

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



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



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Key for Icons:

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| ☺ All Providers | R Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers | C Community Mental Health Center (CMHC) Providers |
| 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

**National Provider Identifiers (NPIs) News Flash**

Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.

**News Flash - Understanding the Remittance Advice**

Don't pass up a chance to get all of the information you need to read and understand a Remittance Advice (RA) – the Medicare Learning Network has the following resources available to help you: **Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers** – this guide contains information on topics such as the types of RAs, their purpose, and the types of codes that appear on a RA; **also available** is a web based training course (WBT) that provides general RA information and instructions to help you interpret the RA - **Understanding the Remittance Advice for Professional Providers**. These products can be accessed via the Medicare Learning Network Product Ordering page at <http://www.cms.hhs.gov/MLNProducts> on the CMS Web site.



News Flash - Flu Season is Upon Us!

Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of flu vaccine and its administration, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website. **Get Your Flu Shot. – Not the Flu.**



Expanded Benefits - A New Preventive Services Brochure

A new preventive services brochure entitled Expanded Benefits, ICN# 006433, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. The brochure is available at http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf on the CMS Web site.



Bone Mass Measurements— A New Preventive Services Brochure

A new preventive services brochure entitled Bone Mass Measurements, ICN# 006437, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of bone mass measurement services. The brochure is available at http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf on the CMS Web site.



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 website.



Medicare Advantage Enrolled Beneficiary

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

News from CMS For All Providers



Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs)

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: MM5726

Related CR Release Date: November 2, 2007

Related CR Transmittal #: R302OTN

Related Change Request (CR) #: 5726

Effective Date: May 23, 2008

Implementation Dates: January 7, 2008, and April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare administrative contractors (MACs), and DME Medicare administrative contractors (DME MACs)).

Provider Action Needed

STOP – Impact to You

This article is based on CR 5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR 5726 specifically addresses changes around the processing of electronic claim status requests and the responses to such requests.

CAUTION – What You Need to Know

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers).

Background

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to DDE claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information

The official instruction, CR 5726, issued to your Medicare contractor can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf> on the CMS Web site.

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

Disclaimer

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How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

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

MLN Matters Number: MM5674

Related Change Request (CR) #: 5674

Related CR Release Date: October 26, 2007

Effective Date: May 23, 2008

Related CR Transmittal #: R225PI

Implementation Date: April 7, 2008

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (A/B MACs) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI. For Medicare purposes this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI**, regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.

- Physicians (MDs and DOs) and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
 - Nurse practitioners (NPs);
 - Clinical nurse specialists (CNSs);
 - Physician assistants (PAs); and
 - Certified nurse midwives (CNMs).
- Established NPI business requirements for beneficiary submitted (CR 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

Background

This article is based on CR 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

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

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, FI, or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf> on the CMS Web site.

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New Patient Status Discharge Code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List

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: MM5764

Related CR Release Date: November 2, 2007

Related CR Transmittal #: R1361CP

Related Change Request (CR) #: 5764

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on CR 5764, which provides implementing instructions for a new patient discharge status code 70 and a definition change to existing patient discharge status code 05.

CAUTION – What You Need to Know

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharge dates on or after April 1, 2008, and patient discharge status code 05 has been redefined to indicate a discharge/transfer to a designated cancer center or children's hospital.

GO – What You Need to Do

See the "Background" and "Additional Information" sections of this article for further details regarding these changes.

Background

The UB-04 claim form includes the patient status code as field locator 17. The patient status code is a two digit code to indicate the disposition or discharge status of the beneficiary on a submitted claim, and it is a required field on all institutional claims. Several members of the NUBC participated in a workgroup to ensure the clarity of the definitions of patient discharge status codes, and as a result of the NUBC workgroup meeting, the following patient discharge status code changes are being implemented by NUBC effective April 1, 2008:

- New **patient discharge status code 70** was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008.

Patient Status Code	Descriptor
70	Discharge/transfer to another type of health care institution not defined elsewhere in the code list

- **Patient discharge status code 05** has been redefined, effective April 1, 2008, to indicate a discharge/transfer to a designated cancer center or children's hospital.

Note: For Inpatient Prospective Payment System (IPPS) hospitals, the post-acute transfer payment policy will not apply to claims that contain patient discharge status code 70.

CR 5764 also revises the *Medicare Claims Processing Manual*, (CMS Pub 100-04) Ch. 1, §50.2.1 (Inpatient Billing from Hospitals and SNFs), to reflect these patient status code changes and these revisions can be found in the attachment to CR5764.

Additional Information

The official instruction, CR 5764, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1361CP.pdf> on the CMS Web site.

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

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National Uniform Billing Committee (NUBC) Update on Revenue Codes and Corrected Skilled Nursing Facility (SNF) Spell of Illness Chart

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: MM5734

Related CR Release Date: October 19, 2007

Related CR Transmittal #: R1355CP

Related Change Request (CR) #: 5734

Effective Date: October 1, 2007

Implementation Date: January 22, 2008

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on CR 5734 which updates the *Medicare Claims Processing Manual* by removing two (2) revenue codes with a “9-Other” subcategory code.

CAUTION – What You Need to Know

The NUBC has discontinued several revenue codes with a "9 - Other" designation. CR 5734 removes revenue codes 0709 and 0719 from the list of “Packaged Revenue Codes” in Chapter 3 of the *Medicare Claims Processing Manual*. In addition, for skilled nursing facilities (SNF), a corrected spell of illness chart is included with CR 5734.

GO – What You Need to Do

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

Background

In the process of developing the UB-04 (also known as CMS-1450), the National Uniform Billing Committee (NUBC) reviewed the “9 – Other” subcategory codes for necessity, clarity, and redundancy. As a result of their review, several “9” codes were designated as reserved for assignment by the NUBC because the “0 – General Classification” codes were deemed sufficient.

Specific revenue codes removed include: 0599, 0709, 0719, 0749, 0759, 0779, 0789, and 0799.

As a result of NUBC’s decision regarding these codes, CMS is removing two revenue codes, 0709 and 0719, from the *Medicare Claims Processing Manual*, (CMS Pub. 100-04) Ch. 3, §20.5.1.1 (Packaged Revenue Codes), effective October 1, 2007. The remaining revenue codes include:

0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0681, 0682, 0683, 0684, 0689, 0700, 0710, 0720, 0721, 0762, 0810, 0819, and 0942.

In addition, CMS discovered that the skilled nursing facility (SNF) spell of illness chart posted in the *Medicare Claims Processing Manual*, (CMS Pub 100-04) Ch. 6, §40.8.1 (Spell of Illness Quick Reference Chart) contained formatting errors.

An updated spell of illness chart is included with CR 5734 and is provided as follows:

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Medicare Skilled	YES	YES	N/A	YES	Submit monthly covered claim
	NO	YES	N/A	YES	Submit monthly covered claim
	YES	NO	YES	YES	Submit monthly covered claim
	NO	NO	YES	YES	Patient should be returned to certified area for Medicare to be billed. Submit monthly covered claim
	NO	NO	NO	NO	Facility should determine whether it would be appropriate to a certified area for coverage

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

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

** In some states, licensing laws for all nursing homes have incorporated requirements of the basic

SNF definition (Social Security Act §1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see State Operations Manual, Chapter 2, §2164 at <http://www.cms.hhs.gov/manuals> on the CMS Web site).

Additional Information

The official instruction, CR 5734, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1355CP.pdf> on the CMS Web site.

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

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2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0748

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this *Special Edition MLN Matters* article and refer to it throughout the 2007 - 2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries (i.e., no deductible or copayment/coinsurance).
- Stay abreast of the latest flu information and inform your patients.
- Order appropriate provider resources for yourself and your staff.
- Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications

arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities.

Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!

- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. **Get Your Flu Shot – Not the Flu!**

Helping You Stay Informed

- CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Products

1. MLN Matters Articles

- **MM5744:** Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf> on the CMS Web site.
- **MM5511:** Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 for Part B Influenza Billing located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf> on the CMS Web site.
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf> on the CMS Web site.
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf> on the CMS Web site.

2. MLN Influenza Related Products for Health Care Professionals

- **Quick Reference Information: Medicare Immunization Billing** - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS Web site.
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Web site.
- **Medicare Preventive Services Adult Immunizations Brochure** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf on the CMS Web site.
- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course** - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program** - This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.
- **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS Web site.
- **Medicare Preventive Services Bookmark** - This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a

give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at

<http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf> on the CMS Web site.

MLN Preventive Services Educational Products Web Page - This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** located at <http://www.cms.hhs.gov/AdultImmunizations/> on the CMS Web site.
- **CMS Frequently Asked Questions** located at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi on the CMS Web site.
- **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations** located at <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf> on the CMS Web site.
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** located at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 – 2008 flu season:

- **Advisory Committee on Immunization Practices** located at <http://www.cdc.gov/vaccines/recs/acip/default.htm> on the Internet.
- **American Lung Association’s Influenza (Flu) Center** located at <http://www.lungusa.org> on the Internet. - This site provides a flu clinic locator at <http://www.flucliniclocator.org> on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Centers for Disease Control and Prevention** - <http://www.cdc.gov/flu>
- **Immunization Action Coalition** - <http://www.immunize.org>
- **Immunization: Promoting Prevention for a Healthier Life** - <http://www.nfid.org/pdf/publications/naiaw06.pdf>
- **Medicare Quality Improvement Community** - <http://www.medqic.org>
- **National Alliance for Hispanic Health** - <http://www.hispanichealth.org/>
- **The National Center for Immunization and Respiratory Diseases (NCIRD)** (established spring 2007) replaces the name National Immunization Program (NIP) - <http://www.cdc.gov/vaccines/about/>
- **National Foundation For Infectious Diseases** - <http://www.nfid.org/influenza>
- **National Network for Immunization Information** - <http://www.immunizationinfo.org/>
- **National Vaccine Program** - <http://www.hhs.gov/nvpo>
- **Office of Disease Prevention and Promotion** - <http://odphp.osophs.dhhs.gov>

- **Partnership for Prevention** - <http://www.prevent.org>
- **World Health Organization** - <http://www.who.int/csr/disease/influenza/en/>

Additional Information

For information to share with your Medicare patients, please visit, <http://www.medicare.gov> on the Web.

***Note:** The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course were developed without any commercial support.

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.



Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP)

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: MM5744

Related CR Release Date: October 26, 2007

Related CR Transmittal #: R1357CP

Related Change Request (CR) #: 5744

Effective Date: September 1, 2007

Implementation Date: November 26, 2007

Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries (FIs), carriers, and Medicare administrative contractors (A/B MACs)) for influenza virus and pneumococcal vaccines.

Provider Action Needed

Be sure your billing staff are aware of the billing rates that are effective for influenza and pneumococcal vaccines provided on or after September 1, 2007. These rates apply, **except where the vaccine is furnished in the hospital outpatient department, in which payment for the vaccine is based on reasonable cost.**

Background

CR 5744, from which this article is taken, provides the payment allowances for: Influenza Virus Vaccines (Current Procedural Terminology (CPT) codes 90655, 90656, 90657, 90658, and 90660), and Pneumococcal Vaccine (CPT 90732 and 90669); when payment is based on 95% of the AWP.

Effective September 1, 2007, the Medicare Part B payment allowance in these situations is as follows:

Influenza vaccine payments are:

- CPT 90655 is \$16.109;
- CPT 90656 is \$17.366;
- CPT 90657 is \$6.609;
- CPT 90658 is \$13.218; and
- CPT 90660 (FluMist, a nasal influenza vaccine) is \$21.176 and providers should note that CPT 90660 may be covered in those cases where the local Medicare contractor determines that its use is medically reasonable and necessary for the beneficiary.

Pneumococcal vaccine payments are:

- CPT 90732 is \$29.730; and
- CPT 90669 is \$78.803.

Please note:

- These rates apply, except where the vaccine is furnished in the hospital outpatient department, where payment is based on reasonable cost.
- Annual Part B deductible and coinsurance amounts do not apply.
- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Your Medicare contractors will not search their files to adjust payment for claims paid prior to implementation of these changes; however, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 5744, issued to your Medicare contractor is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1357CP.pdf> on the CMS Web site.

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

Disclaimer

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Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes

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: MM5680

Related Change Request (CR) #: 5680

Related CR Release Date: August 29, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R77BP and R1325CP

Implementation Date: January 7, 2008

Provider Types Affected

Providers who bill contractors (fiscal intermediaries (FIs), carriers and Medicare administrative contractors (A/B MACs) for ambulatory surgical center services for Medicare beneficiaries.

What You Need to Know

CMS is required to implement a new Ambulatory Surgical Center (ASC) payment system no later than January 1, 2008. An overview of the new system has already been provided in the MLN Matters article SE0742, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Web site. CR 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

Background

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to implement a new ASC payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See MLN Matters article SE0742 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> for an overview of the new ASC payment system.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include an FC modifier on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the FC modifier may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the FC modifier.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/revisions are included in this article.) These revised manual instructions are attached to CR 5680.

Revisions to the Medicare Claims Processing Manual (CMS Pub 100-04)

(These revisions are attached to CR 5680 at <http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf> on the CMS Web site.) Key revisions are:

Chapter 1 (General Billing Requirements)

§30.3.1 (Mandatory Assignment on Carrier Claims)

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS))

§120 (General Rules for Reporting Outpatient Hospital Services)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on type of bill (TOB) 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC.

§180.1 (General Rules)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC.

Chapter 14 (Ambulatory Surgical Centers)

§10 (General)

Beginning January 1, 2008, Medicare will:

- Pay ASCs (under Part B) for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC;
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures;
- Continue to pay ASCs for new technology intraocular lenses (NTIOLs) and corneal tissue acquisition as it did prior to January 1, 2008; and
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with CMS. The *State Operations Manual*, which you can find at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10> describes the certification process.

§10.2. (Ambulatory Surgical Center Services on ASC List)

Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver;
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);
- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at: [http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42;);
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42>;
- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42>;

- Splints and casts and related devices;
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;
- Administrative, recordkeeping and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthesiologist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the Outpatient Prospective Payment System (OPPS);
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPPS; and
- Certain radiology services for which separate payment is allowed under the OPPS.

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the outpatient prospective payment system (OPPS). Beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPPS.

§10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services)

Physician Services

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASCs and the beneficiaries' recovery from the anesthesia.

Implantable Durable Medical Equipment (DME)

If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

Non-Implantable DME

If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

Services of Independent Laboratory

As noted in the *Medicare Claims Processing Manual*, (CMS Pub. 100-04) Ch. 14, §10.2, only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since Section 1861(s) of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42> on the Internet.

§20 (List of Covered Ambulatory Surgical Center Procedures)

The complete lists of ASC covered surgical procedures and ASC covered ancillary services; the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations; and the wage adjusted payment rates, and wage indices are available at <http://www.cms.hhs.gov/ASCPAYMENT> on the CMS Web site.

§20.1 (Nature and Applicability of ASC List)

The ASC list of covered procedures indicates procedures, which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. In addition, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.

§20.2. (Types of Services Included on the List)

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures. The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require an overnight stay following the surgical procedure.

Surgical procedures are defined as Category I CPT codes within the surgical range of CPT codes, 10000 through 69999. Also considered to be included within that code range are Level II HCPCS and Category III CPT codes that crosswalk to or are clinically similar to the Category I CPT codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

§30 (Rate-Setting Policies)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for performing the procedure; and
- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see MLN Matters article SE0742 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Web site.

§40.3. (Payment for Intraocular Lens (IOLs))

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, (CMS Pub 100-04) Ch. 14, §40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of \$50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the \$150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

§40.4 (Payment for Terminated Procedures)

Facilities use a 73 modifier to indicate that the procedure terminated prior to induction of anesthesia.

Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.

Beginning January 1, 2008, Medicare contractors will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

Beginning January 1, 2008, ASC surgical services billed with the -52 or- 73 modifiers are not subject to the multiple procedure discount.

§40.5. (Payment for Multiple Procedures)

Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100 percent of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008, to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier -73 and -52 will not be subjected to further pricing reductions

(i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

§40.6 (Payment for Extracorporeal Shock Wave Lithotripsy (ESWL))

Beginning January 1, 2008, with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

§40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider. Code pairs subject to this policy would be updated quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a “look-up” table.

§40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008)

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB modifier on the procedure code when a device is furnished without cost or for which full credit is received.

If the ASC receives a partial credit for the device, the ASC is required to include the FC modifier on the procedure code. A single procedure code should not be submitted with both a FB and a FC modifier. The pricing determination related to the FB and FC modifiers is performed prior to the application of the multiple procedure pricing reductions.

§40.9 (Payment for Presbyopia Correcting IOLs (P-C IOLs and Astigmatism Correcting IOLs (A-C IOLs))

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR 3927) and Transmittal 1228 (CR 5527) respectively. See <http://cms.hhs.gov/center/asc.asp> for a current list of CMS recognized P-C IOL and A-C IOL lenses.

§50 (ASC Procedures for Completing the Form CMS-1500)

The Place of Service (POS) code is 24 for procedures performed in an ASC.

Prior to January 1, 2008, Type of Service (TOS) code is “F” (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS “2” (surgery) for professional services rendered in an ASC is appropriate.

Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. Modifier – TC is required unless the code definition is for the technical component only.

§60 (Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs))

§60.1 (Applicable messages for NTIOLs)

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in §40.5.2, Chapter 14, of the *Medicare Claims*

Processing Manual (CMS Pub. 100-04). They will use the following messages for these returned claims:

- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes; and
- RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers or A/B MACs will deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility; and
- Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers or A/B MAC will deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service; and
- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it; and
- Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

§60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 using the following messages:

- Claim Adjustment Reason Code 8 - The procedure code is inconsistent with the provider type/specialty;
- RA Remark Code N95 - This provider type/provider specialty may not bill this service; and
- MSN 26.4 – This service is not covered when performed by this provider.

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors will return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASC DRUG list as unprocessable using the following messages:

- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA Remark Code MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- MSN 16.2 – This service cannot be paid when provided in this location/facility;

- Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility;
- RA Remark Code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility; and
- RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny separately billed implantable devices using the following messages:

- MSN 16.32 - Medicare does not pay separately for this service;
- RA Remark Code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility;
- RA Remark Codes M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;
- MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- M16 - Please see our web site, mailings or bulletins for more details concerning this policy/procedure/decision (contractor discretion).

If there is a related, approved surgical procedure for the billing ASC for the same date of service, they will also include the following message:

- MSN 16.8 - Payment is included in another service received on the same day.

Chapter 19 (Indian Health Services)

Section 40.2.1 (Provider Enrollment with FI or AB MAC - Ambulatory Surgical Services)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of several national accrediting organizations recognized by the CMS and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located at http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl on the Internet.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on

freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

Chapter 26 (Completing and Processing Form CMS-1500 Data Set)

§10.7 (Type of Service (TOS))

Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the SG modifier on Medicare ASC facility claims.

Revisions to the Medicare Benefit Policy Manual

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual* (CMS Pub. 100-04). The revised portions of the *Medicare Benefits Policy Manual* (Pub 100-02) are also attached to CR 5680 at <http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf> on the CMS Web site.

Additional Information

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

The two transmittals related to CR 5680 are at <http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf> on the CMS Web site. Attached to these transmittals are the revised manual chapters discussed in this article. These transmittals are the official instructions issued to your Medicare contractor.

Also, the MLN Matters article providing an overview of the new ASC payment system is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Web site.

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Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses,” which was published in the November 1, 2007, *Medicare A Newslines*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5740 Revised
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP

Related Change Request (CR) #: 5740
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: This article was revised on November 7, 2007, to change the title to the chart showing the payment limits. That chart should have read “2008” and not “2007”. All other information is unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician’s office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

CR 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: <http://www.gpoaccess.gov/cfr/retrieve.html> on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf> on the CMS Web site.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician’s office**. CR 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician’s Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639
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Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008, through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (§80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in §§80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in §80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Web site.

For complete details regarding this CR please see the official instruction (CR 5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf> on the CMS Web site.

2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	\$7.38	Q4025	\$32.45
Q4001	\$42.01	Q4026	\$101.30

Code	Payment Limit	Code	Payment Limit
Q4002	\$158.81	Q4027	\$16.23
Q4003	\$30.18	Q4028	\$50.66
Q4004	\$104.49	Q4029	\$24.81
Q4005	\$11.12	Q4030	\$65.31
Q4006	\$25.08	Q4031	\$12.41
Q4007	\$5.58	Q4032	\$32.65
Q4008	\$12.54	Q4033	\$23.14
Q4009	\$7.43	Q4034	\$57.56
Q4010	\$16.72	Q4035	\$11.57
Q4011	\$3.71	Q4036	\$28.79
Q4012	\$8.36	Q4037	\$14.12
Q4013	\$13.52	Q4038	\$35.37
Q4014	\$22.81	Q4039	\$7.08
Q4015	\$6.76	Q4040	\$17.68
Q4016	\$11.40	Q4041	\$17.16
Q4017	\$7.82	Q4042	\$29.30
Q4018	\$12.47	Q4043	\$8.59
Q4019	\$3.91	Q4044	\$14.66
Q4020	\$6.24	Q4045	\$9.96
Q4021	\$5.78	Q4046	\$16.03
Q4022	\$10.44	Q4047	\$4.97
Q4023	\$2.91	Q4048	\$8.02
Q4024	\$5.22	Q4049	\$1.82

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

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Medicare Payments for Ambulance Transports—**Revised**

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

MLN Matters Number: SE0724 Revised

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Note: This article was revised on November 8, 2007, to clarify when an ambulance transport claim may result in a beneficiary liability (see “Caution” section). In addition, there was a change made in the “Documentation Requirements” section to note that a PCS is required for non-emergency transports only “in some circumstances”. It previously implied that it was always required. All other information is unchanged.

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (A/B MACs) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), “Medicare Payments for Ambulance Transports,” during the calendar year 2002 twenty-five percent of ambulance transports did not meet Medicare’s program requirements. This resulted in an estimated \$402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare’s requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

GO – What You Need to Do

Please refer to the “Background” and “Additional Information” sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether the use of an ambulance transport for your patient would be covered by Medicare, and if so, what level of service would be covered. Please refer to the “Background” section of this Special Edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient’s health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, CMS will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient’s illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

- a) Basic life support
- b) Advanced life support
- c) Specialty care transport
- d) Air transport – fixed wing and rotary wing

Emergency Ambulance Transport

An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy;
- Result in serious impairment of bodily functions; or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage;
- Unconsciousness or shock;
- Injuries requiring immobilization of the patient;
- Patient needs to be restrained to keep from hurting himself or others;
- Patient requires oxygen or other skilled medical treatment during transportation; and
- Suspicion that the patient is experiencing a stroke or myocardial infarction. See Ch. 15 of the *Medicare Claims Processing Manual* (CMS Pub. 100-04) and Ch.10 of the *Medicare Benefit Policy Manual* (CMS Pub. 100-02) at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Web site.

Non-Emergency Ambulance Transports

Non-emergency ambulance transportation is appropriate with a patient who is bed-confined AND his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to him or herself or to others). **Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare benefits.**

To be considered bed-confined, **the patient must be unable to do all three of the following:**

- Get up from bed without assistance;
- Ambulate; and
- Sit in a chair or wheelchair.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to be made available to Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a Physician Certification Statement (PCS) for non-emergency transports **in some circumstances** (see 42 CFR 410.40

link in the “Additional Information” section). The PCS states the reason(s) a patient requires non-emergency transportation by ambulance. It is effective for 60 days from the date it is signed. The PCS, or proof of the supplier’s attempt to obtain it, is required within 48 hours after provision of the ambulance service. The “trip ticket” is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to CR 5422 “Ambulance Fee Schedule – Medical Conditions List – Manualization,” which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient’s condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.
- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician’s office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, Medicare Payments for Ambulance Transports, which is located at <http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf> on the OIG HHS Web site.

CR 5422, dated February 23, 2007, “Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions,” is located at <http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf> on the CMS Web site.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found at http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf on the CMS Web site.

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

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Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0746

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for colorectal cancer screening services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article is being provided by CMS to clarify billing instructions for the Medicare beneficiary who 1) presents for a screening colonoscopy (or flexible sigmoidoscopy), 2) has no gastrointestinal symptoms, and 3) during their screening colonoscopy (or flexible sigmoidoscopy), have an abnormality identified (such as a polyp, etc.) which is biopsied or removed.

Background

CMS has become aware of confusion regarding billing for colorectal screening arising because of wording in the Medicare Physician Fee Schedule (MPFS) Final Rule for 2007 (Federal Register, Vol. 71, No. 231, page 69665, December 1, 2006 (See the MPFS Final Rule at <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf> on the CMS Web site).

The relevant section of the 2007 MPFS states, regarding screening colonoscopies, that:

“if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.” Based on this statutory language, in such instances the test or procedure is no longer classified as a “screening test.” Thus, the deductible would not be waived in such situations.

The above scenario can be restated as follows:

- A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms.
- During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed.

CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination.

As an example, the above scenario should be billed as follows using claim form CMS-1500 (or its electronic equivalent):

- Item 21 (Diagnosis or Nature of Illness or Injury)
 - Indicate the Primary Diagnosis using the International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM) code for the screening examination (colonoscopy or sigmoidoscopy), and
 - Indicate the Secondary Diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.).
 - For example, V76.51 (Special screening for malignant neoplasms, Colon) would be used as the first listed code, while the secondary code might be 211.3 (Benign neoplasm of other parts of digestive system, Colon).
- Item 24D (Procedures, Services, or Supplies)
 - Indicate the procedure performed using the CMS Healthcare Common Procedure Coding System/Common Procedure Terminology (HCPCS/CPT) code for the procedure (biopsy or polypectomy), and
- Item 24E (Diagnosis Pointer)
 - Enter only "2" (to link the procedure (polypectomy or biopsy) with the abnormal finding (polyp, etc.))

A Medicare beneficiary undergoing a screening colonoscopy (no symptoms and no abnormal findings prior to the procedure) will be responsible for the deductible if a polyp is identified and either biopsied or removed.

When there is no need for a therapeutic procedure, the appropriate HCPCS G-code is reported with the ICD-9-CM code reflecting the indication. Effective January 1, 2007, CMS began waiving the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS G-codes listed in the following table:

HCPCS Screening Code	Descriptor
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk;
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Additional Information

For related MLN Matters articles on colorectal cancer screenings, see articles SE0710 and MM5387, which are available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf>, respectively, on the CMS Web site.

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Updated Women's Health Web-Based Training Course

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based (WBT) training course: Medicare Preventive Services Series: Part 2 Women's Health. This WBT course provides information to help fee-for-services providers understand Medicare's coverage and billing guidelines for mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit, http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Website.

Visit the [Medicare Learning Network](#) ~ it's free!

News from CMS for Hospital/CAH and RDF Providers



Medicare's Common Working File (CWF) Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays

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: MM5768

Related CR Release Date: November 2, 2007

Related CR Transmittal #: R1364CP

Related Change Request (CR) #: 5768

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on CR 5768, which changes processes for Common Working File (CWF) Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays.

CAUTION – What You Need to Know

CR 5768 implements an informational unsolicited response from the CWF to prompt the Medicare systems to adjust 72X claims that have line item dates of service overlapping a subsequently received inpatient claim.

GO – What You Need to Do

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

Background

CR 5039 implemented line item billing for RDFs effective April 1, 2007. (See related MLN Matters article, MM5039 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf> on the CMS Web site.) In addition, CR 5039 (Transmittal 1084) implemented system functionality in the Medicare systems to compare line item dates of service on RDF claims to the dates of services on other potential overlapping claims. When an incoming RDF claim (bill type 72X) includes line item dates of service(s) that are included in an inpatient claim, the line item services that are listed with dates that overlap the inpatient stay dates are rejected while allowing the remainder of the claim for dates of service that are not overlapping to be paid. RDFs may bill for and be paid for services on the admission date and discharge date of a hospital stay. Therefore, the inpatient admission date and discharge date are not considered overlapping dates of service. CR 5039 (Transmittal 1084) did not include a process for rejecting services on the RDF claim overlapping an inpatient stay when the RDF claim is received before the inpatient hospital claim.

Therefore, CR 5768 implements processes in Medicare systems to identify previously processed RDF claims received for a patient where a subsequent inpatient claim is received. When such RDF claims are identified, Medicare systems will adjust the already processed 72X claims that have line item dates of service overlapping the incoming inpatient claim.

Additional Information

The official instruction, CR 5768, issued to FIs and A/B MACs regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf> on the CMS Web site. The revised sections of *Medicare Claims Processing Manual* (CMS Pub 100-04), Ch. 8 are attached to CR 5768.

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

Disclaimer

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



Correction to Calculation of Coinsurance for Indian Health Service Critical Access Hospitals (IHS CAHs)

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: MM5769

Related Change Request (CR) #: 5769

Related CR Release Date: November 2, 2007

Effective Date: April 1, 2007

Related CR Transmittal #: R1362CP

Implementation Date: April 7, 2008

Provider Types Affected

Indian Health Service critical access hospitals (IHS CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You—CR 5769 corrects the calculation of Medicare Part B coinsurance for IHS CAHs.

CAUTION

What You Need to Know— The calculation of coinsurance for IHS CAHs for services paid on the facility-specific per visit rate is to be based solely on billed charges, not on the payment amount for the particular IHS CAH. On April 7, 2008, Medicare systems will be corrected to calculate coinsurance for IHS CAHs accordingly. FIs or MACs will not search their claims histories to find and correct claims processed by Medicare since April 1, 2007, through April 6, 2008, but will correct any claims that you bring to their attention.

GO – What You Need to Do—Make certain that your billing staffs are aware of this change.

Background

The change directed in CR 5769 corrects an error in the Medicare system that calculates Part B coinsurance for IHS CAHs on claims processed since April 1, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction (CR 5769) issued to your Medicare A/B MAC or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1362CP.pdf> on the CMS Web site.

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

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A New Look for the EDSNET Screen

The EDSNET screen will soon have a new look. We anticipate that the change will occur by January 2008; however, at this time we do not have an exact implementation date. Currently, after you select the session ID "EDCNET" from the CL/Supersession menu, the following screen (EDSNET screen) displays.

```
EEEEEEEE DDDDDDD SSSSSSS NNN NNN EEEEEEEE TTTTTTTTTTTT
EEEEEEEE DDDDDDD SSSSSSS NNNN NNN EEEEEEEE TTTTTTTTTTTT
EEE DDD DDD SSS NNNNN NNN EEE TTT
EEEEEEEE DDD DDD SSSSSSS NNN NN NNN EEEEEEEE TTT
EEEEEEEE DDD DDD SSSSSSS NNN NN NNN EEEEEEEE TTT
EEE DDD DDD SSS NNN NNNNN EEE TTT
EEEEEEEE DDDDDDD SSSSSSS NNN NNN EEEEEEEE TTT
EEEEEEEE DDDDDDD SSSSSSS NNN NNN EEEEEEEE TTT

ELECTRONIC DATA SYSTEMS CORPORATION DALLAS, TEXAS
Use of the network is restricted to authorized users. User activity is moni-
tored and recorded by system personnel. Anyone using the Network expressly
consents to such monitoring and recording. BE ADVISED: if possible criminal
activity is detected, system records, along with certain personal information,
may be provided to law enforcement officials.
*****
* LOGON-ID: NETWORK-ID: USEDNC01 DATE: 11/12/07 *
* PASSWORD: HOST: OKI PC1B TIME: 09:07:09 *
* NEW PASSWORD: TERMINAL-ID: L649431 SECURITY *
* CDRM: CP1EDC2 HELP: *
*****
ENTER OPTIONAL INITIAL SELECTION BELOW, PF1 FOR HELP, OR 'LOGOFF'.

SELECTION=>
```

After the new look is implemented, instead of the EDSNET screen, (above), the new screen will display as follows:

```
CMS MENU

You are accessing a United States Government information system; CMS maintains
ownership and responsibility for its computer systems; users must adhere to
CMS information security policies, standards, and procedures; your usage may be
monitored, recorded, and audited; unauthorized use is prohibited and subject to
criminal and civil penalties; and the use of the information system establishes your
consent to any and all monitoring and recording of your activities.

Use of the network is restricted to authorized users. User activity is moni-tored
and recorded by system personnel. Anyone using the Network expressly consents to
such monitoring and recording. BE ADVISED: if possible criminal activity is
detected, system records, along with certain personal information, may be provided
to law enforcement officials.
*****
* LOGON-ID: NETWORK-ID: SRFMENU DATE: 11/12/07 *
* PASSWORD: HOST: OKI PC1B TIME: 09:07:09 *
* NEW PASSWORD: TERMINAL-ID: L649431 SECURITY *
* CDRM: CP1EDC2 HELP: *
*****
ENTER OPTIONAL INITIAL SELECTION BELOW, PF1 FOR HELP, OR 'LOGOFF'.

SELECTION=>
```

If you or your software vendor has developed a script to automate signing on to the Fiscal Intermediary Standard System (FISS), or the eligibility screens, ELGA/ELGH, modifications may be necessary to your script.

Note: Your current logon-id and password will not change; however, if your password is due to expire, the message saying “password expired” will display.



Reminder of Timely Claim Filing Requirements

It is that time of year! Please review your billing records to ensure all services are billed within the timely claim filing requirements. Remember, **all** Medicare billing transactions are subject to the timely filing requirements. This includes new billing transactions, corrections (return to provider (RTP)) and adjustment (type of bills XX7) requests. In addition, if you cancel a claim with dates of service that are outside of the timely filing parameters, any resubmitted claim will be subject to the timely filing requirements, and will be rejected if untimely. Please review the following requirements and submit your older claims now.

Timely Claim Filing Requirements

Services provided in the first three quarters of a calendar year are considered timely if received by December 31 of the year following the service year. **All claims with dates of service between October 1, 2005, and September 30, 2006, must be filed (received) by December 31, 2007. Note that the receipt date of a claim in the Return to Provider (RTP) file is the date the claim is corrected and moved out of the RTP file. If the receipt date is outside the timely filing standards, the claim will reject (FISS status/location R B9997).**

Instructions for Timely Filing for Home Health Claims

Under home health prospective payment system (HH PPS), claims represent an episode of care of up to 60 days. Therefore, episodes may easily span from the third quarter (July, August, and September) into the fourth quarter (October, November, and December) of a given calendar year. Under this situation, the Fiscal Intermediary Standard System (FISS) will compare the receipt date of a home health (HH) claim to the latest line item service date to determine whether the HH claim is filed timely. For example, a HH claim with dates of service September 10, 2006, to November 8, 2006, with the last line item date of service (LIDOS) of September 29, 2006, would be considered timely if submitted by December 31, 2007. Refer to the following chart for additional guidance.

Date of Service	LIDOS	Submit by:
09/10/2005 – 11/8/2005	10/29/2005	12/31/2007
09/10/2006 – 11/8/2006	09/29/2006	12/31/2007
09/10/2006 – 11/8/2006	10/29/2006	12/31/2008
09/10/2007 – 11/8/2007	09/29/2007	12/31/2008
09/10/2007 – 11/8/2007	10/29/2007	12/31/2009

For additional information about timely filing requirements, refer to the Centers for Medicare & Medicaid Services (CMS), [Medicare Claims Processing Manual, \(CMS Pub. 100-04\) Ch. 1](#), §70.



Reason Code 31999—Requiring 9-Digit ZIP Code

The reason code 31999 became effective October 1, 2007, as a result of Change Request (CR) 5208. The related Medicare Learning Network (MLN) Matters article MM5208, “Use of Nine-Digit ZIP Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services—Revised” was published in the [April 1, 2007, Medicare A Newsline](#).

As a result of CR 5208, the Fiscal Intermediary Standard System (FISS) will apply reason code 31999 to claims with dates of service on or after October 1, 2007, when:

- Services submitted on the claim are paid under the Medicare Physician Fee Schedule (MPFS) or the claim includes anesthesia services in a payment locality whose ZIP code appears in Table 1 (see MM5208 article); and
- The provider’s ZIP code contained on the Provider File Master Address file is either missing, does not include a 4-digit extension, or is not a valid 9-digit ZIP code. In this case, a CMS-855A, the [Medicare Enrollment Application](#), must be submitted with a valid 9-digit ZIP code.
- The “FAC.ZIP” field, located on the FISS claim page 01, does not match the Provider File Master Address file.

Claims with reason code 31999 will suspend in status/location (S/LOC) “S MSUP2”, “S MSPR1”, or “S M3199”. These claims can be accessed using the FISS “Claim Summary” Inquiry Option 12. Refer to the [“Inquiry Menu”](#) section of the *FISS Reference Guide* for more information on using this option in FISS.

Note: At this time, claims are suspending in status/location S MSUP2, S MSPR1 or S M3199 and are unable to continue processing. For more details, and the status of this issue, refer to the [“Fiscal Intermediary Standard System Claims Processing Issues”](#) Web page.

In addition, claims with laboratory services are receiving reason code 31999 incorrectly; therefore, our suspense department will be able to override the reason code when appropriate to allow these claims to continue processing. In addition, our suspense staff is working in conjunction with our Provider Enrollment department to identify and contact those providers who must submit an 855A.

If our suspense department determines that a valid 9-digit ZIP code is required, the claim will be moved to the Return to Provider (RTP) S/LOC T B9997. If your claim is in RTP with reason code 31999, contact the Provider Contact Center (PCC) and follow the steps below for assistance in determining what action is required to resolve reason code 31999. Refer to the [“Telephone Us”](#) Web page for the appropriate PCC telephone numbers for your location.

- Give the Customer Service Representative (CSR) your practice location address and the ZIP code. This information will be verified against the information in the CMS Provider Enrollment Chain and Ownership System (PECOS), which is used to update the Provider File Master Address. If your facility is listed in PECOS, and the address given to the CSR matches the address in PECOS, Cahaba will update the Provider File Master Address with the correct ZIP code. Allow 2-3 days before resubmitting your claim(s).
- If your practice location address does not match the address in PECOS, you must submit a CMS-855A application with the change of address and ZIP. For instructions on completing the CMS-855A, refer to the [Medicare Enrollment Application](#), page on our Web site.

- If your facility is not listed in PECOS, you must submit a full CMS-855A application along with all supporting documentation, as outlined in Section 17 of the application. If the CMS-855A is not completed in full and/or not all attachments are submitted as required, the application will be returned. For instructions on completing the CMS-855A, refer to the [Medicare Enrollment Application](#), page on our Web site.

Note: We anticipate additional instructions from CMS in regard to submitting the CMS-855A. Therefore, the above information may change. Updates will be made available on the [What's New from Cahaba GBA](#) Web page. In addition, subscribe to the [Cahaba E-mail Notification Service](#) to receive updates.

Submitting a CMS-855A

If you are required to file a CMS-855A, include a cover letter with the Medicare Enrollment Application stating that the purpose of filing is to correct the 9-digit ZIP code reason code 31999. Your request will be processed as quickly as possible. Applications are processed in the order they are received. Depending on whether your facility is in PECOS, allow 60-90 days to update our records. If additional information is required, a letter will be faxed to the contact person listed in Section 13 of the CMS-855A form. It is very important that this information be completed and returned to us timely in order to update your records.

Once we have completed our review of the CMS-855A, a letter will be issued to the contact person listed in Section 13 of the CMS-855A. Please wait until you receive this letter before resubmitting your claim(s).

Refer to the article “Revisions to 9-Digit ZIP Code List Provided in Change Request (CR) 5208”, which was published in the [November 1, 2007, Medicare A Newsline](#), for additions and deletions to the ZIP code list.



Resolving Reason Code F5052

Data analysis has shown that Cahaba’s Provider Contact Centers (PCCs) continue to receive a high volume of calls for rejected claims or claims in a suspended status/location (S/LOC) in the Fiscal Intermediary Standard System (FISS). One reason code that creates questions among providers is F5052.

This reason code is received when the Common Working File (CWF) is unable to locate the beneficiary’s Health Insurance Claim Number (HICN) as it was submitted on the Medicare billing transaction. The most common reasons why providers receive this reason code include:

- the HICN has not been previously processed by this office and the system is attempting to locate it at another CWF host site;
- the HICN is in the process of being updated or changed; OR
- the HICN submitted on the claim is not valid.

To avoid billing errors for invalid or changed HICNs, providers are encouraged to authenticate the beneficiary’s HICN by reviewing the “CN” and “CORRECT CN” fields found on page 1 of ELGA or ELGH, prior to submitting billing transactions to Medicare. Information about accessing and reading these

screens can be found in the “[Checking Beneficiary Eligibility](#)” section of the *FISS Reference Guide* or the Cahaba online course, “[Verifying Beneficiary Eligibility](#)”.

The following example shows that the beneficiary’s HICN has been updated from 111222333A to 111222333B. The latter is the HICN that should be submitted on Medicare claims.

ELGH	CWF PART A	ELIGIBILITY SYSTEM	FLCHORO
10/26/2007	13:59:04	BENEFICIARY INFORMATION	PAGE 01 OF 09
IP-REC	CN 111222333A	NM XXXXXX	IT X DB MMDDCCYY SX X INT XXXXX
PN XXXXXX	AP	REAS 1	REQ XXXX
CORRECT CN 111222333B	NM	IT	DB SX

If your claim is rejected (FISS S/LOC **R B9997**) for an incorrect HICN, you will need to submit the corrected HICN on a new claim. If your claim is in the Return to Provider (RTP) S/LOC **T B9997**, you can correct the HICN by entering the correct HICN in the “PROCESS NEW HIC” field on FISS Claim Page 01. Detailed instructions for using this field can be found in the “[Claims Correction Menu](#)” section of the *FISS Reference Guide*.

If your claim is suspended (FISS S/LOC S BXXXX or S MXXXX) while the system is attempting to access the HICN at another CWF host site, please be aware that this process takes time. Once the beneficiary’s HICN has been located at the host site, a “link” is created and the system will be able to process future claims you submit for this beneficiary more quickly. **With the exception of FISS S/LOC, S B6001, please do not call the PCCs regarding a claim in a suspended S/LOC, unless it has been in the same S/LOC for more than 30 days.** Additional information on suspended claims can be accessed at the “[Claims in a Suspended Status/Location \(S/LOC\)](#)” Web page.



CahabaGBA.com Web Site Updates

Revisions to the Cahaba Web site (www.cahabagba.com) are often made to ensure the most updated information and educational materials are available to providers. The following includes important resources that have recently been revised.

- [Medicare Part A Provider Enrollment](#)—If your facility was selected for revalidation or is part of the home health demonstration project, tips are now available to assist you in completing the full [CMS-855A Medicare Federal Health Care Provider Enrollment Application](#).
- [Fiscal Intermediary Standard System Claims Processing Issues](#)—This Web page includes the most current status of claims processing issues that have been reported to the Fiscal Intermediary Standard System (FISS) maintainers and the Centers for Medicare & Medicaid Services (CMS). Check here often for updates before contacting the Provider Contact Center with questions.

- [CMS Links](#)—This Web page was previously located on the “Education and Outreach” page. Now you can easily access this link from any Web page using the top navigation bar (under the Cahaba logo) to access important Web pages on the Centers for Medicare & Medicaid Services (CMS) Web site.
- [FISS Logon Instructions](#)—(This applies to providers who submit claims to the Cahaba office in Des Moines, Iowa.) The following logon instructions have been updated:
 - Initial Login Instructions for the EDC – New Subscribers
 - Establishing Automated Password Reset (APR) Questions – One Time Only
 - EDC Logon Instructions for Established Users
 - Instructions for Accessing Multiple Sessions Simultaneously
 - EDC Quick Reference Tool
- [Top EDI Claim Rejections](#)—(This applies to providers who submit claims to the Cahaba office in Birmingham, Alabama.) The top five reasons for claim rejections for October 2007 were added.

Updates are continuously made to the following Web pages. We suggest that you bookmark these pages for quick access to important updates.

- [What’s New from CMS](#)
- [What’s New from Cahaba GBA](#)
- [Calendar of Educational Events](#)

Stay informed!

Subscribe to the [Cahaba E-mail Notification Service](#) to receive immediate notification of changes to our Web site.



System Availability During the Christmas Holiday

While we celebrate the Christmas holiday with our families, our office will be closed on Monday and Tuesday, December 24 and 25, 2007. Our data center has informed us that FISS will not be available either day. 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 (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on December 24 and 25. However, the **Interactive Voice Response (IVR) unit will be available to providers to check beneficiary eligibility or the status of claims.**



Medicare Part A Local Coverage Determination Updates

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

Retiring LCD

- **Carboplatin (Paraplatin[®]) L1394**
The Carboplatin (Paraplatin[®]) LCD will be retired effective December 1, 2007.

Please update your records.

December 2007 and January 2008 Education Events

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

➤ **[“Dial In & Win Timely Medicare Payments Ask-The-Contractor Teleconference \(ACT\)”](#)**

Date: December 12, 2007

Time: 1:00-2:00 p.m. Central Time (CT)

Registration Deadline: December 7, 2007

Intended Audience: All Medicare Part A providers, except home health and hospice, including administrators, CFOs, billing, admission and quality assurance staff.

Description: This ACT will present the most common reasons why fiscal intermediary (FI) Medicare Part A claims are rejected or sent for correction to FI providers who bill Cahaba. Questions received in advance will be discussed during this call.

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

Date: December 18, 2007

Time: 10:00-11:30 a.m. CT

Registration Deadline: December 13, 2007

Intended Audience: This event is tailored for all Medicare Part A providers and staff who have less than 25 full-time employees and who are new or have staff new to Medicare billing and recently received Medicare certification or new staff members of existing Medicare providers.

Description: This webinar will explore critical Medicare resources for Part A providers found on the Cahaba and the Centers for Medicare & Medicaid Services (CMS) Web sites.

➤ **[“The Medicare Part A Appeals Process for Small and New Providers” Teleconference](#)**

Date: January 8, 2008

Time: 10:00-11:00 a.m. CT

Registration Deadline: January 3, 2008

Intended Audience: This event is tailored for all Medicare Part A providers and staff who have less than twenty-five full-time employees and who are new or have staff who are new to Medicare billing.

Description: This teleconference will provide information about each appeal level, including how to request an appeal, the timeframe to request an appeal, and the amount of the denied claim, which must be in controversy.

- 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	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.
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](#).