

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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| ☺ 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

**A New MLN Feature**

A New MLN Feature – the Quarterly Journal Ad-- Each calendar quarter, the Medicare Learning Network will create a journal advertisement based on an initiative or new product of particular importance during that time frame. National, state and local associations are encouraged to use this journal ad in their publications and/or newsletters and websites, as appropriate. This quarter's journal ad features a basic message about the Medicare Learning Network and where to go on the CMS Web site to get more information. The ad is designed to fit the requirements for most journals' print specifications. The files for this quarter's ad, as well as future ads, can be found at

http://www.cms.hhs.gov/MLNGenInfo/downloads/MLNQuarterly_Journal.zip on the CMS Web site.

**News Flash - "Flu season is here!"**

Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize

yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu.** Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare’s coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site.”



News Flash - Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The RA Guide is available as a downloadable document from the Medicare Learning Network Publications Web page. To download and view, please go to http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.



Diabetes Screening Tests

News Flash - The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes, as well as other covered services for people with diabetes. CMS has published a new provider brochure entitled Diabetes-Related Services. This tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. You may download, view and print this new brochure by visiting the Medicare Learning Network (MLN) at <http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf> on the CMS Web site. Printed copies of the brochure may be ordered, free of charge, from the MLN Product Ordering Page by visiting http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.



Medicare Advantage Plan Directory

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



New Preventive Services Brochure

A new preventive services brochure entitled Cancer Screenings, ICN# 006434, 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 the following screening services: mammography, colorectal, prostate, Pap test, and pelvic exam. The brochure is available at http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf on the CMS Web site.

News from CMS For All Providers



2008 Annual Update to the Therapy 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: MM5810

Related CR Release Date: November 23, 2007

Related CR Transmittal #: R1377CP

Related Change Request (CR) #: 5810

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for rehabilitation services.

Provider Action Needed

STOP – Impact to You

One new code will be added to the therapy code list for CY 2008. Code 96125 will be used for standard cognitive performance testing per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.

CAUTION – What You Need to Know

Code 96125 is considered "always therapy" regardless of who performs the service and will always require a therapy modifier (GN, GO, GP).

GO – What You Need to Do

Make certain your office staffs are aware of the new code.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2008 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

Therapy services, including “always therapy” services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, (CMS Pub. 100-04), Ch. 5 and the *Medicare Benefit Policy Manual*, (CMS Pub. 100-02), Chapters 12 and 15. That manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the Centers for Medicare & Medicaid Services (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.

For complete details regarding CR 5810, please see the official instruction issued to your Medicare FI, RHHI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1377CP.pdf> on the CMS Web site.

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.



An Overview of Medicare Covered Diabetes Supplies and Services

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: SE0738

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary:

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor says it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes;
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.);
- Whether they use insulin;
- How often they should test their blood glucose; and
- How many test strips and lancets they need for one month.

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy;
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order. Their doctor cannot order it for them;
- Must ask for refills for their supplies; and
- Needs a new prescription from their doctor for their lancets and test strips every 12 months.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier does not accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is “no,” they should call another supplier or pharmacy in their area who answers “yes” to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary cannot find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or

- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:
 - Partial or complete foot amputation;
 - Past foot ulcers;
 - Calluses that could lead to foot ulcers;
 - Nerve damage because of diabetes with signs of problems with calluses;
 - Poor circulation; or
 - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80 percent of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of \$131 in 2007), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of \$131 in

2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies;
- Insulin; and
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes;
- Needles;
- Alcohol swabs;
- Gauze; and
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Blood glucose that is not controlled by insulin may be maintained by anti-diabetic drugs, and Medicare drug plans can cover anti-diabetics drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide);
- Biguanides (i.e. metformin);
- Thiazolidinediones (i.e. Starlix[®] and Prandin[®]); and
- Alpha glucosidase inhibitors (i.e. Precose[®]).

Medicare Part B Covered Diabetic Services

All of the diabetes services listed in this section are covered by Medicare Part B unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings;
- Diabetes self-management training;
- Medical nutrition therapy services;
- Hemoglobin A1c tests; and
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure;
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels);
- Obesity (with certain conditions);
- Impaired blood glucose tolerance; and
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers “yes” to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy)? or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary’s doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests; and
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

- They were diagnosed with diabetes;
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin;
- They have diabetes and have recently become eligible for Medicare;
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
 - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes,
 - They have been diagnosed with eye disease related to diabetes,
 - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation, or
 - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. These programs are accredited by the American Diabetes Association or the Indian Health Service. Classes are taught by health care providers who have special training in diabetes education.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within 2 months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The 2 hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;
- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit <http://www.cms.hhs.gov/center/fqhc.asp> on the CMS Web site. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are community health centers, Tribal FQHC clinics, certified rural health clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for people with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria.

Also, their doctor must prescribe these services for them. These services can be given by a registered dietitian or certain nutrition professionals, and the services include the following:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan);
- How to manage lifestyle factors that affect diabetics; and
- Follow-up visits to check on progress in managing diet.

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Diabetes Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes (shoes for people whose feet are impaired, but intact);
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first 6 months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.); and
- Weight loss programs.

Additional Information

CMS has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Web site.

- **Medicare Learning Network** - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's Web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS Web site.
- **Patient Resources** - For literature to share with Medicare patients, please visit <http://www.medicare.gov> on the Internet.
- **The National Diabetes Education Program** - NDEP (<http://ndep.nih.gov/>) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

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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Ambulance Inflation Factor for CY 2008

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

MLN Matters Number: MM5801

Related CR Release Date: November 9, 2007

Related CR Transmittal #: R1375CP

Related Change Request (CR) #: 5801

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What You Need to Know

CR 5801, from which this article is taken provides the Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2008. The AIF for CY 2008 is 2.7 percent.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2008 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

CR 5801, from which this article is taken furnishes the CY 2008 AIF, which will be 2.7 percent. The following table displays the AIF for CY 2008 and for the previous 5 years.

Ambulance Inflation Factor by CY	
2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004, through December 31, 2009) is subject to a “floor amount.”

Payment will not be less than this “floor,” which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division’s fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

Payments Based on Blended Methodology

During the five-year transition period, your payments have been based on a blended methodology. For CY 2008, this blend is 20 percent regional ground base rate and 80 percent national ground base rate.

Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional (if it applied)), and to the reasonable cost or charge portion of the blended payment amount. Then, these two amounts were added together to determine each provider or supplier’s total payment amount.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national ambulance fee schedule. As of January 1, 2008, the total payment amount for ground ambulance providers and suppliers is based on either 100 percent of the national ambulance fee schedule or 80 percent of the national ambulance fee schedule and 20 percent of the regional ambulance fee schedule, whichever is greater.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

You can find more information about the 2008 ambulance inflation factor by going to CR 5801 located at <http://www.cms.hhs.gov/transmittals/downloads/R1375CP.pdf> on the CMS Web site. There you will find updated *Medicare Claims Processing Manual*, Ch. 15 (Ambulance), §20.6.1 (Ambulance Inflation Factor (AIF)) as an attachment to that CR.

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

Disclaimer

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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 December 1, 2007, *Medicare A Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: 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 16, 2007, to correct a reference to a related CR. The reference should have been to CR 5442 instead of CR 5422. The article had previously been changed 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 5442 “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 5442, 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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Addition to Medicare Telehealth Services

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

MLN Matters Number: MM5628

Related Change Request (CR) #: 5628

Related CR Release Date: June 29, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1277CP and R74BP

Implementation Date: January 7, 2008

Provider Types Affected

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

Provider Action Needed STOP – Impact to You

This article is based on CR 5628 which adds the neurobehavioral status exam (as represented by HCPCS code 96116) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

Effective January 1, 2008, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with HCPCS code 96116.

GO – What You Need to Do

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

Background

CMS announced in CR 5628 that the neurobehavioral status exam (Healthcare Common Procedure Coding System (HCPCS) code 96116) has been added to the list of Medicare telehealth services (see the final rule for the calendar year (CY) 2008 physician fee schedule (CMS-1385-FC)). Previously, CMS determined that if the eligibility criteria and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR 5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;
- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;
- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005;
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006); and
- **Neurobehavioral status exam (HCPCS code 96116) (Effective January 1, 2008).**

In addition, effective January 1, 2008, the following modifiers are valid when billed with HCPCS code 96116:

Modifier	Descriptor
GT	Via interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system

The expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, or payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (CMS Pub. 100-02, Ch. 15, §270) and the *Medicare Claims Processing Manual* (CMS Pub. 100-04, Ch. 12, §190).

For example, originating sites must be located in either a non- Metropolitan Statistical Area (non-MSA) county or rural Health Professional Shortage Area (HPSA) and must be one of the following:

- Physician’s or practitioner’s office;
- Hospital;
- Critical access hospital (CAH);
- Rural health clinic; or
- Federally qualified health center.

Also, an interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Effective January 1, 2008, CR 5628 instructs that:

- Your local part B carriers and/or A/B MACs will pay for HCPCS code 96116 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier; and
- Your local FIs and/or A/B MACs will pay for HCPCS code 96116 when submitted with a GT or GQ modifier, by CAHs that have elected Method II payment on type of bill (TOB) 85X.

Additional Information

To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR 5628 at <http://www.cms.hhs.gov/Transmittals/downloads/R1277CP.pdf> and <http://www.cms.hhs.gov/transmittals/downloads/R74BP.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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Adjustment to Payment Under Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for Partial Device Credit

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: SE0732

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: CR 5668

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries, which are paid under the OPSS or the ASC payment system.

Provider Action Needed STOP – Impact to You

This article informs affected providers of how partial credits for medical devices are to be reported and paid under the OPSS and ASC payment systems.

CAUTION – What You Need to Know

CMS is implementing a partial device credit policy for hospitals paid under the OPSS and for ASCs paid under the revised ASC payment system (for services furnished on or after January 1, 2008). The partial credit policy applies to the same devices, Ambulatory Payment Classifications (APCs), and ASC procedures to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device (i.e., the device offset percentage) in cases in which the hospital or ASC reports that it received a partial credit of 50 percent or more of the cost of the new device that is being implanted. See the table of applicable APCs at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> for the percentage reduction to the payment when the hospital reports a partial credit of 50 percent or more for a specified replacement device (also listed in those tables).

A table of covered ASC surgical procedures to which the partial device credit policy applies is available at <http://cms.hhs.gov/ASCPayment/>. Table 58 provides the device offset percentages for the selected OPSS APCs to which the partial device credit policy applies under the revised ASC payment system. ASCs will receive the same amount of payment reduction (in dollars) as a hospital when reporting a partial credit for a new replacement device.

GO – What You Need to Do

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

Background

In general, CMS includes the full payment for devices with the payment for the service in which the device is used by using only outpatient hospital claims that contain the full cost of medical devices in setting the Medicare payment rates.

In some cases, the cost of the device is a very large proportion of the cost of the procedure on which the APC payment for the procedure is based. Thus, when the provider receives partial credit for the device and therefore, does not incur the full cost of the procedure, it is necessary to adjust the payment so that the payment reflects the reduced cost of the device. This is necessary to:

- Provide an appropriate payment for the service, and
- Ensure that the Medicare beneficiary's co-payment liability is reduced when appropriate.

CMS determined that partial credits occur more commonly than do full credits or no cost devices. In addition, CMS has learned that typical industry practice for some types of devices is to:

- Provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed before 3 years of use, and
- Prorate the credit over time between 3 and 5 years after the initial device implantation, as the useful life of the device declines.

In these cases, neither the hospital nor ASC is incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.

Effective for services furnished on or after January 1, 2007, CMS implemented a policy to adjust the OPSS payment for procedures assigned to selected APCs when any of the specified devices was implanted in a beneficiary (and remained in the patient at least temporarily) and was furnished either without cost or with full credit for the cost of the device being replaced. See CR 5263 (Transmittal 1103, November 3, 2006; <http://www.cms.hhs.gov/transmittals/downloads/R1103CP.pdf>) or related MLN Matters article (MM5263: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf>) and the *Medicare Claims Processing Manual* (CMS Pub.100-04, Ch. 4, §61.3; <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) on the CMS Web site.

Hospitals report the occurrence of a no cost or full credit device to CMS by reporting the –FB modifier on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. The lists of affected devices and APCs is located at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS Web site.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626) requires implementation of a revised ASC payment system no later than January 1, 2008. The revised payment system to be implemented January 1, 2008, is based on the relative payment weights established under the OPSS and many of the payment policies of the OPSS, including the full device credit policy. A special edition MLN Matters article outlining the new ASC payment system is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Web site.

Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPSS and the ASC payment system.

Hospitals and ASCs report the occurrence of a partial credit device to CMS by reporting the –FC modifier on the line with the procedure code in which the partial credit device is used when the device is on the list of

specified devices to which this policy applies. The devices, APCs, and covered ASC surgical procedures to which the partial device credit policy applies are the same as the devices, APCs, and covered ASC surgical procedures to which the full device credit policy applies (–FB modifier).

For services furnished on or after January 1, 2008, hospitals and ASCs are required to report modifier –FC, with the procedure code for all cases in which:

- The device being implanted is on the list of creditable devices;
- The procedure code in which the device is used is assigned to an APC that is on the list of APCs to which the policy applies in the case of hospitals, or on the list of procedures to which the policy applies in the case of ASCs; and
- The hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device.

The list of devices, APCs, and ASC procedures to which this policy applies is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS Web site. The reduction to the APC payment amount when the hospital reports a partial credit for the new replacement device is available on that Web site as well. An ASC will receive the same amount of payment reduction (in dollars) as a hospital when it reports receiving a partial device credit for a particular procedure.

Remember that both hospitals and ASCs are required to report the –FC modifier with the code for the device implantation procedure, not with the code for the device. Failure to include the proper modifiers on claims as appropriate may result in payment to which the provider is not entitled. If hospitals report the modifier with the device code instead of the procedure code, the claim will be returned.

Because hospitals may not know the amount of credit the manufacturer will provide for the replacement device when the replacement procedure takes place, hospitals will have the option of either: (1) submitting the claim for the device replacement procedure to their Medicare contractor immediately without the FC modifier and then submitting a claim adjustment with the FC modifier at a later date once a credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit amount, and submitting the claim with the FC modifier appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device.

ASCs have the same two billing options as outlined above for hospitals, but if an ASC chooses Option 1 and bills for a replacement device procedure prior to receiving a manufacturer’s credit determination, it must subsequently contact the Medicare contractor regarding a claims adjustment if a credit of 50 percent or more is received.

When hospitals or ASCs use Option 1, they should be mindful that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.

Following are some hypothetical examples that illustrate the revised policy:

OPPS Examples (all payment amounts are hypothetical):

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 1:	33240 FB	Implant ICD	T	1	0107	\$18,000	\$17,000	\$1,000
Full Credit or No Cost Replacement Device	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24
Because Claim 1 is being billed as a full credit or no cost replacement device, it receives the full offset of \$17,000.								

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 2:	33240 FC	Implant ICD	T	1	0107	\$18,000	\$8,500	\$9,500
Partial Credit Replacement Device							(\$17,000 x 0.5)	(\$8,500 + \$1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG		1	0099	\$24	---	\$24
Because Claim 2 is being billed with a partial credit replacement device, the offset is half of the full offset value.								

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 3:	33240 FC	Implant ICD	T	1	0107	\$18,000	\$8,500	\$9,500
Multiple Procedure Discount and Partial Credit Replacement Device							(\$17,000 x 0.5)	(\$8,500 + \$1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24
	35180	Fistula Repair	T	1	0093	\$1,500	---	\$750
								(\$1,500 x 0.5)
Because Claim 3 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0093 is discounted according to the multiple procedure discount rule. If the payment for APC 0093 were greater than the payment for APC 0107 after discount for the partial device credit, the multiple procedure discount would have been applied to further discount payment for APC 0107. The post-offset payment rate is used in discount determination, rather than the pre-offset payment rate.								

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 4: Terminated Procedure and Partial Credit Replacement Device	33240 FC and 73	Implant ICD	T	1	0107	\$18,000	\$8,500 (\$17,000 x 0.5)	\$4,750 (((\$8,500 + \$1,000) x 0.5)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24
Because Claim 4 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0107 is discounted due to the presence of modifier 73, which identifies the service as being terminated prior to the administration of anesthesia or initiation of the procedure.								

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 5: FC Modifier on Partial Credit Replacement Device Line	33240	Implant ICD	T	1	0107			
	C1721 FC	ICD	N	1	==			
	93005	EKG	S	1	0099			
I/OCE Edit #75: Incorrect billing of FB or FC modifier								
Because the FC modifier is located on the line for the device, instead of the procedure used to implant the device, the claim is returned to the provider due to I/OCE Edit #75.								

ASC Examples (All payment amounts are hypothetical):

Note: Payment for devices, with the exception of pass through devices, are packaged into payment for the device implantation procedure. In the below examples, the device is not shown as a separate line item on the ASC claim because, in order to ensure appropriate payment, ASCs should not report packaged devices as separate line items on the claim.

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device ASC implants ICD replacement device (procedure 33240, device C1721) and receives full credit or incurs no cost for the replacement device.	33240 FB	Implant ICD	J8	1	\$17,500	\$17,000	\$500

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
<p>Claim 2:</p> <p>Partial Credit Replacement Device</p> <p>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.</p>	33240 FC	Implant ICD	J8	1	\$17,500	\$8,500 (\$17,000 x 0.5)	\$9,000 (\$8,500 + \$500)

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
<p>Claim 3:</p> <p>Multiple Procedure Discount and Partial Credit Replacement Device</p> <p>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC also performs an additional procedure (33218), to which the multiple procedure discount applies.</p>	33240 FC	Implant ICD	J8	1	\$17,500	\$8,500 (\$17,000 x 0.5)	\$9,000 (\$8,500 + \$500)
	33218	Electrode Repair	G2	1	\$1000	--	\$500 (\$1000 x 0.5)

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
<p>Claim 4:</p> <p>Terminated Procedure and Partial Credit Replacement Device</p> <p>ASC brings patient into operating room to implant ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC terminates the procedure prior to the administration of anesthesia or initiation of the procedure.</p>	33240 FC and 73	Implant ICD	J8	1	\$17,500	\$8,500 (\$17,000 x .5)	\$4,500 (((\$8,500 + \$500) x 0.5)

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
<p>Claim 5:</p> <p>FC modifier on Partial Credit Replacement Device Line</p> <p>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.</p>	33240	Implant ICD	J8	1	Incorrect billing because ASCs may not report device HCPCS codes or device charges on a separate line on the claim. Device payment is packaged into payment for the device implantation procedure, and charges for the device should be included in the line-item charge for the device implantation procedure. This bill will not result in accurate payment because there is no ASC payment rate for the device, and the payment for the implantation procedure will be made at the lesser of the ASC charges or the ASC rate.		
	C1721 FC	ICD	N1	1			

Example	HCPCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
<p>Claim 6:</p> <p>Partial Credit Replacement Device But FC Modifier Not Reported on Procedure Code</p> <p>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device, but fails to append the FC modifier to the procedure code.</p>	33240	Implant ICD	J8	1			<p>Incorrect billing if partial credit is known at the time of billing. FC modifier should have been appended to the procedure code. If partial credit is unknown at the time of billing and the partial credit is received by the ASC at a later time, the ASC should contact the contractor to request an adjustment.</p>

Disclaimer: The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2008. The rates above do not represent actual payment rates.

Additional Information

To view the official instruction (CR 5668) on which this article is based, providers may visit <http://www.cms.hhs.gov/transmittals/downloads/R1383CP.pdf> on the CMS Web site.

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

Disclaimer

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



Update to Requirement to Submit National Provider Identifier (NPI) Notification

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: MM5795
Related CR Release Date: November 2, 2008
Related CR Transmittal #: R227PI

Related Change Request (CR) #: 5795
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier, (hereinafter collectively referred to as “providers”) who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs) and regional home health intermediaries (RHHIs)) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Providers, except DMEPOS suppliers, are no longer required to submit to the Medicare contractor a copy of the NPI notification received from the National Plan and Provider Enumeration System (NPPES), unless requested to do so by the contractor. Similarly, if the provider, except DMEPOS supplier, obtained the NPI via the Electronic File Interchange (EFI) mechanism, the provider need not submit a copy of the notification received from the EFI Organization (EFIO), unless requested to do so by the contractor. If paper documentation of a provider’s NPI is requested by the contractor, the contractor may accept a copy of the provider’s NPI Registry’s Details Page in lieu of a copy of the NPI notification.

Additional Information

You may see the official instruction (CR 5795) issued to your Medicare A/B MAC, FI, RHHI, or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R227PI.pdf> on the CMS Web site.

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

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Clarification on the National Provider Identifier (NPI) Enumerator’s Responsibilities

The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). If you need assistance with questions for which the NPI Enumerator is not responsible, refer to <http://www.cms.hhs.gov/NationalProvIdentStand/> on the Centers for Medicare & Medicaid Services NPI Web site. This site includes NPI Frequently Asked Questions (FAQs), and the NPI Application/Update form, which is a good source of information. In addition, refer to the instructions, which are part of the form, for clarification on information needed in order to obtain NPIs or update your records. Another resource available is the “Application Help” tab located on the NPPES Web site (<https://nppes.cms.hhs.gov>).

The NPI Enumerator **cannot** assist health care providers with the following issues.

- Assistance with the Medicare NPI Crosswalk and Medicare claims processing issues;
 - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
 - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
 - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
 - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
 - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.
 - The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
 - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- Assistance with information disseminated or not disseminated via the NPI Registry or the NPPES downloadable file;
 - The NPI Enumerator **cannot** assist providers with questions regarding “temporarily suppressed” information found on the NPI Registry or downloadable file. Although the NPI Enumerator can confirm whether or not the information still exists in the provider’s active NPPES record; this confirmation is limited to the health care provider or contact person on the provider’s NPPES record. Third party sources, including Medicare contractors, cannot call the NPI Enumerator for confirmation of information in a health care provider’s NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.
- Assistance with Medicare-related provider enrollment information;
 - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
 - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers’ NPPES records.
 - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
 - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- Assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs); and
- Assistance with questions related to to;
 - Defining subparts.
 - Which subparts should receive NPIs.
 - Where NPIs or legacy identifiers are to be placed in claims transactions.
 - Health Insurance Portability and Accountability Act (HIPAA) regulations or regulatory policies.
 - Proper use of NPIs in transactions with health plans.
 - Determining if the provider is a sole proprietor or an incorporated individual.



Individuals Authorized Access to CMS Computer Services—Provider Community (IACS-PC): The First in a Series of Articles

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: SE0747

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

These articles will help providers to register for future access to CMS online computer services. This article contains:

- Ten questions and answers to get you started; and
- An overview of the registration process for IACS-PC defined provider organization users.

Provider Types Affected

Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Medicare administrative contractors (A/B MACs).

Special Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS-PC at this time. DMEPOS suppliers may want to review question # 10 below.

What Providers Need to Know

In the near future, CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

Provider Action Needed

Even though these new internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

Ten Questions and Answers to Get You Started

1. What is IACS-PC?

IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (see question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: This release of IACS-PC will not impact access to FI/carrier/MAC internet applications or the DME Competitive Bidding System (DBidS) application. New enterprise CMS systems will not offer the internet services FIs/carriers/MACs are providing in the near future.

2. Who can use this system?

Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question # 10 below.)

3. Why register NOW?

Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it can still take several weeks to finalize registration. Since the system is new, registering now gives you a “cushion” so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early in 2008.

4. If I register now, how long is my password valid?

Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How do I register as an IACS-PC user?

IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

NOTE: The CMS Web site contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by email at EUSsupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?

An individual practitioner is defined by IACS-PC as a physician or non-physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have no staff who will be accessing the applications.

More details can be found in the Individual Practitioner Registration - Quick Reference Guide, which can be found on the CMS Web site at:

http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Individual_Practitioner_Registration_QRG_111607.pdf

7. When would I register as an IACS-PC provider organization?

The term “organization”, as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, “organization” includes

providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and non-physician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.

IACS-PC provider organizations require Security Officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization Security Official.

8. What should I have in hand before I register?

For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:

- Social Security Number; and
- Correspondence Information.

For an IACS-PC provider organization, the Security Official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer Identification Number (TIN);
- Legal Business Name;
- Corporate Address; and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

9. How do I register my IACS-PC provider organization?

IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's CP-575 form, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the "Overview" section, which follows question #10.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the "Security Official Registration - Quick Reference Guide," which is available on the CMS Web site at:

http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf

The next MLN article in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why are you excluding DMEPOS suppliers from IACS-PC?

DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which will be released closer to the 2008 bid window.

OVERVIEW: Registering in IACS-PC as a Provider Organization or a Provider Organization User

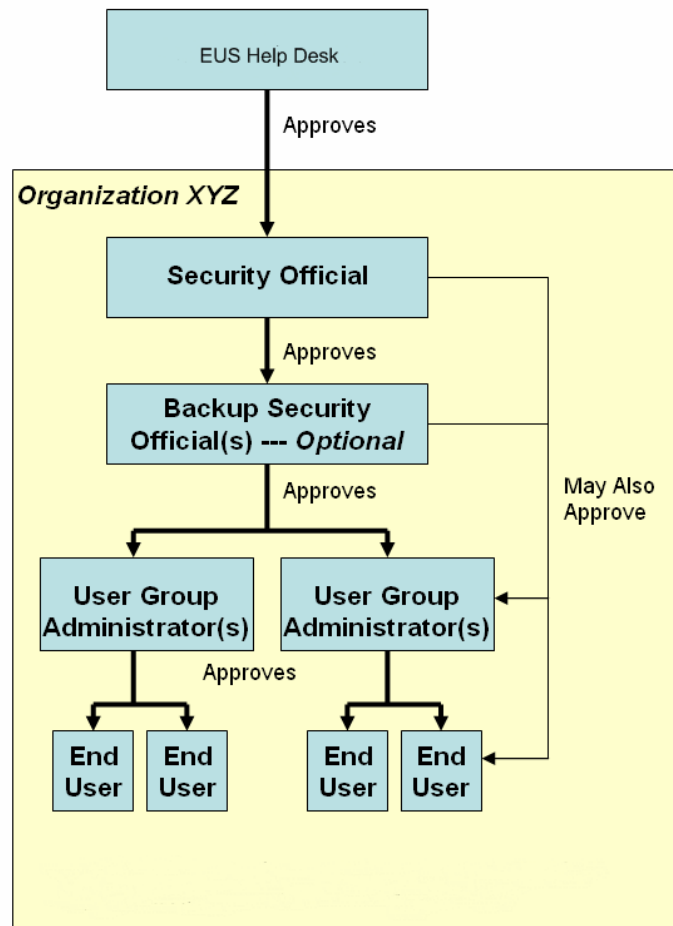
For IACS-PC registration purposes, “organization” includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and non-physician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access IACS-PC applications.

The “delegated authority model” previously described is below. The EUS Help Desk will be responsible for approving the organization’s Security Official. Then the Security Official may approve the Backup Security Official(s) etc.

IACS-PC Community: Delegated Authority Model



II. REGISTRATION ROLES

1. The first person to register must be the **Security Official**.

The Security Official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There can be only one Security Official for an organization. The Security Official is trusted to approve the access request of Backup Security Official(s) and can approve the access requests of User Group Administrators and End Users. The Security Official will be approved by CMS through its EUS Help Desk. The Security Official is held accountable by CMS for the behavior of those they approve including the End Users for the organization.

The Security Official Registration - Quick Reference Guide may be found on the CMS Web site at: http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_ORG_111607.pdf

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk.

2. An organization may choose to have one or more **Backup Security Officials**. (Optional)

This is an optional role. You need not have a Backup Security Official. The Backup Security Official is approved by the Security Official. A Backup Security Official performs the same functions as a Security Official in an organization, with the exception of approving other Backup Security Officials. There can be one or more Backup Security Officials in an organization. The Backup Security Official can approve the access requests of User Group Administrators and End Users and may aid the Security Official with the administration of User Groups and User Group Administrators' accounts.

3. The next registrant must be a **User Group Administrator (UGA)**.

The UGA is approved by the Security Official or Backup Security Official. The UGA is trusted to approve the access requests of End Users for that User Group.

Organizations with 2-9 IACS-PC users must, at a minimum, have a Security Official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA.

A UGA registers the User Group within an organization in IACS-PC and updates the User Group profile information in IACS-PC. There can be multiple UGAs for the same User Group within an organization.

4. Organizations with ten or more IACS-PC users must also have **End Users**.

An End User is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An End User is part of a User Group within the provider organization. An End User may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An End User may belong to multiple groups in one or more organizations. The End User is approved by the UGA.

Note: End User requests cannot be approved until after the User Group Administrator has been approved.

III. SURROGATE USER GROUPS

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a Surrogate User Group. Examples include clearinghouses, credentialing departments, independent contractors. A Surrogate User Group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A Surrogate User Group may be associated with multiple provider organizations.

1. The first contractor employee to register in a Surrogate User Group must be the UGA.

If there will be only one user in a Surrogate Group, that user must register as a UGA. The UGA for the Surrogate User Group will register the Surrogate User Group and update the User Group profile information in IACS-PC. There can be multiple UGAs within the same Surrogate User Group. The UGA is trusted to approve the access requests of End Users for their user group.

The UGA of the Surrogate User Group must be approved by the Security Official or Backup Security Official in the provider organization on whose behalf it performs work. Once approved, the UGA of a Surrogate Group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an End User.

An End User is approved to perform Medicare business for a surrogate or provider User Group by their UGA. An End User may belong to multiple groups in one or more organizations.

ADDITIONAL HELP

The EUS Help Desk will support this process for IACS-PC. It may be reached by email at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

Disclaimer

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

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

MLN Matters Number: MM5800

Related Change Request (CR) #: 5800

Related CR Release Date: November 30, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1384CP

Implementation Date: January 7, 2008

Provider Types Affected

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

Impact on Providers

CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes> on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The new Web site address is <http://www.cmsremarkcodes.info/> on the Internet.

Note that this Web site does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR 5800) issued to your Medicare carrier, A/B MAC, FI, DME MAC or RHHI by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.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.

For additional information about Remittance Advice, please refer to “Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers” at:

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. Note: (New Code 8/1/07)	Medicare initiated

Code	Current Narrative	Comment
N389	Duplicate prescription number submitted. Note: (New Code 8/1/07)	Medicare initiated
N390	This service cannot be billed separately. Note: (New Code 8/1/07)	Medicare initiated
N391	Missing emergency department records. Note: (New Code 8/1/07)	Not Medicare initiated
N392	Incomplete/invalid emergency department records. Note: (New Code 8/1/07)	Not Medicare initiated
N393	Missing progress notes or report. Note: (New Code 8/1/07)	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. Note: (New Code 8/1/07)	Not Medicare initiated
N395	Missing laboratory report. Note: (New Code 8/1/07)	Not Medicare initiated
N396	Incomplete/invalid laboratory report. Note: (New Code 8/1/07)	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). Note: (New Code 8/1/07)	Not Medicare initiated
N398	Missing elective consent form. Note: (New Code 8/1/07)	Not Medicare initiated
N399	Incomplete/invalid elective consent form. Note: (New Code 8/1/07)	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. Note: (New Code 8/1/07)	Not Medicare initiated
N401	Missing periodontal charting. Note: (New Code 8/1/07)	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. Note: (New Code 8/1/07)	Not Medicare initiated
N403	Missing facility certification. Note: (New Code 8/1/07)	Not Medicare initiated
N404	Incomplete/invalid facility certification. Note: (New Code 8/1/07)	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	Not Medicare initiated

Code	Current Narrative	Comment
N407	You are not an approved submitter for this transmission format. Note: (New Code 8/1/07)	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. Note: (New Code 8/1/07)	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Note: (New Code 8/1/07)	Not Medicare initiated
N410	This is not covered unless the prescription changes. Note: (New Code 8/1/07)	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. Note: (New Code 8/1/07)	Not Medicare initiated

Code	Current Narrative	Comment
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. Note: (New Code 8/1/07)	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Note: (New Code 8/1/07)	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. Note: (New Code 8/1/07)	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. Note: (New Code 8/1/07)	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. Note: (New Code 8/1/07)	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. Note: (New Code 8/1/07)	Medicare initiated
N425	Statutorily excluded service(s). Note: (New Code 8/1/07)	Medicare initiated
N426	No coverage when self-administered. Note: (New Code 8/1/07)	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. Note: (New Code 8/1/07)	Medicare initiated
N428	Service/procedure not covered when performed in this place of service. Note: (New Code 8/1/07)	Medicare initiated
N429	This is not covered since it is considered routine. Note: (New Code 8/1/07)	Medicare initiated

***NOTE:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have “Alert” in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

These informational codes will be used only if specific information needs to be communicated but not as default codes

Modified Codes

Code	Current Modified Narrative	Comment
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	Alert: This is a telephone review decision.	Modified 4/1/07, 8/1/07
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	Modified 8/1/07
N84	Alert: Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	Alert: This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

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Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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: SE0750

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Sample of 35,000 Medicare providers served by Medicare Fee-for-Service (FFS) Contractors, including Medicare administrative contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME/MACs) and regional home health intermediaries (RHHIs))

Provider Action Needed STOP – Impact to You

CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than \$280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

CAUTION – What You Need to Know

CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

GO – What You Need to Do

Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background

The 2008 MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship:

- Provider inquiries;
- Provider outreach and education;
- Claims processing;

- Appeals;
- Provider enrollment;
- Medical review; and
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with “1” representing “not at all satisfied” and “6” representing “completely satisfied.” The results of the second MCPSS are available to health care providers and contractors at <http://www.cms.hhs.gov/MCPSS> on the CMS Web site. Last year’s findings showed that 85 percent of respondents rated their contractors between 4 and 6.

Further, the 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider’s overall satisfaction.

Additional Information

CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit: <http://www.cms.hhs.gov/MCPSS> on the CMS Web site.

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Medicare Preventive Services Series

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: “Medicare Preventive Services Series: Part 3 Expanded Benefits”. This Web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as, the “Welcome to Medicare” physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements. Note: 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 Web site.

Visit the Medicare Learning Network <http://www.cms.hhs.gov/MLNgeninfo> ~ it's free!



Quarterly Provider Update

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

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

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

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

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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Unsolicited/Voluntary Refunds

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

MLN Matters Number: MM3274

Related CR Release Date: July 30, 2004

Related CR Transmittal #: 50

Related Change Request (CR) #: 3274

Effective Date: October 1, 2004/January 1, 2005

Implementation Date: October 1, 2004/January 3, 2005

Provider Types Affected

All Medicare providers

Provider Action Needed

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

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

Disclaimer

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News from CMS for Hospital/CAH Providers



Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Inpatient Psychiatric Facility (IPF) PPS 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: MM5748

Related CR Release Date: November 7, 2007

Related CR Transmittal #: R1374CP

Related Change Request (CR) #: 5748

Effective Date: Discharges on or after October 1, 2007

Implementation Date: October 18, 2007

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries and paid under the IPPS, the LTCH PPS, or the IPF PPS.

Provider Action Needed

This article is based on CR 5748, which announces changes to the IPPS and LTCH PPS payment policies based on the FY 08 IPPS Final Rule. It also includes the ICD-9-CM coding changes that affect the IPF PPS comorbidity adjustment. The FY 08 IPPS Final Rule also established a new diagnosis-related group (DRG) system, the Medicare Severity DRGs, or MS-DRGs, effective October 1, 2007. Be sure billing staff are aware of the changes.

Background

CMS annually updates the IPPS, and CR 5748 announces changes for the IPPS hospitals for FY 2008. The policy changes for FY 2008 appeared in the *Federal Register* on August 22, 2007, (http://www.access.gpo.gov/su_docs/fedreg/a070822c.html) and the final IPPS rates are available on the CMS Web site. All items covered in CR 5748 are effective for hospital discharges occurring on or after October 1, 2007, unless otherwise noted.

The FY 08 IPPS Final rule established a new DRG system, the MS-DRGs, effective October 1, 2007. By better taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. To assure that improvements in coding and documentation do not lead to an increase in the aggregate payments without corresponding growth in actual patient severity, the final rule established a documentation and coding adjustment of -1.2 percent for FY 2008. However, Section 7 of the “TMA, Abstinence Education, and QI Programs Extension Act of 2007” limits that adjustment to -0.6 percent for discharges occurring in FY 2008. This -0.6 percent adjustment is not being applied to the hospital-specific rates in the Pricer. This is consistent with the policy established in the IPPS notice issued on November 1, 2007.

CR 5748 also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2007, for hospitals paid under the IPPS, as well as under LTCH PPS. LTCH PPS rate changes occurred on July 1, 2007. (Please refer to CR 5652 (Transmittal 1268, published on June 15, 2007, at <http://www.cms.hhs.gov/transmittals/downloads/R1268CP.pdf> or its corresponding MLN Matters articles MM5652 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5652.pdf> on the CMS Web site for LTCH policy changes).

The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2007. Rate changes occurred on July 1, 2007. Please refer to CR 5619 (Transmittal 1256, published on May 25, 2007, at <http://www.cms.hhs.gov/transmittals/downloads/R1256CP.pdf> or it corresponding MLN Matters article MM5619 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5619.pdf> on the CMS Web site) for IPF PPS policy changes.

ICD-9-CM coding changes are effective October 1, 2007. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6A and 6B of the August 22, 2007, *Federal Register*, and the ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6C and 6D. You can also find the revised code titles in Tables 6E and 6F. See the August 22, 2007, *Federal Register* (Pages 47129-48175) at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm> on the Internet.

A new DRG Grouper, Version 25, software package is effective for discharges on or after October 1, 2007. GROUPER 25.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2007. The Medicare Code Editor (MCE) 24.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2007. Key changes in CR 5748 are as follows:

A. Furnished Software Changes

The following software programs were issued for FY 2008:

IPPS PRICER 08.0

The **IPPS Pricer, version 08.0, will be used** for discharges occurring on or after October 1, 2007. The IPPS Pricer 08.0 also processes bills with discharge dates on or after October 1, 2002.

Rates

Standardized Amount Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	\$22,185.00
Federal Capital Rate	\$426.14
Puerto Rico Capital Rate	\$201.67
Outlier Offset-Operating National	0.948983
Outlier Offset-Operating Puerto Rico	0.964060
Indirect medical education (IME) Formula	1.35*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor	0.995743

Operating Rates:

Rates With Full Market Basket & Wage Index Greater than 1

	Labor Share	Non-Labor Share
National	3478.45	1512.15
Puerto Rico/ National	3478.45	1512.15
Puerto Rico Specific	1462.27	896.23

Rates With Full Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3094.17	1896.43
Puerto Rico/ National	3094.17	1896.43
Puerto Rico Specific	1384.44	974.06

Rates With Reduced Market Basket & Wage Index Greater Than 1

	Labor Share	Non-Labor Share
National	3411.10	1482.87

Rates With Reduced Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3034.26	1859.71

Cost-of-Living Adjustment Factors - Alaska and Hawaii Hospitals:

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Postacute Care Transfer Policy

The DRGs determined in the post acute care transfer policy have been modified due to Medicare Severity Diagnosis Related Groups (MS-DRGs). See Section B (Grouper 25.0) below regarding MS-DRGs.

The special pay DRGs are paid at 50 percent of the appropriate PPS rate for the first day of the stay and 50 percent of the amount calculated for the rest of the stay. These special pay DRGs are as follows:

028	029	030	040	041
042	219	220	221	477
478	479	480	481	482
492	493	494	500	501
502	515	516	517	956

Note: See attachment A of CR 5748 for list of the postacute care transfer DRGs.

New Technology Add-On Payment

Effective for discharges on or after October 1, 2007, there will be no continuing add-on payments from last year and no new ones starting for this year.

Burn DRGs

Burn DRGs receive 90 percent of costs exceeding the outlier threshold instead of the 80 percent that other DRGs receive. The Burn DRGs for FY08 are 927, 928, 929, 933, 934 and 935. These have been updated for MS-DRGs.

B. GROUPER 25.0

For discharges occurring on or after October 1, 2007, PRICER calls the appropriate GROUPER based on discharge date. This version of Grouper will include logic to group to MS-DRGS. Grouper will have increased field lengths for the diagnosis and procedure codes and dates and fields for the Present on Admission (POA) indicator. The Medicare Severity DRGs or MS-DRGs are modifications of the CMS-DRGs to better account for severity of illness and resource consumption for Medicare patients. The MS-DRGs increase the number of DRGs by 207 to a total of 745, while maintaining the reasonable patient volume in each DRG. There are three levels of severity in the MS-DRGs based on the secondary diagnosis codes: MCC (Major Complication/Comorbidity), CC (Complication/Comorbidity), and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the CMS DRGs or the MS-DRGs.

C. Medicare Code Editor (MCE) 24.0

For discharges occurring on or after October 1, 2007, the MCE selects the proper internal tables based on discharge date. Effective October 1, 2007, MCE will have increased field lengths for diagnosis and procedure codes, fields for the POA indicator, other new edits and retroactivity.

D. Provider Specific Information

Tables 8A and 8B of Section VI of the addendum to the PPS final rule contain the FY 2008 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.238 and the capital ceiling is 0.152. See the August 22, 2007, *Federal Register* (Pages 47129-48175) at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm> on the Internet.

Core-Based Statistical Area (CBSA) Designations

Attachment B of CR 5748 shows the IPPS providers that will be receiving a “special” wage index for FY 2008 (i.e., receives an out-commuting adjustment under section 505 of the Medicare Modernization Act (MMA)).

For any provider with a Special Wage Index from FY 2007, FIs shall remove that special wage index, unless they receive a new special wage index as listed in Attachment B of CR 5748.

Micropolitan areas are “rural” areas, but hospitals in these areas were given an urban area wage index for 3 years (known as the hold harmless provision. This provision expired on September 30, 2007, and these hospitals now receive 100 percent of their wage index based upon the CBSA configurations.

Low Volume Hospitals

Hospitals considered low volume will receive a 25 percent bonus to the operating final payment. To be considered “low volume” the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify FIs if they believe they are a low volume hospital.

The Low Volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination. If the hospital is no longer low volume, the ‘Y’ indicator should be removed. If the hospital does meet the low volume criteria, a ‘Y’ should be inserted into the low volume indicator field.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org> on the Internet. Attachment C of CR 5748 includes the list of providers that did not meet the criteria for FY 08. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site and FIs must update the provider file as needed.

For new hospitals, FIs will provide information to the appropriate Quality Improvement Organization (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

E. Other Changes

Capital PPS Adjustment for Hospitals Located in Large Urban Areas

In the FY 2008 final rule, the capital PPS 3.0 percent “large urban add-on” was eliminated effective for discharges on or after October 1, 2007. That is, the regulations at §412.316(b) were revised to specify that beginning in FY 2008 and after, there will no longer be any additional payment under the capital PPS for hospitals located in large urban areas, as currently provided under that section. The PRICER has been updated to reflect this policy change.

Capital PPS Payment for Providers Redesignated Under Section 1886(d)(8)(B) of the Act

Under this section of the Act, certain rural counties (commonly referred to as “Lugar counties”) adjacent to one or more urban areas are redesignated as urban for the purposes of payment under the IPPS. Hospitals located in these “Lugar counties” are deemed to be located in an urban area and they receive the Federal payment amount for the urban area to which they are redesignated. Such hospitals, however, may decline this redesignation and retain their rural status.

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

Hospitals reclassified as rural under 42 CFR 412.103 (http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1); http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html). Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under 42 CFR 412.103 is determined from the applicable statewide rural wage index.

F. LTCH Changes

A new patient classification system is being adopted under the LTCH PPS, beginning in FY 2008. It is the same as the one being adopted under the IPPS (i.e., MS-DRGs), but under LTCH, the DRGs are referred to as “MS-LTC-DRGs”. The LTCH PRICER has been updated with the MS-LTC-DRG table and weights.

In the IPPS computation of the “IPPS Comparable Amount” for LTCH Short-Stay Outlier (SSO) cases, in the calculation of the Capital IPPS comparable payment amount, the 3 percent large urban add-on has been eliminated effective with discharges occurring on or after October 1, 2007.

G. Inpatient Psychiatric Facility Changes

Coding Changes -DRG Adjustment Update:

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment and all

other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS' identified 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, please note these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS- DRGs, which will be effective October 1, 2007.

(version 24) DRG	(version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
12	056	Degenerative nervous system disorders w MCC	1.05
	057	Degenerative nervous system disorders w/o MCC	
023	080	Nontraumatic stupor & coma w MCC	1.07
	081	Nontraumatic stupor & coma w/o MCC	
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	

Comorbidity Adjustment Update:

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity

adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

As explained above, the IPF PPS is adopting the new MS-Severity DRG coding system in order to maintain consistency with the IPPS, which are effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. The FY 2008 GROUPER, Version 25.0, is effective for discharges occurring on or after October 1, 2007.

There are two tables in CR 5748 listing the FY 2008 new ICD-9-CM diagnosis codes and the one invalid FY 2008 ICD diagnosis code, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2008 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

One table in CR 5748 is an extensive table that lists the FY 2008 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2008 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. CR 5748 can be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1374CP.pdf> on the CMS Web site.

There is one ICD-9-CM codes no longer applicable for the comorbidity adjustment. This code is:

Diagnosis Code	Description	Comorbidity Category
233.3	Carcinoma in situ, other and unspecified female genital organs	Oncology Treatment

Additional Information

The official instruction (CR5748) issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1374CP.pdf> on the CMS Web site.

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

Disclaimer

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



Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services— Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Special Edition Medicare Learning Network* (MLN) article entitled “Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services,” 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: SE0436 Revised

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Note: This article was revised on November 28, 2007, to clarify that services covered under the Part D benefit are not subject to SNF consolidated billing. The clarification is under the heading “Example of Special Circumstance” in bold. All other information remains unchanged.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers.

Provider Action Needed

This Special Edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor (DME MAC).)

Background

When the SNF prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. See *MLN Matters* article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS Web site.

Preventive and Screening Services

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998, *Federal Register* (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Billing for Preventive and Screening Services

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to check for the possible presence of a specific condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). As discussed below, such services are always covered under the applicable Part B benefit (or, in certain circumstances, under the Part D drug benefit), even when furnished to a beneficiary during the course of a covered Part A SNF stay.

Priority of Payments

Priority of payment between the various parts of the Medicare law (title XVIII of the Social Security Act) basically proceeds in alphabetical order: Part A is primary to Part B (see Section 1833(d) of the Social Security Act), and both Parts A and B are primary to Part D (see Section 1860D-2(e)(2)(B) of the Social Security Act). In the case of a vaccine, for example, this means that Part B can cover the vaccine only to the extent that it is not already coverable under Part A; similarly, the Part D drug benefit can cover such a vaccine only to the extent that it is not already coverable under either Part A or Part B.

Thus, when an SNF's Part A resident receives a preventive vaccine for which a specific Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), the vaccine would be covered under Part B. It would not be covered under Part A (because, as explained above, the scope of the Part A SNF benefit does not encompass preventive services), and it also would not be covered under Part D (because Part B already includes a specific benefit category that covers each of these three types of vaccines and, as discussed above, Part B is primary to Part D). Similarly, a preventive vaccine (such as poliomyelitis) for which no Part B benefit category exists would be coverable under the Part D drug benefit when administered to the SNF's Part A resident, rather than being covered under the Part A SNF benefit.

Example of Special Circumstance

However, there are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease (such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF's Part A resident would be considered reasonable and necessary to treat an existing condition and, accordingly, would be included within the SNF's global Part A per diem payment for the resident's Medicare-covered stay.

In terms of billing for an SNF's Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes (such as a tetanus booster shot given in response to an actual exposure to the disease) would be included on the SNF's global Part A bill for the resident's covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines for which a Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), then the SNF would submit a separate Part B bill to its fiscal intermediary for the vaccine. (Under Section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.) Finally, if the resident receives a type of preventive vaccine for which no Part B benefit category exists (e.g., poliomyelitis), then the vaccine would not be covered under either Parts A or B, and so would be coverable under the Part D drug benefit.

Further, it is worth noting that unlike preventive services covered under Part B, those services covered under Part D are not subject to CB, even when furnished to an SNF's Part A resident. This is because Section 1862(a)(18) of the Social Security Act specifies that CB applies to **“. . . covered skilled nursing facility services described in section 1888(e)(2)(A)(i) . . .”** Section 1888(e)(2)(A)(i), in turn, defines **“covered skilled nursing facility services” specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of CB) would be types of services “. . . for which payment may be made under Part B . . .”**

Additional Information

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS Web site.

The CMS MLN Consolidated Billing Web site is at: <http://www.cms.hhs.gov/SNFConsolidatedBilling/>

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site can be found at http://www.cms.hhs.gov/SNFPSPS/05_ConsolidatedBilling.asp on the CMS Web site. It includes the following relevant information:

- Background;

- Historical questions and answers;
- Links to related articles; and
- Links to publication (including transmittals and *Federal Register* notices).

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News from Cahaba GBA, LLC for All Providers



Update to the New EDSNET Screen and Information About Testing Automated Sign-on Systems

The following is an update to the article “A New Look for the EDSNET Screen,” which was posted to the “What’s New from Cahaba GBA” Web page on November 14, 2007, and published in the December 1, 2007, *Medicare A Newslines* and the *Home Health & Hospice Medicare A Newslines*. An implementation date for the new look to the EDSNET screen has been determined, and providers will see the new EDSNET screen beginning January 20, 2008.

Automated Sign-on Testing Information

If you or your software vendor use an automated process to sign-on to the Fiscal Intermediary Standard System (FISS), or the eligibility screens, ELGA/ELGH, and it is necessary for you to modify your script, testing will be available. You may test your modifications during the following time periods:

January 6, 2008	Noon – 6:00 p.m. Central Time (CT)
January 13, 2008	Noon – 6:00 p.m. CT

The “A New Look for the EDSNET Screen” article is available for your reference at:
https://www.cahabagba.com/part_a/whats_new/20071114_eds.htm



Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **January 31, 2008**, for the quarter ending **December 31, 2007**.

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

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

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

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

Or, if sending overnight:

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

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

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

Medicare Part A Credit Balance Reporting
Cahaba GBA
P.O. Box 10808
Birmingham, AL 35202-0808

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

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



Cahaba Offices Closed for the January Holidays

While we celebrate the holidays with our families, our office will be closed New Year's Day, Tuesday, January 1, 2008. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the ELGA/ELGH eligibility system will not be available January 1, 2008. In addition, FISS will not cycle on January 1st, which means that claims will not be sent to the Common Working File (CWF) that night. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfer (EFTs) will not be produced on January 1, 2008.

Martin Luther King Jr.'s Birthday

In observation of Martin Luther King Jr.'s birthday, our office will be closed on Monday, January 21, 2008. However, because January 21 is a regular business day for our data center, FISS will be available. Claims will process through FISS and the CWF as usual the night of January 21. In addition, Medicare Electronic Remittance Advices (ERAs) will be issued. Paper remittance advices, checks and Electronic Funds Transfer (EFT) payments will not be issued until January 22, 2008. Providers will be able to transmit claim files and receive their Daily Log report. Please note that support staff will not be available for assistance.



Availability of the Provider Contact Center

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

CSR Training Date	Time
January 11, 2008	9:00 a.m.–11:00 a.m. CT
January 18, 2008	9:00 a.m.–11:00 a.m. CT

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



Medicare Part A Local Coverage Determination Update

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

- **Speech-Language Pathology - Outpatient Clarification**

The local coverage determination (LCD) for Speech-Language Pathology – Outpatient (L1078) has been updated. In response to a provider request, the definition and documentation requirements for CPT code 97532 have been further clarified.

Providers are encouraged to review this clarification to ensure compliance, effective December 1, 2007.

This LCD can be viewed at: https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm

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.

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

Date: January 8, 2008

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

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.

➤ "[Uncovering the Errors from the 2007 CERT Report Ask-the-Contractor \(ACT\) Teleconference](#)"

Date: January 10, 2008

Time: 1:00-2:00 p.m. Central Time

Registration Deadline: January 3, 2008

Intended Audience: This event is tailored for all Medicare Part A providers and staff.

Description: This event will present the highlights of the Comprehensive Error Rate Testing (CERT) November 2007 Report, including top errors nationally as well as the top errors assessed to Cahaba.

➤ "[FISS 101: The FISS Triangle; Function Keys, Status/Locations, and Inquiries](#)" Webinar

Date: January 29, 2008

Time: 1:00-3:00 p.m. Central Time

Registration Deadline: January 24, 2008

Intended Audience: This event is tailored for all Medicare Part A providers and staff.

Description: This event will discuss the various function keys used in the Fiscal Intermediary Standard System (FISS), as well as status/location codes, and inquiry screens.

Cahaba GBA, LLC Learning Corner

- 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](#).