; and the importance of consistent, complete documentation in the medical record cannot be overemphasized.

NOTE: You, your billing office, third party billing agents and anyone else involved in the transmission of this data must insure that any resequencing of diagnoses codes prior to their transmission to CMS, also includes a resequencing of the POA indicators.

Additional Information

You can find the official instruction, CR 5499, issued to your FI or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1240CP.pdf> on the CMS Web site.

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News from CMS for SNF/SB Providers



Clarification of Skilled Nursing Facility (SNF) Billing Requirements for Beneficiaries Enrolled in Medicare Advantage (MA) Plans

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5653

Related CR Release Date: July 13, 2007

Related CR Transmittal #: R1290CP

Related Change Request (CR) #: 5653

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Skilled nursing facilities (SNFs) billing either a Medicare administrative contractor (A/B MAC) or fiscal intermediary (FI) for SNF services provided to Medicare beneficiaries enrolled in a Medicare Advantage (MA) plan.

Provider Action Needed

This article is based on CR 5653, which clarifies the Medicare billing requirements for beneficiaries enrolled in MA plans. CR 5653 reminds SNFs (and Swing Bed (SB)) providers of the need to submit claims for such beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness information in Medicare systems.

Background

This instruction incorporates SNF billing requirements for beneficiaries that are enrolled in MA plans into the *Medicare Claims Processing Manual*. SNF providers must submit bills for beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness in the Medicare's Common Working File (CWF) system.

In addition, Medicare is making system changes to allow hospital qualifying stay edits to be overridden by contractors. This change is necessary in case of a disaster or emergency-related situation, or some other circumstance indicated by CMS, which requires special processing of claims.

Key Points of CR 5653

Be aware that if a Medicare beneficiary chooses an MA plan as their form of Medicare, he/she cannot look to traditional "fee for service" Medicare to pay the claim if the MA plan denies coverage. SNF providers will apply the following policies to MA beneficiaries who are admitted to a SNF:

- If the SNF is non-participating with the plan, the beneficiary must be notified of their status because they are private pay in this circumstance.
- If the SNF is participating with the plan, pre-approve the SNF stay with the plan.
- If the plan denies coverage, appeal to the plan, not to the "fee for service" FI or A/B MAC.
- Count the number of days paid by the plan as Part A days used. (This counts as part of the beneficiary's 100 days of Medicare SNF benefits.)
- Submit a claim to the "fee for service" FI or A/B MAC to take benefit days from the CWF records. (**Note:** The MA plans do not send claims to Medicare for SNF stays.) Failure to send a claim to the FI or A/B MAC will inaccurately show days available.
- Submit the claim using bill type 18X or 21X and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges and condition code 04 (informational only bill).

Note: If the beneficiary drops their MA plan participation, beneficiaries have the balance of their 100 SNF days available to use under Medicare fee-for-service.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5653) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1290CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Clarification of Skilled Nursing Facility (SNF) No Payment Billing—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Clarification of Skilled Nursing Facility (SNF) No Payment Billing,” which was published in the July 1, 2007, *Medicare A Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5583 Revised

Related Change Request (CR) #: 5583

Related CR Release Date: May 25, 2007

Effective Date: October 1, 2006

Related CR Transmittal #: R1252CP

Implementation Date: August 27, 2007

Note: This article was revised on July 11, 2007, to delete a reference to “Part A exhausted” in the first paragraph under “No Pay Billings”. All other information remains the same.

Provider Types Affected

Skilled nursing facilities (SNFs) submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for SNF services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on CR 5583, which clarifies SNF No-Payment Billing when the no-pay services overlap periods covered by a previously paid SNF type of bill (TOB) 22X.

CAUTION – What You Need to Know

Providers must include occurrence span code 74 with the ‘statement covers period’ of the 210 bill being submitted in order to bypass Medicare edits that do not allow SNF TOB 210 (SNF Non-covered level of care) to process when overlapping with previously paid 22x bill types (SNF inpatient stay, Part B only services (Part A exhausted)). CR 5583 also clarifies provider billing requirements for beneficiaries who have disenrolled from Medicare Advantage (MA) plans, and it updates various sections of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual* (CMS Pub. 100-04). **However, there are no policy changes made by CR 5583.**

GO – What You Need to Do

See the “Background” and “Additional Information” sections of this article for further details regarding these clarifications.

Background

No Pay Billings

CR 5583 clarifies No Pay billing instructions for SNF TOB 210 (SNF Noncovered level of care) that overlap previously paid SNF TOB 22X (SNF inpatient stay, Part B only services).

In order to bypass Medicare edits that do not allow SNF TOB 210 to process when overlapping with previously paid 22X bill types, providers must include occurrence span code 74 with the ‘statement covers period’ of the 210 bill being submitted.

Beneficiaries Disenrolled from Medicare Advantage (MA) Plans

Medicare covers SNF inpatient services for beneficiaries disenrolling from risk MA plans **when the beneficiary has not met the three-day prior hospital stay requirement.** (Where a beneficiary disenrolls from a risk MA, is discharged from the SNF, and then is readmitted to the SNF under the thirty day rule, all requirements of original Medicare will apply, including the three-day prior hospital stay.)

Your FI or A/B MAC will begin counting 100 days of SNF care with the SNF admission date regardless of whether the beneficiary met the skilled level of care requirements on that date. All other Medicare rules apply, including:

- The requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is billed), and
- The rules regarding cost sharing apply to these cases.

In other words, providers may only charge beneficiaries for SNF coinsurance amounts.

SNFs submit the first fee-for-service inpatient claim with **condition code ‘58’** to indicate:

- A patient was disenrolled from an MA Plan, and
- The 3-day prior stay requirement was not met.

Claims with condition code ‘58’ will not require the three-day prior inpatient hospital stay.

CR 5583 updates various sections of Chapter 6 of the Medicare Claims Processing Manual and these updates are provided as enclosures to CR 5583 including **the following SNF Spell of Illness Quick Reference chart:**

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Medicare Skilled	YES	YES	N/A	YES	Submit Monthly Covered Claim
	NO	YES	N/A	YES	Submit Monthly Covered Claim

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Medicare Skilled	YES	NO	YES	YES	Submit Monthly Covered Claim
	NO	NO	YES	Patient should be returned to certified area for Medicare to be billed	N/A
	NO	NO	NO	Patient should be returned to certified area for Medicare to be billed	N/A
Not Medicare Skilled	YES	NO	NO	NO	Do not submit claim if patient (pt) came in non-skilled. Otherwise, submit no-pay claim w/discharge status code when patient leaves the certified area.
	YES	YES	N/A	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	YES	N/A	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/discharge status code when patient leaves the certified area.

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Not Medicare Skilled	NO	NO	YES	NO	Do not submit claim if pt came in nonskilled. Otherwise, submit no-pay claim w/discharge status code when patient leaves the certified area.
	YES	NO	YES	NO	Do not submit claim if pt came in nonskilled. Otherwise, submit no-pay claim w/discharge status code when patient leaves the certified area.

* Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness continues.

** In some states, licensing laws for all nursing homes have incorporated requirements of the basic SNF definition (Social Security Act §1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see the *State Operations Manual*, CMS Pub. 100-7, Ch. 2, §2164 at www.cms.hhs.gov/manuals/ on the CMS Web site).

Additional Information

The official instruction, CR 5583, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1252CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update for FY 2008

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5688

Related Change Request (CR) #: 5688

Related CR Release Date: July 20, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1306CP

Implementation Date: October 1, 2007

Provider Types Affected

Skilled nursing facilities (SNFs) billing Medicare fiscal intermediaries (FIs) for services paid under the SNF PPS.

Background

Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

CMS published the SNF payment rates for FY 2007 (October 1, 2006 through September 30, 2007) in the Federal Register on July 31, 2006, (71 FR 43159.) This article reminds SNFs that the annual update of the rates will be announced soon.

CR 5688 Key Points

- The Fiscal Year (FY) 2008 SNF payment rates will be effective October 1, 2007, through September 30, 2008.
- The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS.
- The statute mandates an update to the Federal rates using the latest SNF full market basket.

Additional Information

Market Basket Definitions and General Information can be found at <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf> on the CMS Web site.

The official instruction, CR 5688, issued to your Medicare FI or A/B MAC regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1306CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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Update to Medicare Benefit Policy Manual, (Publication 100-02), Chapter 8, Coverage of Extended Care Services under Hospital Insurance

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5532

Related Change Request (CR) #: 5532

Related CR Release Date: June 29, 2007

Effective Date: July 30, 1999

Related CR Transmittal #: R73BP

Implementation Date: October 1, 2007

Provider Types Affected

Skilled nursing facilities (SNF) who bill fiscal intermediaries (FI) or Medicare administrative contractors (A/B MACs) for physical therapy, occupational therapy, or speech-language pathology services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

For SNF furnished services, including physical or occupational therapy or speech-language pathology services, to be covered, an initial therapy evaluation must take place within the SNF or your fiscal intermediary or A/B MAC will deny the claim under the SNF benefit.

CAUTION – What You Need to Know

CR 5532, from which this article is taken revises the *Medicare Benefit Policy Manual*, Ch. 8, §30.4.1.1 to clarify that the initial therapy evaluation must be performed in the SNF. If the initial therapy evaluation in the medical record is dated prior to the first day of the SNF admission or readmission, the claim for SNF benefits will be denied.

GO – What You Need to Do

Make certain that all SNF-related therapy evaluations are performed during the beneficiary's SNF stay, and that this is appropriately documented. Please see the "Background" section for more details.

Background

Section 1861(h) of the Social Security Act defines certain services (including physical or occupational therapy or speech-language pathology services) that a SNF (or others under arrangements with the SNF) furnishes to its beneficiaries, to be covered under the Extended Care Benefit. To be covered, the care provided to the SNF beneficiary must meet the requirements set forth in 42 C.F.R. 409 Subpart D.

CR 5532, from which this article is taken, re-emphasizes this requirement and clarifies *Medicare Benefit Policy Manual*, Ch. 8 (Coverage of Extended Care (SNF) Services Under Hospital Insurance), §30.4.1.1 (General) to state (as previously announced in the SNF PPS final rule for FY 2000, (FR 41662, July 30, 1999)) that, in order for services to be covered under the SNF benefit, the associated initial therapy evaluation of a beneficiary must take place in the SNF.

This means that you cannot use an evaluation that was performed, for instance, in the acute care or rehabilitation hospital settings as the therapy evaluation of the beneficiary in the SNF, because the beneficiary's status must be evaluated as he or she presents in the SNF setting. Note that the cost of an initial therapy evaluation in the SNF is included in the SNF Prospective Payment System (PPS) payment made for SNF covered services.

Notes: Your FI or A/B MAC will:

- 1) Deny claims for SNF services when the first three alpha characters of the HIPPS rate code are RHA, RHB, RHC, RHL, RHX, RLA, RLB, RLX, RMA, RMB, RMC, RML, RMX, RUA, RUB, RUC, RUL, RUX, RVA, RVB, RVC, RVL, or RVX; and a review of the medical record finds that an initial evaluation for therapy services is dated prior to the first day of covered care upon admission and or readmission.**
- 2) Not search its files for claims already processed involving the provision of therapy services to determine if an initial evaluation was provided following admission or readmission, except when a claim is brought to its attention.**

Additional Information

You can find more information about SNF-related therapy evaluations by going to CR 5532, located at <http://www.cms.hhs.gov/Transmittals/downloads/R73BP.pdf> on the CMS Web site. You will find revised *Medicare Benefit Policy Manual*, Ch. 8 (Coverage of Extended Care (SNF) Services Under Hospital Insurance), §30.4.1.1 (General) as an attachment to the CR.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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News from Cahaba GBA, LLC for All Providers



Take Action Now! You Need New Security to Continue Accessing FISS or ELGA/ELGH

For Medicare Part A providers who submit claims to the Cahaba GBA, LLC office in Birmingham, Alabama.

On July 2, 2007, Cahaba sent a letter to all Medicare Part A providers who submit claims to our Alabama office. This letter provided important information about a change in your security, effective August 31, 2007, that allows you to access the Fiscal Intermediary Standard System (FISS) and the eligibility screens, ELGA/ELGH. This also affects providers who use File Transfer Protocol (FTP) to download their electronic remittance advice (ERA).

Note: This information does not apply, if your electronic data interchange (EDI) submitter number begins with “IA”.

To establish new Enterprise Data Center (EDC) security access for your staff, each provider was required to complete and send in the “EDI Services Part A Enrollment Application” and the “EDI Services Part A System Access Update Request” forms by August 15, 2007.

What You Need to Do Now

If you have not completed and faxed the “EDI Services Part A Enrollment Application” and the “EDI Services Part A System Access Update Request” forms at https://www.cahabagba.com/part_a/forms_materials.htm#edia you must **TAKE ACTION NOW!** Even though the deadline has passed, you must still complete the forms to allow your staff continued access to FISS and ELGA/ELGH, and FTP for your ERAs. Fax the completed forms to 205-402-5706.

Note: If you have already faxed these forms, and received a successful fax confirmation, please do not fax duplicate forms.

While we cannot guarantee that you will have your new security information allowing access to FISS and ELGA/ELGH beginning August 31, 2007, completing the forms now will minimize the amount of time you don’t have access.

Your new security information will be faxed to the number provided on the “EDI Services Part A System Access Update Request” form. Once you receive your new EDC user ID and password, access the [Enterprise Data Center Logon Instructions](#) for detailed steps on how to sign-on using your new security information.

Questions?

Please call our EDI Department at **866-582-3253**.

What Else Should I Know?

Due to this transition, FISS, and ELGA/ELGH will be unavailable Monday, September 3, 2007. When access is restored beginning Tuesday, September 4, 2007, you must use your new EDC security to access FISS, and/or ELGA/ELGH, and to download ERA files.

Notification about the EDC security changes were issued to providers through the following methods:

- July 1, 2007, *Medicare A Newslines* article, “Important Announcement: Security Changes Coming Soon”
- August 1, 2007, *Medicare A Newslines* article, “Urgent Request: Security to Access FISS or ELGA/ELGH Will be Affected by the Transition of Data Processing Activities”
- August 10, 2007, *Medicare A Newslines* Special Bulletin
- Listserv messages were sent on the following dates to all Alabama Part A providers who subscribe to Cahaba GBA’s E-mail Notification Service.
 - July 3, 13, 20, and 27, 2007
 - August 1, 3, 7, 9, 13, 14, 15, and 16, 2007

Change in Telephone Number for Continued Electronic Data Interchange Support

Effective September 4, 2007, the telephone number to which you call for electronic data interchange (EDI) support will change to **866-582-3253**. This number is also the number providers have been instructed to call for assistance related to the EDC security transition and enrollment.



New Cahaba GBA Redetermination Form

The Medicare Part A Appeals department must often request additional information from the provider to process an appeal request. To help avoid requesting additional information, Cahaba has developed the "[Cahaba GBA Medicare A Redetermination Request Form](#)". This form asks for the additional information Cahaba often needs to request and allows you to type directly on the form via our Web site. Simply, type the requested information in the space provided, print it, and send it to the Appeals department at the appropriate address found on the [Contact Us](#) page. Providers may still use the Centers for Medicare & Medicaid Services (CMS) Redetermination Request Form (CMS-20027); however, using the Cahaba Redetermination Request form will help prevent delays in processing your appeal request.



New Web Page to Assist with Common Part A Provider Questions

As we continue to strive towards our goal of developing education and outreach to assist providers with their Medicare questions, Cahaba GBA, LLC has promoted a new Web page, which lists the most common inquiry topics from Part A providers and the self-service resources providers can use to resolve these.

This information can be accessed from the "[Claims](#)" Web page on our Web site by clicking on the "[Resources for the Most Common Medicare Part A Provider Questions](#)" link.

Prior to calling the Cahaba GBA, LLC Provider Contact Centers (PCC), please access this Web page for assistance with your questions on the following topics:

- Address/Phone/Fax Address
- Beneficiary Demographic Information
- Beneficiary Part B Medicare Entitlement
- Claims in a Suspended Status/Location (S/LOC)
- Explanation of RTP Reason Code
- Filing/Billing Instructions
- Missing/Invalid Codes
- Outpatient Therapy Caps
- Overlapping Claims

This Web page will be updated as new or additional self-service resources become available, or as other top inquiry issues are identified through our call center data analysis. To receive email notifications about updates to our Web site, subscribe to [Cahaba GBA's E-mail Notification Service](#).

Please ensure that your staff has access to this new Web page to assist them in researching their Medicare questions.



Web Site Education Resource News

As Cahaba strives to provide excellent provider outreach and education, we continue to review and assess our Web site and educational resources. As a result, the following revisions will soon be made to the [Cahaba Web site](#).

- The “[Medicare Secondary Payer](#)” section of the *Medicare Reference Guide* will be retired. As a result, the [Medicare Secondary Payer](#) Web page will be revised to offer additional resources. In addition, the link to the Medicare Secondary Payer Web page will no longer be listed as a separate category on the [Home](#) page. Instead it will be moved to display under the “Claims Information” category of the “Medicare A Resources.”
- The “[Appeals](#)” section of the *Medicare Reference Guide* will also be retired. The [Appeals](#) Web page will be revised to include information about the different levels of appeal that are available when a claim is denied by Medical Review. In addition, the link to the Appeals Web page will be moved from the “Claims Information” category and will become its own category under “Medicare A Resources.”
- The “What’s New” information posted under “Medicare A Resources” will be moved. The most current news will be listed under the “Provider News” section of the [Home](#) page. The most current news items will be listed and additional links will direct you to more news and archived news from the Centers for Medicare & Medicaid Services (CMS) and from Cahaba.

It is important to Cahaba to improve customer satisfaction and to make Medicare resources readily available to you. We welcome your feedback. Please email your comments, ideas, and suggestions to ianewslne@cahabagba.com.

Look for more news about modifications in future editions of the *Medicare A Newsline* and the *Home Health & Hospice Medicare A Newsline*.



Watch for Changes to Medical Review Denial Reason Codes

This information applies to Medicare Part A fiscal intermediary providers who submit claims to the Cahaba GBA, LLC office in Des Moines, Iowa.

In the next few months, providers who submit claims to the Cahaba GBA, LLC office in Iowa, may see some changes in the denial reason codes used during the medical review process. You can access the definitions of the denial reason codes through the Fiscal Intermediary Standard System (FISS) by pressing F1 from the “Claim Entry” screen (MAP1711). For more information about accessing the reason code definition, refer to “Option 12” information located in the “Inquiry Menu” section of the *Fiscal Intermediary Standard System (FISS) Reference Guide* at: https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_menu.pdf



Claims With Epogen (EPO) Denied Incorrectly

Claims that included charges for EPO with dates of services on or after May 1, 2007, may have denied incorrectly. The system edit did not recognize that a payable “E” diagnosis code (e.g., E9331) was included on the claim, which caused the claim to deny in error. The edit has been corrected. Please note that no action is required by providers. Cahaba GBA, LLC will initiate mass adjustments to reopen the claims that were denied in error.



Availability of the Provider Contact Center

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our Customer Service Representatives (CSRs). The Provider Contact Center in Birmingham, Alabama (1-866-539-5598 and 1-877-567-3092) will conduct training for CSRs on a weekly basis, on Thursdays from 10:30 a.m. to 12:30 p.m. Central Time (CT). Listed below are the dates and times the Provider Contact Center will be closed for training. We will continue to notify you of future CSR training dates in the *Medicare A Newslines*.

CSR Training Date	Time
September 6, 2007	10:30 a.m.–12:30 p.m. CT
September 13, 2007	10:30 a.m.–12:30 p.m. CT
September 20, 2007	10:30 a.m.–12:30 p.m. CT
September 27, 2007	10:30 a.m.–12:30 p.m. CT



System Availability During the Labor Day Holiday

While we celebrate the Labor Day holiday with our families, our offices will be closed on Monday, September 3, 2007. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the CWF eligibility screens, ELGA/ELGH will not be available on September 3, 2007. In addition, the system will not cycle that night, which means that claims will not be sent to the Common Working File (CWF) on September 3, 2007. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced September 3, 2007.



Medicare Forum

Do you have a Medicare question or topic that you would like addressed in the *Medicare A Newsline*? If so, fax it to the Provider Outreach and Education (POE) department at 515-471-7584, or e-mail it to ianewsline@cahabagba.com. Please include your facility's name, provider number, your name, and your telephone number. Responses to the inquiries received in this e-mail box will be provided only through the Medicare Forum article, if appropriate. If you need an immediate response to a question, please contact a Customer Service Representative (CSR) for assistance. The CSR telephone numbers are listed under the "[Contact Us](#)" page of our Web site. We also welcome your comments or suggestions on this publication and other Cahaba GBA, LLC customer service activities.

Q1. When entering an outpatient skilled nursing facility (SNF) claim, does each day of therapy need to be entered or can a total number for each therapy type be entered?

A1. You must include a single line item date of service (LIDOS) for every day therapy services are provided. If therapy is provided five times during the billing period, the revenue code and HCPCS code must be entered five times, once for each service date.

Q2. When entering the units for therapy, can we enter just the number or must I enter zeros (0) to make a four digit number?

A2. Report therapy units based on the number of times the procedure, as described in the Healthcare Common Procedure Coding System (HCPCS) definition, is performed, without any zeros (0).

*News from Cahaba GBA, LLC for Hospital/CAH, SNF/SB, RDF,
CMHC, and CORF/ORF Providers*



Part A Local Coverage Determination (LCD) Updates

Our Medical Review department continues to develop local coverage determinations (LCDs) and review existing LCDs to ensure policies remain accurate and up-to-date. As a result, please review the following LCD updates.

- **Carboplatin (Paraplatin®)—Effective September 1, 2007**
The list of ICD-9-CM codes that support medical necessity has been revised.
 - The ICD-9-CM code V10.3 has been added to the list.

Please update your records.



Review of Critical Access Hospitals Billing CPT 82962

This information applies to providers who submit claims to the Cahaba GBA office in Des Moines, Iowa.

Medical Review has recently completed the third quarter widespread targeted prepay review of Critical Access Hospitals (CAH) claims with *Current Procedural Terminology* (CPT) 82962 (Glucose, blood by glucose monitoring device(s), cleared by the FDA specifically for home use) processed between April 1, 2007, and June 30, 2007.

The results of the current review are as follows:

Providers included in review	21
Claims Reviewed	51
Claims Denied	37 (partial or full denial)
Charges Reviewed	\$ 24,574.81
Charges Denied	\$ 19,800.52

Error Rate*: **80.57%**

*Error rate is based on the charges denied divided by the charges reviewed.

The review decisions were based on the Centers for Medicare & Medicaid Services (CMS) criteria for laboratory services set forth in part in Section 1862(a)(1)(A) of the Social Security Act which requires services to be reasonable and necessary for diagnosis and treatment in order to be covered by Medicare. The 42 CFR §410.32 further specifies that for a laboratory service to be reasonable and necessary, it must not only be ordered by the physician but the ordering physician must also use the result in the management of the beneficiary's specific medical problem. Implicitly, the laboratory result must be reported to the physician promptly in order for the physician to use the result and instruct continuation or modification of patient care; this includes the physician's order for another laboratory test.

- **Lack of documentation to support the medical justification for the services rendered (Denial Reason 5NM03):** The majority of denials occurred because the medical record documentation lacked the medical justification for the laboratory services as outlined in the above-cited CMS regulations. A standing order for intermittent blood glucose testing, (e.g. before meals and at bedtime) and/or sliding scale insulin injections are examples of noncovered laboratory services when they do not meet the ordering physician's utilization requirements described above. Both instances lack support of a clear use of a laboratory result prior to a similar subsequent laboratory order or use as a result's driven intervention by the ordering physician and therefore do not qualify for separate payment under the Medicare laboratory benefit.
- **Lack of timely submission of requested documentation (Denial Reason 56900):** Additionally, claims were denied due to a lack of record submission in a timely manner. According to *The Medicare Program Integrity Manual*, (CMS Pub. 100-08), Ch. 3, §3.4.1.2, if a coverage or coding determination cannot be made based upon the information on the claim, the fiscal intermediary (FI) may solicit

additional documentation from the provider by issuing an Additional Development Request (ADR) and must notify the provider of the thirty day time-period to respond. If the ADR requested information is not received within forty-five days after the date of the request, the claim must be denied.

Five claims were denied because the ADR information was not received. An ADR is a request for additional information for a claim(s) that has been selected for prepayment review. You are notified of ADRs through the Fiscal Intermediary Standard System (FISS) if you bill electronically. When a claim is selected for medical review, it moves to status/location S B6001. It is very important that you establish a procedure in your office to monitor the ADR status/location on a regular basis. As a result of this probe review, Medical Review will continue the 100 percent targeted pre-pay review of CAHs (type of bill 85X) billing CPT 82962, identified by edit reason code 5121K. Also, providers identified through data analysis as driving this aberrancy may warrant provider specific medical review.

It is your responsibility to check for ADRs. If we do not receive the requested information by the timeline noted on the ADR, the entire claim will be denied with reason code 56900.

In addition to the aforementioned references, CAH providers billing for laboratory services should review 42 CFR §411.15, *Medicare Benefit Policy Manual*, (CMS Pub. 100-02), Ch. 15, §80.1, to ensure adherence to all coverage criteria.



Comprehensive Error Rate Testing (CERT) Errors Web Page Update

The “Summary of Common Errors Identified by the Comprehensive Error Rate Testing (CERT) Program” page on our Web site has been updated. This information reflects recent errors billed by hospital providers which were identified by CERT. The errors relate to incorrect coding, duplicate payment and services being billed which were not rendered. The errors identified corresponded to the following HCPCS codes:

- 83519 vs. 83880
- 76005 vs. 76000 with modifier 59
- 94664
- 64479 vs. 64483
- 50398 and modifier 50
- 87220 vs. 87205

Please take time to review the errors found on the [“Summary of Common Errors Identified by the Comprehensive Error Rate Testing \(CERT\) Program”](#) Web page. This information will help to inform you of recent errors by CERT and enable you to review your internal processes to ensure that similar errors are not made within your facility.

September Education Events

To register go to the “[Calendar of Educational Events](#)” page on our Web site. Select the event title for registration instructions.

➤ “[Navigating the Medicare Resource Sea for Small and New Providers](#)” Webinar

Date: September 12, 2007

Time: 10:00 a.m.–11:30 a.m. Central Time (CT)

Registration Deadline: September 7, 2007

Intended Audience: This webinar is tailored for all Medicare Part A providers and staff that are new to Medicare billing, and small (less than 25 full-time employees) providers.

Description: This webinar will explore critical Medicare resources that are available through the Cahaba and the Centers for Medicare & Medicaid Services Web site for Part A providers.



- Didn't find what you were looking for? [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated. You may want to bookmark the [Medicare Part A](#) page for the most current Medicare A headlines or to subscribe to the Cahaba GBA, LLC [E-mail Notification Service](#). In addition, our online courses are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims <i>Updated</i>	Learn how to adjust or cancel claims.
Appeals Process	Learn about the Medicare appeals process.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Electronic Data Interchange	Learn about the Electronic Data Interchange (EDI) process.

Cahaba GBA, LLC Learning Corner

Course Title	Description
FISS 101: Introduction to FISS	Learn how to access FISS and receive an overview of FISS functions.
Insight into Medicare Coding	Learn the basics about Medicare coding.
Introduction to Medicare Cost Report	Learn the basics about the Medicare Cost Report.
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
NPI (National Provider Identifier)	Learn about the NPI (National Provider Identifier). Additional Resource: CMS NPI Training Package
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment	Learn about provider enrollment and how to apply.
Rural Health Clinic Billing	View a presentation on rural health clinic billing.
Skilled Nursing/Swing Bed PPS Consolidated Billing	View a presentation on skilled nursing facility/swing bed prospective payment system (PPS) consolidated billing.

Please note these courses were designed specifically for providers served by Cahaba GBA, LLC. You can find additional national courses under the [Medicare Learning Network](#).