

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



October 1, 2007

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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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| H Hospital/Critical Access Hospital (CAH) Providers | E Renal Dialysis Facility (RDF) | O Comprehensive Outpatient Rehabilitation Facility (CORF) Providers and Outpatient Physical Therapy (OPT) Providers |
| S Skilled Nursing Facility (SNF) / Swing Bed Providers | | |

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News Flash Messages from CMS For All Providers

**News Flash – New Medicare Learning Network (MLN) Catalog Available!**

The August 2007 edition of the MLN Products Catalog is now available - the MLN Products Catalog is an interactive downloadable document that lists all Medicare Learning Network products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download" when selected, will link you to the online version of the product. The word "hard copy" when selected, will automatically link you to the MLN Product Ordering page. To access the catalog, visit <http://www.cms.hhs.gov/MLNGENINFO> on the CMS Web site.

**2nd Edition of The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals**

The 2nd Edition of The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals is now available in downloadable format from the Centers for Medicare & Medicaid Services, Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf 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/>



National Provider Identifier (NPI) News Flash

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 is at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS Web site.



News Flash – Validating NPIs and Legacy Provider Identifier Pairs

Since May 29, 2007, Medicare fiscal intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating NPIs and Legacy Provider Identifier pairs submitted on claims against the Medicare NPI Crosswalk. Between the period of September 3, 2007, and October 29, 2007, all other Part B carriers and DME MACS will begin to turn on edits to validate the NPI/Legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Contractors have been instructed to inform providers at a minimum of seven days prior to turning on the edits to validate the NPI/Legacy pairs against the Crosswalk.



Vaccines Aren't Just for Kids!

August is National Immunization Awareness Month! Too many adults become ill, disabled, and die each year from diseases that could have been prevented by vaccines. Everyone from the very young to senior citizens can benefit from immunizations. While many consider this to be a time to ensure that children are immunized for school, National Immunization Awareness Month is the perfect time to remind patients, health care employees, family members, friends, co-workers and others to take advantage of opportunities to get up-to date on their vaccinations. For more information about Medicare's coverage of adult immunizations, including coverage, coding, billing and reimbursement, please visit the MLN Preventive Services Educational Products Web Page

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp and the CMS Adult Immunizations site at: http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp



Quick Reference Information: Medicare Preventive Services Laminated Chart Now Available

News Flash – The May 2007 version of the Quick Reference Information: Medicare Preventive Services laminated chart is now available to order or download from the Medicare Learning Network. To order, go to the “MLN Product Ordering Page” located at

http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 or to view online, go to http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS Web site.



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.





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



Quarterly October 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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: MM5710

Related CR Release Date: September 12, 2007

Related CR Transmittal #: R1334CP

Related Change Request (CR) #: 5710

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on CR 5710, which informs Medicare providers of the availability of the October 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP payment files (**if CMS determines that revisions are necessary to the latter files**). CR 5710 also advises Medicare providers that ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP Web page as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP NOC files (**if CMS determines that revisions are necessary to the latter files**). Providers should make certain that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all end-stage renal dialysis (ESRD) drugs furnished by both independent

and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers, and CMS supplies Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Website at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>

As announced in late 2006, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A of the Social Security Act. As part of this effort, CMS reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” are made operational in the context of payment under section 1847A. For the purposes of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The Food and Drug Administration (FDA) approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be made operational through use of existing specific HCPCS codes or “not otherwise classified” HCPCS codes.

For 2007, a separate fee of \$0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and]
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits were not updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after September 18, 2007, the October 2007 ASP file will be available for download from the CMS ASP Web site. If CMS determines that revisions are needed to the January 2007, April 2007, July 2007, and October 2006 ASP payment files, those revised files will also be available for retrieval from the CMS ASP Web page. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> on the CMS Web site. These quarterly files are applicable to claims based on dates of service as shown in the following table:

| Payment Allowance Limit Revision Date | Applicable Dates of Service for Claims Processed or Reprocessed on or after October 1, 2007 |
|--|--|
| October 2006 | October 1, 2006 through December 31, 2006 |
| January 2007 | January 1, 2007 through March 31, 2007 |
| April 2007 | April 1, 2007 through June 30, 2007 |
| July 2007 | July 1, 2007 through September 30, 2007 |
| October 2007 | October 1, 2007 through December 31, 2007 |

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR 5710) 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/R1334CP.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 "Phone Us" to call the Provider Contact Center.

Disclaimer

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Date of Service (DOS) for Laboratory Specimens

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: MM5573

Related CR Release Date: August 17, 2007

Related CR Transmittal #: R1319CP

Related Change Request (CR) #: 5573

Effective Date: January 1, 2007

Implementation Date: January 1, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs), for services provided to Medicare beneficiaries related to tests performed on laboratory specimens.

Provider Action Needed

This article is based on CR 5573 which implements revisions to the date of service (DOS) policy for tests performed on laboratory specimens, in accordance with updates to 42CFR 414.510 that were published in the *Federal Register* on December 1, 2006. **Remember when submitting claims that the general rule is that the date of service is the date the specimen is collected. Where a specimen is collected over a period that spans two calendar days, the date of service is the date the collection period ended.**

Background

The general rule for the date of service (DOS) of a test performed on a laboratory specimen is the date that the specimen is collected. If a specimen is collected over a period that spans two calendar days, then the DOS must be the date that the collection period ended.

The current DOS policy allows an exception to the general rule for tests performed on an archived specimen. If a specimen was stored for more than 30 calendar days before testing (otherwise known as “an archived specimen”), the DOS of the test must be the date that the specimen was obtained from storage.

In the final physician fee schedule regulation published in the *Federal Register* on December 1, 2006, (http://www.access.gpo.gov/su_docs/fedreg/a061201c.html), CMS revised the DOS policy for laboratory specimens to allow additional exceptions to the general rule and the DOS rule for tests performed on an archived specimen.

CR 5573 implements the revisions to the DOS policy for tests performed on laboratory specimens specified in the final rule, in accordance with the updates to 42 CFR §414.510

(<http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-9086.htm>).

As already mentioned, under the revised DOS policy for laboratory specimens, the **General Rule** is that the DOS of the test must be the date the specimen was collected. However, there is a **variation**: If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

The following exceptions apply to the DOS policy for laboratory tests:

DOS for Tests Performed on Stored Specimens:

In the case of a test performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test must be the date the test was performed only if:

- The test is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test do not guide treatment provided during the hospital stay; and
- The test was reasonable and medically necessary for treatment of an illness.

Note: If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived, and the DOS of the test must be the date the specimen was obtained from storage.

DOS for Chemotherapy Sensitivity Tests Performed on Live Tissue:

In the case of a chemotherapy sensitivity test performed on live tissue, **the DOS of the test must be the date the test was performed only if:**

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test do not guide treatment provided during the hospital stay; and
- The test was reasonable and medically necessary for treatment of an illness.

Note: For purposes of applying the above exception, a “chemotherapy sensitivity test” is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents.

Additional Information

The official instruction, CR 5573, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1319CP.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 “Phone Us” to call the Provider Contact Center.

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Clarification of Percutaneous Transluminal Angioplasty (PTA) Billing Requirements Issued in CR 3811

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: MM5667

Related CR Release Date: August 10, 2007

Related CR Transmittal #: R1315CP

Related Change Request (CR) #: 5667

Effective Date: March 17, 2005

Implementation Date: October 1, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5667 which adds ICD-9-CM diagnosis code 433.11, occlusion of the carotid artery with infarct, to the list of payable claims for PTA to ensure all eligible Medicare beneficiaries are covered.

Background

On March 17, 2005, CMS issued a National Coverage Determination (NCD) providing Medicare coverage for Percutaneous Transluminal Angioplasty (PTA) of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). (This was announced in CR 3811, effective March 17, 2005; see related MLN Matters article at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM3811.pdf>.) The NCD provides coverage for patients with symptomatic carotid artery stenosis who meet the coverage criteria specified in the policy. As stated in the NCD,

- Patients who experience non-disabling strokes (modified Rankin scale < 3) are considered to be symptomatic and therefore **are eligible for coverage**; however,
- Patients who experience disabling strokes (modified Rankin scale \geq 3) **are not eligible for coverage**.

Currently, there are no codes that distinguish between non-disabling and disabling strokes. In order to ensure that claims for all eligible patients can be paid, CR 5667 adds the following International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code of 433.11 (Occlusion and stenosis of carotid artery, with cerebral infarction) to the list of payable claims for carotid artery stenting (CAS).

Patients who experience disabling strokes remain ineligible for coverage.

Note that Medicare contractors will not search their files to reprocess claims already processed. However, they will adjust such claims if you bring the claims to their attention. Also, since CMS considers this an administrative error, your Medicare contractor will follow the guidelines in the *Medicare Claims Processing Manual* (CMS Pub 100-04, Ch. 1, §70.7.1) for allowing an extension to the timely filing limits. In essence, this allows your contractor to accept claims with 433.11 outside the timely filing limitations, since such claims were not previously payable due to the administrative error. Medicare manuals are available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site.

CR 5667 also advises providers that they can correctly bill covered bilateral carotid services by coding both 433.30 (Occlusion and stenosis of multiple and bilateral arteries, without mention of cerebral infarction) or 433.31 (Occlusion and stenosis of multiple and bilateral arteries, with cerebral infarction) and 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) or 433.11 in any order on the same claim. Providers would code 433.30 with 433.10 or 433.31 with 433.11 to identify the multiple and bilateral condition and 433.10 or 433.11 to specifically identify the carotid artery.

Claims submitted by physicians to carriers or MACs may also contain a CPT code of 37215 (Transcatheter placement of intravascular stent(s), cervical carotid artery, Percutaneous; with distal embolic protection), 0075T (Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including

radiologic supervision and interpretation, percutaneous; initial vessel), or 0076T (Each additional vessel). Claims submitted by institutional providers to FIs or MACs should contain the appropriate procedure codes of 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessels) and 00.63 (Percutaneous insertion of carotid artery stent(s)).

Additional Information

MM3489, Percutaneous Transluminal Angioplasty (PTA) can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf> on the CMS Web site.

MM3811, Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA) is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf> on the CMS Web site.

MM5022, Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty (PTA) Concurrent with the Placement of an FDA-approved Carotid Stent, is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5022.pdf> on the CMS Web site.

The official instruction, CR 5667, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1315CP.pdf> on the CMS Web site.

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October Update to the 2007 Medicare Physician Fee Schedule Database

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: MM5714

Related CR Release Date: August 30, 2007

Related CR Transmittal #: R1326CP

Related Change Request (CR) #: 5714

Effective Date: January 1, 2007

Implementation Date: October 1, 2007

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries, or Medicare administrative contractors (MACs)) for professional services paid under the MPFS.

What You Need to Know

CR 5714, from which this article was taken, amends the payment files previously issued to your Medicare contractor (based upon the December 1, 2006, Medicare Physician Fee Schedule (MPFS) Final Rule); and includes new codes for the Physician Quality Reporting Initiative.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Medicare contractors, in accordance with the *Medicare Claims Processing Manual*, (CMS Pub 100-04), Ch. 23, §30.1, give providers 30 days notice before implementing the revised payment amounts and the changes identified in CR 5714, which (unless otherwise stated in the CR 5714) will be retroactive to January 1, 2007.

You should be aware that carriers will adjust claims that you bring to their attention, but are not required to search their files to either retract payment for claims already paid or to retroactively pay claims. The changes made as a result of CR 5714 are as follows:

Changes included in the October Update to the 2007 Medicare Physician Fee Schedule Database are as follows:

The following changes are retroactive to January 1, 2007:

| CPT/HCPCS | ACTION |
|-----------|--|
| 16035 | Global Period = 000 Pre Op = 0.00 Intra Op = 0.00 Post Op = 0.00 |
| 20690 | Bilateral Indicator = 0 |
| 38740 | Bilateral Indicator = 1 |
| 38745 | Bilateral Indicator = 1 |
| 54150 | Transitional Non-Facility PE RVU = 3.38 Transitional Facility PE RVU = 0.73 |
| 64412 | Bilateral Indicator = 1 |
| 64418 | Bilateral Indicator = 1 |
| 64613 | Bilateral Indicator = 1 |

As stated in Transmittal 1301, dated July 20, 2007, (Change Request 5665 -- Revised Information on PET Scan Coding), effective January 28, 2005, CPT code 78609 became a non-covered service for Medicare purposes.

| CPT Code | Procedure Status Indicator* |
|---|-----------------------------|
| 78609 | N |
| 78609 – TC (Technical Component) | N |
| 78609 – 26 (Professional Component) | N |

*Effective for dates of service on or after January 28, 2005

New Category II codes for the Physician Quality Reporting Initiative (PQRI)

Effective for dates of service on or after October 1, 2007, the following Category II codes will be added to the MPFS with a status indicator of “M”.

| Code | Long Descriptor | Short Descriptor |
|-------------|--|---|
| 1116F | Auricular or periauricular pain assessed | Auric/peri pain assessed |
| 2035F | Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry | Tymp memb motion exam'd |
| 3215F | Patient has documented immunity to Hepatitis A | Pt immunity to hep a doc'd |
| 3216F | Patient has documented immunity to Hepatitis B | Pt immunity to hep b doc'd |
| 3219F | Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C | Hep c geno tstng doc'd - done |
| 3220F | Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment | Hep c quant rna tstng doc'd |
| 3230F | Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion | Note hring tst w/in 6 mon |
| 3260F | pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report | Pt cat/pn cat/hist grd doc'd |
| 4130F | Topical preparations (including OTC) prescribed for acute otitis externa | Topical prep rx, aoe |
| 4131F | Systemic antimicrobial therapy prescribed | Syst antimicrobial thx rx |
| 4132F | Systemic antimicrobial therapy not prescribed | No syst antimicrobial thx rx |
| 4133F | Antihistamines or decongestants prescribed or recommended | Antihist/decong rx/recom |
| 4134F | Antihistamines or decongestants neither prescribed nor recommended | No antihist/decong rx/recom |
| 4135F | Systemic corticosteroids prescribed | Systemic corticosteroids rx |
| 4136F | Systemic corticosteroids not prescribed | Syst corticosteroids not rx Disclaimer |
| 4150F | Patient receiving antiviral treatment for Hepatitis C | Pt recvng antivir txmnt hepc |
| 4151F | Patient not receiving antiviral treatment for Hepatitis C | Pt not recvng antiv hep c |
| 4152F | Documentation that combination peginterferon and ribavirin therapy considered | Doc'd pegintf/rib thxy consid |
| 4153F | Combination peginterferon and ribavirin therapy prescribed | Combo pegintf/rib rx |

| Code | Long Descriptor | Short Descriptor |
|-------------|--|------------------------------|
| 4154F | Hepatitis A vaccine series recommended | Hep a vac series recommended |
| 4155F | Hepatitis A vaccine series previously received | Hep a vac series prev recvd |
| 4156F | Hepatitis B vaccine series recommended | Hep b vac series recommended |
| 4157F | Hepatitis B vaccine series previously received | Hep b vac series prev recvd |
| 4158F | Patient education regarding risk of alcohol consumption performed | Pt edu re: alcoh drnkng done |
| 4159F | Counseling regarding contraception received prior to initiation of antiviral treatment | Contrcp talk b/4 antiv txmnt |

The payment indicators are identical for all of the above PQRI CPT codes and those indicators are as follows:

| | |
|---|------|
| Procedure Status: | M |
| WRVU: | 0.00 |
| Non-Facility PE RVU: | 0.00 |
| Facility PE RVU: | 0.00 |
| Malpractice RVU: | 0.00 |
| PC/TC: | 9 |
| Site of Service: | 9 |
| Global Surgery: | XXX |
| Multiple Procedure Indicator: | 9 |
| Bilateral Surgery Indicator: | 9 |
| Assistant at Surgery Indicator: | 9 |
| Co-Surgery Indicator: | 9 |
| Team Surgery Indicator: | 9 |
| Physician Supervision Diagnostic Indicator: | 9 |
| Type of Service: | 1 |
| Diagnostic Family Imaging Indicator: | 99 |

*Effective for services performed on or after October 1, 2007

The short descriptor for G8370 was listed incorrectly in Transmittal 1258, dated May 29, 2007, (Change Request 5614 – July Update to the 2007 Medicare Physician Fee Schedule Database). The short descriptor has been corrected to read:

| HCPCS | Revised Short Descriptor |
|--------------|---------------------------------|
| G8370 | Asthma pt w survey not docum |

Additional Information

You can find the official instruction about the October update to the 2007 Medicare Physician Fee Schedule Database by going to CR5714, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1326CP.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 “Phone Us” to call the Provider Contact Center.

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2008 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), Medicare Carriers and Fiscal Intermediaries (FIs)

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: MM5696

Related CR Release Date: August 17, 2007

Related CR Transmittal #: R1317CP

Related Change Request (CR) #: 5696

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), Part A/B Medicare administrative contractors (Part A/B MACs) and fiscal intermediaries (FIs)) for services provided to Medicare beneficiaries in SNFs.

Provider Action Needed

STOP – Impact to You

This article is based on CR 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

CAUTION – What You Need to Know

CR 5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, (CMS Pub. 100-04) Ch. 6, §110.4.1 for carriers and Ch. 6, §20.6 for FIs.

GO – What You Need to Do

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

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site. Institutional providers note that this site will include new Excel® and PDF format files.

Note: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information

The official instruction, CR 5696, issued to your Medicare contractor regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.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 "Phone Us" to call the Provider Contact Center.

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Sunset of the Physician Scarcity Area (PSA) Bonus Payment

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: MM5711

Related CR Release Date: August 24, 2007

Related CR Transmittal #: R1321CP

Related Change Request (CR) #: 5711

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Providers billing a Medicare carrier, fiscal intermediary (FI), or Medicare administrative contractor (A/B MACs) for services provided to Medicare beneficiaries in physician scarcity areas.

Provider Action Needed

STOP – Impact to You

This article is based on CR 5711 that reminds physicians that the PSA bonus under Section 413(a) of the Medicare Modernization Act (MMA) will sunset after December 31, 2007.

CAUTION – What You Need to Know

The PSA bonus is payable for dates of service January 1, 2005, through December 31, 2007. The PSA bonus is not payable for dates of service after December 31, 2007.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes as listed in the “Background” section below and in the revisions to the *Medicare Claims Processing Manual* (Pub 100-04) Ch. 4, §§250.2.1, 250.2.2 and 250.3.2. The revised manual sections are attached to the official instruction in CR 5711. The Web address for accessing CR 5711 is in the “Additional Information” section of this article.

Background

Section 413(a) of the Medicare Modernization Act (MMA) requires Medicare to pay an additional 5 percent bonus to physicians rendering service in a designated PSA. Physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county or the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural census tract. The bonus payment is based on the amount actually paid, not the amount Medicare approved for each service. The Key Point of CR 5711 is that the PSA termination date is December 31, 2007, and is not payable for dates of service after that date.

Additional Information

For complete details regarding this issue, see the official instruction (CR 5711) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1321CP.pdf> on the CMS Web site.

For the CMS Web site with information about HPSA/PSA (Physician Bonuses) and zip code downloadable files you may visit <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> on the CMS Web site.

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

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Ultrasound Diagnostic Procedures

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: MM5608

Related Change Request (CR) #: 5608

Related CR Release Date: September 12, 2007

Effective Date: May 22, 2007

Related CR Transmittal #: R76NCD

Implementation Date: September 28, 2007

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs) for ultrasound diagnostic procedures.

What Providers Need to Know

CR 5608, from which this article is taken, announces that effective on and after May 22, 2007, CMS will allow payment for the monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the intensive care unit (ICU) and for operative patients with a need for intra-operative fluid optimization.

Make sure that your billing staffs are aware of this change in the *National Coverage Determinations (NCD) Manual*, (CMS Pub 100-03) Ch. 1 (Coverage Determinations), §220.5 (Ultrasound Diagnostic Procedures) to allow coverage for this procedure.

Background

CR 5608, from which this article is taken, announces:

- Effective for claims with dates of service on and after May 22, 2007, CMS has determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and for operative patients with a need for intra-operative fluid optimization is reasonable and necessary; and
- The previous national noncoverage of cardiac output Doppler monitoring is therefore removed.

Specifically, in CR 5608, CMS amends the *Medicare NCD Manual*, Ch. 1 (Coverage Determinations), §220.5 (Ultrasound Diagnostic Procedures), by adding: “Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization” to Category I (covered procedures), and deleting “Monitoring of cardiac output (Doppler)” from Category II (non-covered procedures).

Notes:

There is no specific CPT code for this service. CPT code 76999 is for unlisted ultrasound procedures.

When performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for ultrasound diagnostic procedures, the professional services only are separately payable when billed using CPT code 76999 with the modifier -26 to show professional component.

Such services, when globally billed in a hospital setting with code 76999, will be returned as unprocessable to the provider with a reason code such as 58 denoting “Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.”

When such services are billed in a hospital setting as technical services with the code 76999-TC, Medicare will deny the services with the 58 reason code and an M77 remark code to show “Missing/Incomplete/Invalid place of service.”

When performed in an ambulatory surgery center (ASC), ultrasound diagnostic procedures are covered when performed by an entity other than the ASC if globally billed using code 76999, or the technical and professional components may be separately billed using codes 76999-TC and 76999-26, respectively.

Ultrasound diagnostic procedures professional services billed using codes 76999, 76999-T, and 76999-26 are carrier-priced.

Medicare contractors will not search their files to identify and adjust claims processed prior to the implementation of this change, which are for services rendered on or after May 22, 2007. However, they will adjust such claims when you bring the claims to their attention.

Additional Information

You can find more information about the coverage of esophageal Doppler monitoring of cardiac output by going to CR 5608, located at <http://www.cms.hhs.gov/Transmittals/downloads/R76NCD.pdf> on the CMS Web site. You will find the amended *Medicare NCD Manual*, Ch.1 (Coverage Determinations), §220.05 (Ultrasound Diagnostic Procedures), 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 “Phone Us” to call the Provider Contact Center.

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News from CMS for Hospital/CAH Providers



Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services

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: MM5684

Related CR Release Date: August 17, 2007

Related CR Transmittal #: R47GI

Related Change Request (CR) #: 5684

Effective Date: September 17, 2007

Implementation Date: September 17, 2007

Provider Types Affected

Physicians and hospitals who bill Medicare fiscal intermediaries (FIs), carriers, and Part A/B Medicare administrative contractors (A/B MACs) for ambulance services for Medicare patients.

Background

CR 5684 furnishes the revised Certification for Hospital Services by the Supplementary Medical Insurance Program as those requirements pertain to physician certification of ambulance services in Ch. 4, §20 of the *Medicare General Information, Eligibility, and Entitlement Manual* (CMS Pub. 100-01).

Key Points of CR 5684

- Prior to the effective date (September 17, 2007) of CR 5684, certification by a physician in connection with ambulance services furnished by a participating hospital was required.
- As of the effective date of CR 5684, language requiring physician certification for ambulance services furnished by a participating hospital is deleted from the above mentioned Medicare manual.
- Your Medicare FI, carrier or A/B MAC has been instructed to comply with this revision.

Additional Information

To view the official instruction (CR 5684) issued to your Medicare FI, carrier or A/B MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R47GI.pdf> on the CMS Web site. The revised manual section is attached to CR 5684.

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

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Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for IRF PPS services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on CR 5694, which provides details about the annual IRF PPS rate updates for Fiscal Year (FY) 2008.

CAUTION – What You Need to Know

Updated rates are effective for claims with discharges that fall on or after October 1, 2007, and on or before September 30, 2008.

GO – What You Need to Do

See the “Background” section of this article for further details regarding this IRF annual update.

Background

On August 7, 2001, CMS published a Final Rule in the *Federal Register* (http://www.access.gpo.gov/su_docs/fedreg/a010807c.html) that established the Prospective Payment System (PPS) for Inpatient Rehabilitation Facilities (IRFs) as authorized under the Social Security Act (Section 1886(j)). In that final rule, CMS set forth per discharge Federal rates for Federal FY 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002, and annual updates to the IRF PPS rates are required by the Social Security Act (Section 1886(j)(3)(C)).

On August 7, 2007, CMS published the FY 2008 IRF PPS Final Rule in the *Federal Register* (<http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f.pdf>) which provides the prospective payment rates applicable for IRFs for FY 2008.

A new IRF PRICER software package will be released prior to October 1, 2007, that will contain the updated rates that are effective for claims with discharges that fall on or after October 1, 2007, through September 30, 2008. Your FI or Part A/B MAC will install the new revised Pricer program in a timely fashion to ensure you receive accurate payments for IRF PPS claims with discharges occurring on or after October 1, 2007, through September 30, 2008.

The IRF PPS FY 2008 rates applicable to discharges on or after October 1, 2007, through September 30, 2008 are as shown in the following table:

| | |
|---|----------|
| Standard Federal rate | \$13,451 |
| Fixed loss amount | \$7,362 |
| Labor-related share | 75.818% |
| Non-labor related share | 24.182% |
| Urban national average cost-to-charge ration (CCR) | 0.476 |
| Rural national average CCR | 0.596 |

Additional Information

The official instruction, CR 5694, issued to your Medicare FI or A/B MAC regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1323CP.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 “Phone Us” to call the Provider Contact Center.

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Present On Admission (POA) Indicator—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Present on Admission (POA) Indicator,” which was published in the September 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: MM5499 Revised

Related Change Request (CR) #:5499

Related CR Release Date: May 11, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R1240CP

Implementation Date: October 1, 2007

Note: This article was revised on September 6, 2007, to clarify the timeframes for reporting the POA indicators.

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 providers should begin to submit a Present On Admission (POA) Indicator for every diagnosis on your inpatient acute care hospital claims. 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 October 1, 2007, 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.

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 admission (POA) of patients effective for discharges on or after October 1, 2007. By 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.

Between October 1, 2007, and December 31, 2007, CMS will collect the information on the hospital claim, but does not intend to provide any remittance or other information to hospitals if the information is not submitted correctly for each diagnosis on the claim. 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 Present On Admission (POA) indicator for all claims involving inpatient admissions to general acute care hospitals. CR 5499, from which this article is taken, announces this requirement 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.

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 CR 5679 (<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: “POAYNUW1YZ,” 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 (I), 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 diagnose 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

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



Contractor Workload Transition Causes Fiscal Intermediary Standard System (FISS) “Dark Days”

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

The Centers for Medicare & Medicaid Services (CMS) requires that separate contractor workload numbers be created for the Cahaba Iowa Part A workload and the regional home health intermediary (RHHI) workload. To complete the contractor workload transition, the Fiscal Intermediary Standard System (FISS) and the eligibility systems ELGA/ELGH will be unavailable (“dark days”) on November 1 and 2, 2007. Providers will not have access to FISS, ELGA and ELGH; however, providers will have the ability to submit electronic claims via file transfer. Although our Provider Contact Center will be available to take your call, the Customer Service Representatives (CSRs) will not have access to FISS, ELGA and ELGH as well. Therefore, the CSRs will be unable to assist with claim specific, or eligibility questions. In addition, FISS will not cycle, which means that claims will not be sent to the Common Working File (CWF) either night. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on November 1 and 2, 2007. Access to FISS, ELGA and ELGH will be restored on Monday, November 5, 2007.

Additional information about this transition and how it affects you will be posted to the “[What’s New from Cahaba GBA](#)” page of our Web site and through email messages. To receive the email messages, subscribe now to [Cahaba GBA’s E-mail Notification Service](#).

For additional information about the separation of contractor workload numbers, refer to the article, “New Contractor Workload Number for Cahaba Part A Iowa Data”, which was published in the June 1, 2007, [Medicare A Newsline](#) and the [Home Health & Hospice Medicare A Newsline](#).



CMS Awards the Medicare Administrative Contractor to Process Part A & Part B Medicare Claims in Iowa, Kansas, Missouri and Nebraska

On September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) announced it had awarded the contract for the processing of both Part A and Part B Medicare claims for Iowa, Kansas, Missouri and Nebraska. The winning contractor, Wisconsin Physician Service Health Insurance Corporation (WPS), is headquartered in Madison, Wisconsin.

WPS will immediately begin implementation activities and will assume full responsibility for the work no later than September 9, 2008. Cahaba GBA, LLC will work closely with WPS throughout the transition process to ensure a smooth transfer of business functions for the Medicare Part A providers in Iowa that are impacted by this contractor change.

Note: This Medicare administrative contractor (MAC) award does not impact home health and hospice providers who bill Cahaba as their regional home health intermediary (RHHI).

For additional information, refer the CMS Web site at:

http://www.cms.hhs.gov/MedicareContractingReform/02_What's%20New.asp#TopOfPage



New Web Page to Assist with Common Part A Claim Submission Errors (CSEs)

In our continuing effort to strive toward our goal of developing education and outreach to assist providers with their billing errors, Cahaba has promoted a new Web page, which lists the most common CSEs among all Part A providers, the reason the error occurs, the claim processing result (return to provider (RTP) or reject) and tips for resolving/preventing future errors for these reasons.

This information can be accessed from the "[Claims](#)" Web page on the Cahaba Web site by clicking on the "[Top Claim Submission Errors and How to Resolve](#)" link.

Please access this Web page for assistance with resolving or preventing billing errors for the following reason codes:

- 19201
- 32103
- 32226
- 37402
- 38050
- 38107
- 38157
- 38200
- C7010
- U5233

This Web page will be updated as new or additional resources become available, or as other claim submission errors are identified through 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 appropriately submitting your services for Medicare payment.



New Process and Clarification on Submitting Adjustments

Cahaba will be standardizing the process by which all providers submit adjustments to partially denied claims. Effective November 1, 2007, Iowa Part A providers and home health and hospice providers will be allowed to submit electronic adjustments for partially denied claims. While this is not a new process for Alabama providers, this article serves as a reminder for appropriately submitting an adjustment to a partially denied claim.

The following information only applies when an adjustment needs to be made to paid lines. **Adjustments cannot be made to any part of a denied line.** If your facility is disputing the denied charges, you must submit an appeal.

Cahaba strongly encourages your facility to submit electronic adjustments which provides a shorter claim processing time frame. However, Cahaba will still accept adjustments submitted via paper claims (UB-04). Please review the appropriate process below depending upon whether your facility submits adjustments via batch file transfer or using the Fiscal Intermediary Standard System (FISS).

- **For providers submitting adjustments via Batch File Transfer:**

Step 1: Verify that the claim you wish to adjust contains partially denied charges by using the FISS Inquiry Menu, Option 12 (Claims), or by reviewing your facility's remittance advice.

Step 2: Select the claim that was originally submitted via batch file transfer and move the denied charges to the noncovered field. If the charges are not moved to the noncovered field, the adjustment will not process.

Step 3: Make the desired changes and add the appropriate adjustment codes.

Step 4: Include remarks to indicate the reason for the adjustment.

Step 5: Submit claim via batch file transfer.

Step 6: Monitor the status of your adjustment using the FISS. If there are processing issues resulting from the submitted adjustment, the claim will be sent to the return to provider (RTP) file.

- **For providers submitting adjustments using FISS (Direct Data Entry (DDE)):**

Step 1: Access the claim via FISS using the Claim Adjustment Menu Options (30-35)

Step 2: Make the desired adjustments and add the appropriate adjustment codes.

Step 3: Include remarks on FISS Claim Page 04 to indicate the reason for the adjustment.

Step 4: Submit the claim by pressing the F9 key.

Step 5: Monitor the status of your adjustment using the FISS. If there are processing issues resulting from the submitted adjustment, the claim will be sent to the RTP file.

If you have any questions regarding these instructions or if you experience difficulties in submitting adjustments via batch file transfer or DDE, refer to the "[Contact Us](#)" page of our Web site and select "Phone Us" to call the appropriate Provider Contact Center.



Follow-up to Questions from August 2, 2007 Ask-The-Contractor Teleconference (ACT)

The questions below were received following the August 2, 2007, "Dial In And Win With Timely Medicare Payments" Ask-The-Contractor Teleconference. The questions and responses are being published so that all providers billing Cahaba have access to this information.

Question 1: Please provide information on how to handle a Medicare claim which rejected due to another insurance, and now, we need to bill Medicare because that insurance did not pay. Is it best to do an adjustment on the rejected claim using Claim Change Reason Code (CCRC) “D8”?

Answer 1: Generally, claims that reject for Medicare Secondary Payer (MSP) issues should be adjusted. The instructions below are based on the following scenario: Medicare was originally billed as the primary payer and the claim rejected because there was a valid MSP record posted to the beneficiary’s eligibility file. The true primary insurer was billed and denied the charges necessitating the billing of Medicare as the secondary payer. If Medicare was billed as the primary payer and should have been billed as the secondary payer, CCRC “D8” **is not** used. Instead, CCRC “D7” is entered in FL 18-28 of the CMS-1450 claim form. Also ensure that the adjustment contains the following data elements:

- TOB (FL 4), the last digit of the type of bill should be "7"
- DCN (FL 64), enter the Document Control Number (DCN) of the rejected claim
- OCC CDS/DATE (FL 31-34), enter “24” and the date of denial by the primary insurer. If Medicare is secondary because of injuries sustained in an accident enter the appropriate “Accident” occurrence code (01, 02, 03, or 04) and date the injuries were sustained.
- VALUE CODES (FL 39-41), enter the appropriate value code of the type of MSP record and zeros (0000.00) in the **amount** field. See the [Medicare Secondary Payer \(MSP\) Manual \(Pub. 100-05, Ch. 3, § 50\)](#) for a listing of MSP value codes.
- PAYER (FL 50A), enter the name of the primary insurer
- PAYER (FL 50B), enter “Medicare”
- INSURED NAME (FL 58A), enter the name of the individual who carries the primary insurance
- INSURED NAME (FL 58B), enter the name of the Medicare beneficiary
- REL (59A), enter the patient’s relationship to the insured. See the [Medicare Secondary Payer \(MSP\) Manual \(Pub. 100-05, Ch. 3, § 50\)](#) for a listing of patient relationship codes
- REL (59B), enter “18” for patient’s relationship to self.
- CERT/SSN/HIC (FL 60A), enter the identification number of the primary insurance
- CERT/SSN/HIC (FL 60B), enter the beneficiary’s Medicare number
- GROUP NAME (FL 61A), enter the name of the primary insurance
- GROUP NAME (FL 61B), enter Medicare as the secondary payer
- INSURANCE GROUP NUMER (FL 62A), enter the primary insurance group number
- REMARKS (FL 80), enter remarks to indicate that a denial was received from the primary insurer, why the primary insurer denied payment, and any additional comments relevant to the adjustment request.
- If using the Fiscal Intermediary Standard System (FISS) to submit MSP information on a claim, enter the appropriate payer code for the type of MSP insurance on line A and “Z” for Medicare as the secondary insurance on line B in the CD field on Claim Page 03. See the [“Claims and Attachments Menu” section](#) of the *FISS Reference Guide* for a listing of MSP payer codes. This information begins on page 12.

If using FISS to submit the adjustment, you will also need to add an adjustment reason code on Claim Page 03. Please access the [“Claims Correction”](#) section of the *FISS Reference Guide* for step-by-step instructions on adjustments.

The [“Medicare Secondary Payer”](#) Web page also contains information to assist in the appropriate billing of MSP claims to Medicare, including a flow chart to determine if Medicare is secondary, instructions on how to submit an MSP claim to Medicare, depending on the type of primary insurance, as well as information for submitting an adjustment when your claim was paid or denied incorrectly because of an MSP record.

Question 2: Will staff residents be required to apply for an NPI? In the past, we were able to use RES000 as the generic Unique Physician's Identification Number (UPIN). Will there be a similar generic code for residents under the NPI system?

Answer 2: The Centers for Medicare & Medicaid Services (CMS) has issued guidelines regarding the National Provider Identifier (NPI) requirements for Medicare providers, which include resident physicians. All providers are required to obtain an NPI. CMS will no longer issue generic codes for billing purposes. If a valid NPI is not acquired, charges for Medicare-covered services cannot be billed to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs) or Medicare administrative contractors (MACs).

Question 3: Our Medicare provider number is missing from the "Hospice Provider ID" list on the CMS Web site. How do we have this list updated?

Answer 3: This issue was addressed in the "Medicare Forum" information published in the [June 1, 2007, Home Health and Hospice Medicare A Newsline](#) on page 35. To reiterate the information published, providers themselves do not apply to be added to the list. The "Hospice Provider ID Information" list is generated from data reported to the Healthcare Cost Report Information System (HCRIS). The information currently included in this list is based on data from fiscal year (FY) 1999 through FY 2006 of hospice cost reports that were received by HCRIS through March 31, 2007. Typically, the information is updated quarterly.

Question 4: Is patient status code "06" used on home health claims when a beneficiary elects a Medicare Advantage (MA) plan during an episode? What dates are billed on the claim? How are HHAs reimbursed? What happens when the patient terminates their MA Plan election?

Answer 4: Yes, patient status code "06" is used on home health claims when the beneficiary's payer source changes from Medicare Fee-For-Service (FFS) to a Medicare Advantage (MA) plan during a 60-day episode. The dates of service on the claim should only reflect the services that were provided during the episode prior to the MA plan enrollment date.

If a beneficiary elects an MA plan during an episode, the HHA receives a partial episode payment (PEP), which is a proportion of the episode payment based on the span of days during which the Medicare FFS covered services were provided.

When a Medicare beneficiary is covered under an MA organization during a period of home care, and subsequently decides to change to Medicare FFS coverage, a new 60-day home health episode is established and may be billed beginning with the date of the patient's return to FFS coverage. The "From" date billed on the RAP should reflect the date of the first visit provided after the FFS effective date.

Please refer to the [Medicare Claims Processing Manual, \(CMS Pub. 100-04, Ch. 10, § 10.1.5.2 & 80\)](#) for additional information regarding how MA Plans impact home health episodes.



Tips for Adjusting Rejected Claims

Please use the following tips to ensure that the adjustment submitted for a rejected claim (status/location R B9997) processes successfully in the Fiscal Intermediary Standard System (FISS).

- **Ensure the rejected claim is appropriate to adjust.**
 - Select Option ‘03’ (Claims Correction) from the FISS Main Menu.
 - Select the appropriate “Claim Adjustments” option (30-35) based on the type of claim you want to adjust.
 - At the Claim Summary Inquiry screen, tab to the ‘S/LOC’ (status/location) field and key ‘R’ to replace the existing ‘P’. The type of bill (TOB) may also need to be changed. A Health Insurance Claim Number (HICN), ‘From’ date and ‘To’ date may also be entered. Press Enter to see those claims matching the criteria you entered.
 - When selecting a claim through the “Claims Adjustment” menu in FISS, information should appear as usual on the FISS claim pages.
 - If the claim is selected and no information appears, look for a message at the bottom of the page that states “ADJUSTMENT CLAIM IS ALREADY CANCELED”.
 - The claim cannot be adjusted, and should instead be resubmitted to Medicare with the changed information.

NOTE: It is **never** appropriate to adjust a claim that rejected because it was a duplicate of a previously submitted Medicare claim. See the “[Claim Correction](#)” section of the *FISS Reference Guide* for a list of other situations when adjusting rejected claims is not appropriate.

- **Update Claim Page 02.**
 - When claims reject, FISS places charges into the NCOV CHARGES field on claim page 02. Charges should only appear in the TOT CHARGES field.
 - Due to modifications in FISS effective January 1, 2007, providers must delete and add revenue code detail lines to change information contained in them.
 - See the “[Claims Correction](#)” section of the *FISS Reference Guide* for detailed instructions for adding and deleting revenue lines.
- **Verify required data elements for adjustments.**

| Data Element | FISS Claim Page | UB-04 Form Locator (FL) | Comments |
|---|-----------------|-------------------------|---|
| Type of Bill (TOB) | 1 | 4 | Third digit of TOB = 7. Examples: 327, 337, 817, 827 If using FISS, this information is auto-plugged. |
| Condition Codes (COND CODES) - Claim Change Reason Codes (CCRC) | 1 | 18-28 | See the “ Claims Correction ” section of the <i>FISS Reference Guide</i> for a listing of CCRCs. |
| Document Control Number (DCN) | 1 | 64 | Enter the DCN of the rejected claim to be adjusted. If using FISS to submit adjustment, this information is auto-plugged. |

| Data Element | FISS Claim Page | UB-04 Form Locator (FL) | Comments |
|--|-----------------|-------------------------|--|
| Adjustment Reason Code (ADJUSTMENT REASON CODE) | 3 | N/A | If using FISS to submit adjustment, this field is required. See the “ Claims Correction ” section of the <i>FISS Reference Guide</i> for a listing of Adjustment Reason Codes. |
| Remarks (REMARKS) | 4 | 80 | Remarks are encouraged on all adjusted claims and required on adjustments when CCRC “D9” is used. Include your initials and date you entered your remarks. |

Additional Resources:

- “[Claims Correction](#)” section of the *FISS Reference Guide*
- “[Adjusting and Canceling Claims](#)” online course
- *CMS Medicare Claims Processing Manual* ([Pub. 100-04, Ch. 25](#))



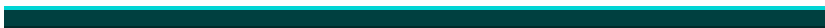
Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the *Federal Register*.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update [listserv](#) (electronic mailing list).

We encourage you to bookmark the [Quarterly Provider Update](#) Web site and visit it often for this valuable information.





Postpayment On-site Reviews

A postpayment review is one of the activities performed by our Medical Review staff and is a comprehensive review of individual beneficiary medical records. This review of records may be conducted either on-site at your facility or may be done in our Medical Review department. Please be aware that if the review is done on-site at your facility, the Medicare Medical Review staff person who visits your facility must show your staff a photo identification indicating their affiliation with Cahaba GBA, LLC. Verifying proper identification is important before allowing access to your patient's medical records.

For additional information about postpayment reviews, refer to §3.6.2 in Chapter 3 of the *Medicare Program Integrity Manual*, Publication 100-8. This manual can be found on the CMS Web site at: <http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf>



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 Newsline*.

| CSR Training Date | Time |
|-------------------|--------------------------|
| October 4, 2007 | 10:30 a.m.–12:30 p.m. CT |
| October 11, 2007 | 10:30 a.m.–12:30 p.m. CT |
| October 18, 2007 | 10:30 a.m.–12:30 p.m. CT |
| October 25, 2007 | 10:30 a.m.–12:30 p.m. CT |

October Federal Holiday

In observance of the federal holiday, Columbus Day, on Monday, October 8, 2007, the Provider Contact Center will not be available. The Fiscal Intermediary Standard System (FISS) will be available and providers can submit claims and receive reports electronically.





Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **October 31, 2007**, for the quarter ending **September 30, 2007**.

The [Medicare Credit Balance Report \(CMS-838\)](#) and certification must be postmarked by the date indicated above. If the information is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

To ensure timely receipt and processing, please send the report to the appropriate address listed below.

If you submit your Medicare claims to the Cahaba GBA office in Des Moines, Iowa, send the report to:

Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA
P.O. Box 14537
Des Moines, IA 50306-3537

Or, if sending overnight:

Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA
400 E Court Ave
Des Moines, IA 50309-2019

If you submit your Medicare Credit Balance report to the above address and have any questions, please contact the Medicare Credit Balance telephone line at **515-471-7444**.

If you submit your Medicare claims to the Cahaba GBA office in Birmingham, Alabama, send the report to:

Medicare Part A Credit Balance Reporting

Cahaba GBA
P.O. Box 10808
Birmingham, AL 35202-0808

If you submit your Medicare Credit Balance report to the above address and have any questions, please contact the Medicare Credit Balance telephone line at **205-220-1280**.

If you need a paper copy of the CMS-838 form, contact the appropriate Medicare Credit Balance telephone line listed above.



Medicare A Local Coverage Determination (LCD) Update

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 information.

Finalized Draft LCDs

The following Part A draft LCDs have been finalized and can be viewed on our Web site. Following a 45-day notice period, which begins October 1, 2007, the LCDs will become effective November 15, 2007.

- Oxaliplatin for Injection (Eloxatin™)
- Zoledronic Acid

Draft LCDs can be found at https://www.cahabagba.com/part_a/policies_medical_review/lcd_draft.htm on our Web site. There were no comments for these Draft LCDs.

Revised LCDs

- **Erythropoietin Analogues**—Effective July 30, 2007, the Centers for Medicare & Medicaid Services (CMS) announced revisions in its National Coverage Determination (NCD) 000383 for the use of Erythropoietin Analogues (EA). In response to these changes, the local coverage determination (LCD) for EA (L20432) has been revised.

The ICD-9-CM codes 285.0, 208.10, and 742.59 have been added to the “Indications” and “Limitations” sections.

2008 ICD-9-CM Coding Changes—Effective October 1, 2007

Revisions to the following Alabama and Iowa LCDs are based on the 2008 ICD-9-CM coding changes.

2008 ICD-9 CM Codes

| LCDs | Invalid | Replaced with | ADD |
|---|---------|--------------------|-----------------|
| Carboplatin (Paraplatin) | | | 200.30 - 200.78 |
| Colony Stimulating Factors | | | 202.70 - 202.78 |
| Computed Tomography of the Abdomen and Pelvis | 233.3 | 233.30 - 233.32 | 200.30 - 200.78 |
| | 255.4 | 255.41 - 255.42 | 202.70 - 202.78 |
| | 789.5 | 789.51 - 789.59 | |
| Computed Tomography of the Head or Brain | 255.4 | 255.41 - 255.42 | 202.70 - 202.78 |
| | 389.2 | 389.20 - 389.22 | 331.5 |
| | | | 389.13 |
| | | | 389.17 |

| LCDs | Invalid | Replaced with | ADD |
|---|---------|-----------------|-----------------|
| Computed Tomography of the Thorax | | | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Dysphagia/Swallowing Therapy | 787.2 | 787.20 - 787.24 | |
| Erythropoietin Analogues | 284.8 | 284.89 | |
| Gemcitabine Hydrochloride (Gemzar) | | | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Immune Globulin Intravenous (IVIg) | 284.8 | 284.81 - 284.89 | |
| Magnetic Resonance Imaging of the Brain | 389.2 | 389.20 - 389.22 | 202.70 - 202.78 |
| | | | 331.5 |
| | | | 389.13 |
| | | | 389.17 |
| Magnetic Resonance Imaging of the Spine | | | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Pamidronate Disodium (Aredia) | | | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Rituximab (Rituxan) | | | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Speech Language Pathology - Outpatient | 389.2 | 389.20 - 389.22 | 389.05 |
| | | | 389.06 |
| | | | 389.13 |
| | | | 389.17 |
| Ultrasound of the Abdomen and Retroperiteum | 789.5 | 789.51 - 789.59 | 200.30 - 200.78 |
| | | | 202.70 - 202.78 |
| Upper Gastrointestinal Endoscopy | 787.2 | 787.20 - 787.24 | |
| X-Ray of the Chest | 255.4 | 255.41 - 255.42 | 200.30 - 200.78 |
| | 258.0 | 258.01 - 258.03 | 202.70 - 202.78 |
| | 284.8 | 284.81 - 284.89 | 414.2 |
| | 787.2 | 787.20 - 787.24 | 415.12 |
| | 789.5 | 789.51 - 789.59 | 423.3 |
| | 999.3 | 999.31 - 999.39 | 440.4 |

Please update your records. These LCDs can be viewed on our Web site:

https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm

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Medicare Forum

Do you have a Medicare question or topic that you would like addressed in the *Medicare A Newslines*? If so, fax it to the Provider Outreach and Education (POE) department at 515-471-7584, or e-mail it to ianewslines@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. We would like Cahaba to clarify the information given in the August 2007 Newslines in regards to CAH infusion billing. The question was asked: "If a patient receives either injections or infusions during the recovery process, is that considered as inherent to the procedure and therefore a separated injection or infusion code should not be charged?" In the answer is in item #2 it states that "Pain control is an inherent part of a procedure; therefore, the delivery and the medication (as well as the medication) are not separately billable". We understand why the administration of the drug would be included in the procedure but do not understand why the medication could not be billed separately. Not every patient receives pain medication and/or anti-nausea drugs as part of the recovery process. Can you please provide more information on this?**
- A1. Outpatient procedures include both post-procedure recovery services and associated pain management treatments. The administration of drugs and any pain medications and/or anti-nausea drugs provided following surgery are related to the procedures. The only time a drug and its administration are separately billable is if the reason for the drug is unrelated to the surgical procedure and documented appropriately in the medical record. References: [Medicare Claims Processing Manual, Pub. 100-04, Ch. 4, §230.2](#) and Question 6 of the "[CY 2006 OPDS Drug Administration Questions Related to Pub 100-04, Medicare Claims Processing Chapter 4, Section 230.2](#)".
- Q2. When we have an inpatient admission cancelled after the patient has been discharged, are any ancillary charges billable to Medicare? If so, is there a listing somewhere of billable revenue codes in this situation?**
- A2. Payment may be made under **Part B** for services furnished by a hospital to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. Refer to the [Medicare Claims Processing Manual, Pub. 100-02, Ch. 2, §10](#), for a description of the situations in which Part B payment can be made, and the type of services.

October Education Events

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

➤ **“Roster Billing for Medicare Part A Providers” Webinar**

Date: October 10, 2007

Time: 10:00 a.m.—12:00 p.m. Central Time (CT)

Registration Deadline: October 3, 2007

Intended Audience: This event is being hosted by Noridian Administrative Services and is intended for Medicare Part A and Part B providers in Iowa.

Description: The event will review basic criteria coverage for flu and pneumonia vaccines, billing and reimbursement information. To register, access the [Noridian Administrative Services](#) Web site.



- 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. |

| 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. |
| 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. |
| Verifying Beneficiary Eligibility | Learn how to identify various eligibility information by using ELGA and ELGH. |

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](#).