Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC

March 1, 2008 **Vol. 15, No. 6**

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 https://www.cahabagba.com.

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Key for Icons:

- All Providers
- Hospital/Critical Access Hospital (CAH) Providers
- Skilled Nursing Facility (SNF) / Swing Bed Providers
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- Renal Dialysis Facility (RDF)
- Community Mental Health Center (CMHC) Providers
- Comprehensive Outpatient Rehabilitation Facility (CORF) Providers and Outpatient Physical Therapy (OPT) Providers

The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC as their Fiscal Intermediary or Regional Home Health Intermediary. *The CPT codes, descriptors and other data only are copyright © 2007 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.*

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News Flash Messages from CMS For All Providers

Test Your Medicare Claims Now!

After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

Influenza Vaccine

It's Not Too Late to Give and Get the Flu Shot! In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Don't Get the Flu. Don't Give the Flu. Get Vaccinated! Remember - Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf on the CMS Web site.

Ambulatory Surgical Center Fee Schedule Fact Sheet

The Ambulatory Surgical Center Fee Schedule Fact Sheet, which provides general information about the Ambulatory Surgical Center (ASC) Fee Schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508.pdf on the CMS Web site.

Acute Inpatient Prospective Payment System Fact Sheet

The Acute Inpatient Prospective Payment System Fact Sheet (revised November 2007), which provides general information about the Acute Inpatient Prospective Payment System (IPPS) and how IPPS rates are set, is now available in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network. If the URL above does not take you directly to the fact sheet, please copy and paste the URL in your web browser.

Home Health Prospective Payment System Fact Sheet

The Home Health Prospective Payment System Fact Sheet, which provides information about coverage of home health services and elements of the Home Health Prospective Payment System, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/HomeHlthProspPymtfctsht08-508.pdf on the CMS Web site.

Processing Mammography Claims

According to the Mammography Quality Standards Act (MQSA), all facilities must be certified to perform screening and diagnostic mammography services. A table of certified facilities is provided weekly by the Food and Drug Administration (FDA). The Fiscal Intermediary Standard System (FISS) will check the data to ensure that the facility listed on the claim is in fact certified to perform the services. Occasionally, claims for screening and diagnostic mammography services are submitted before the data is installed into FISS. This causes erroneous rejections/denials of claims submitted by valid certified facilities. To avoid erroneous claim rejections/denials, providers may wish to hold their mammography claims for 7 business days to allow for any changes in certification data to be installed accordingly. After the 7 business days, providers may submit their claims for payment.

January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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: MM5912
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R1417CP

Related Change Request (CR) #: 5912
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the OPPS.

Impact on Providers

This article is based on Change Request (CR) 5912, which describes changes to the OPPS to be implemented in the January 2008 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 5912 describes changes to and billing instructions for various payment policies implemented in the January 2008 OPPS update. The January 2008 Integrated Outpatient Code Editor (I/OCE) changes are discussed in CR5865. MLN Matters article, MM5865, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5865.pdf on the Centers for Medicare & Medicaid (CMS) Web site. The January 2008 I/OCE and OPPS PRICER will reflect January 2008 changes to:

- The Healthcare Common Procedure Coding System (HCPCS);
- Ambulatory Payment Classification (APC);
- HCPCS modifier; and
- Revenue Code additions, changes, and deletions identified in this notification.

CR5912 affects Chapter 4, Sections 10, 20, 30, 50, 61, 70, 130, 160, 190, 200, 230, and 290; Chapter 16, Section 40.3; and Chapter 17, Section 90.2 of the Medicare Claims Processing Manual. CMS is reorganizing or deleting information in these sections. These manual revisions will be released in a future CR.

Key Changes

The key changes according to CR5912 are as follows:

- For CY2008, Medicare has created two parallel Level II HCPCS G-Codes (G0396 and G0397) to allow for proper reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. Medicare contractors will make payment

under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance(other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes), only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Social Security Act. For more information regarding this change, refer to CR5912.

- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires Medicare to pay for brachytherapy sources for the period of January 1 through June 30, 2008, at hospitals' charges, adjusted to the costs (with the exception of C2637, which is non-payable). Therefore, the prospective payment rates for each source, which are listed in Addendum B of the VY2008 final rule for OPPS, will NOT be used for payment during that time period. Instead, the status indicators of brachytherapy source HCPCS codes (except C2637), which were previously paid at charges adjusted to cost, will remain "H" effective January 1 through June 30, 2008. Further instructions will be issued later for payment after June 30, 2008. CR5912 also has a table (Table 5) containing a comprehensive list of brachytherapy sources payable as of January 1, 2008.

- Table 9 of CR5912 contains updated payment rates for certain HCPCS codes (J0152, J0881, J1438, J1440, J1441, J2425, J2505, J0215, J0289, J1740, J7342, J8560, and J9268) that are effective January 1, 2007 through March 31, 2007. The Medicare contractors will adjust as appropriate claims you bring to their attention that:

  - Have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007;
  - Contain HCPCS code listed in Table 9 which is included in the business requirements section of CR5912; and
  - Were originally processed prior to the installation of the January 2008 OPPS Pricer.

- Table 10 of CR5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1324, J1438, J1440, J1441, J2425, and J2502) that are effective from April 1, 2007 through June 30, 2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:

  - Have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007;
  - Contain HCPCS code listed in Table 11; and
  - Were originally processed prior to the installation of the January 2008 OPPS Pricer.

- Table 11 of CR5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1438, J1440, J1441, J2505, Q3025, andQ4089) that are effective from July 1, 2007 through September 30, 2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:

  - Have dates of service that fall on or after July 1, 2007, but prior to October 1, 2007;
  - Contain HCPCS code listed in Table 11; and
  - Were originally processed prior to the installation of the January 2008 OPPS Pricer.

- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for therapeutic radiopharmaceuticals for the period of January 1 through June 30, 2008 at hospitals' charges adjusted to the costs. Therefore, the prospective payment rates for each therapeutic

radiopharmaceutical, which are listed in Addendum B of the CY2008 final rule from CMS dated November 27, 2007, will NOT be used for payment of therapeutic radiopharmaceuticals from January 1 through June 30, 2008. Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at charges adjusted to costs will remain at “H” effective January 1 through June 30, 2008, for payment at hospitals’ charges adjusted to costs. The codes for therapeutic radiopharmaceuticals, long descriptors, status indicators, and APCs for CY2008 are listed in Table 12 of CR5912.

- Effective January 1, 2008, Medicare contractors will return to the provider claims that report a nuclear medicine service but do not also report a diagnostic radiopharmaceutical.

- Providers who bill A/B MACs and RHHIs need to be aware that C-codes: C9237, C9240, C9354, and C9355 are included in the January 2008 I/OCE update. However, these codes are not on the 2008 HCPCS file. Contractors will manually add these codes to their systems. Status and payment indicators for these codes will be listed in the January 2008 update of the OPPS Addendum A and Addendum B at: http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage on the CMS website.

CR5912 is quite lengthy and also includes important changes regarding certain OPPS issues. Those details will not be repeated in this article, but are available in CR5912 at http://www.cms.hhs.gov/Transmittals/downloads/R1417CP.pdf on the CMS Web site for those details. The issues discussed in CR5912 include:

- Payment for cardiac rehabilitation services and the medical evaluation which is required to meet the Medicare comprehensive program requirements; Payment for extended assessment and management composite APCs, including a table (Table 1 of CR5912) that shows criteria for composite payment;

- Payment for direct admission to observation, including a discussion of HCPCS codes used for these services;

- Changes to packaged services for the 2008 OPPS, including a table (Table 2 of CR5912) of composite APCs and criteria for composite payment;

- Billing for wound care services, including a list of revisions to revenue codes that may be reported with CPT codes 97597, 97598, 97602, 97605, and 97606;

- Billing for bone marrow and stem cell processing services;

- Update billing for implantable cardioverter defibrillators (ICDs), which reports that the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) are deleted effective January 1, 2008, and hospitals are required to bill the appropriate CPT codes, specifically 33240 or 33249, as appropriate, along with the applicable device C-codes, for payment under the OPPS;

- Adjustment to payment in cases of devices replaced with partial credit for the replaced device, including two helpful tables (Tables 4.1 and 4.2) regarding the use of the FC modifier;

- Changes to device edits for 2008, including a reference that these edits are available under the “downloads” section at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site;

- As previously mentioned, a discussion of payment for brachytherapy sources, including a table (Table 5) that lists brachytherapy sources payable as of January 1, 2008, along with associated APCs and payment rates;

- Billing for drugs and biologicals, including a table (Table 6) of new 2008 HCPCS codes (A9501, A0509, A9569, A9570, A9571, A9576,A9577, A9578, C9237, C9238, C9239, C9240, C9354, C9355, J0400, J1573, J2724, and J9226), a table (Table 7) of HCPCS code and dosage descriptor changes for 2008, a table (Table 8) of new drugs separately payable under OPPS in 2008 (C9237 - (Injection, lanreotide acetate, 1mg) and C9240 – (Injection, ixabepilone, 1mg);

- New Drug Administration codes for 2008 (90769, 90770, 90771, and 90776);

- Billing for cardiac echocardiography services, including a table (Table 13) of HCPCS codes for echocardiograms with contrast (HCPCS codes C8921, C8922, C8923, C8924, C8925, C8926, C8927, and C8928);

- Modification of the methodology for calculating hospital overall cost-to-charge ratios for hospitals that have nursing and paramedical education programs;

- Changes to the OPPS PRICER logic; and

- OCE logic changes for the partial hospitalization program (PHP) services.

Additional Information

To see the official instruction (CR5912) issued to your Medicare FI, RHHI or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1417CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers (ASCs)-Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Medicare Learning Network (MLN) Matters article entitled “2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers (ASCs)”, which is published in the February 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: MM5211-Revised	**Related Change Request (CR) #:** 5211
Related CR Release Date: December 20, 2006	**Effective Date:** January 1, 2007
Related CR Transmittal #: R1134CP	**Implementation Date:** January 2, 2007

Note: This article was revised on January 24, 2008, to add a reference to SE0742. SE0742 announced that CMS was implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008. SE0742 may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0742.pdf on the CMS Web site. All other information remains the same.

Provider Types Affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

Background

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, §1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the CY 2007 Common Procedural Terminology (CPT). These changes include replacing the ASC 2-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with a “yy” designation for these codes, which will be defined as “the procedure is approved to be performed in an ambulatory surgical center.”

CR5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and fiscal intermediaries (FIs) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in Calendar Year (CY) 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups.

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS's notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the Federal Register. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link at http://www.cms.hhs.gov/center/asc.asp on the CMS Web site.

Also note that your carriers and FIs will continue to use the wage index values contained in Transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service F Healthcare Common Procedural Coding System (HCPCS) codes until further notice. This transmittal is available at http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf on the CMS Web site.

Additional Information

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located at http://www.cms.hhs.gov/Transmittals/downloads/R1134CP.pdf on the CMS Web site. The "2007 ASC Approved HCPCS Codes and Payment Rates" Changes are available at http://www.cms.hhs.gov/ASCPayment/01_Overview.asp on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Notifying Medicare Patients About Lifetime Reserve Days (LRDs)- Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Special Edition (SE) Medicare Learning Network (MLN) Matters article entitled "Notifying Medicare Patients About Lifetime Reserve Days (LRDs)", which is published in the November 2006 *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: SE0663 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 January 31, 2008, to update the deductible and coinsurance rates to reflect the 2008 rates. In addition, some editorial changes were made to provide further clarification and references to A/B MACs were added.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient hospital services furnished during a spell of illness.

Provider Action Needed

This special edition article is for informational purposes only and reflects no change in Medicare policy. The article is based on information contained in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 5, Sections 30 - 30.4). This manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

Under the Social Security Act (Section 1861; http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), a Medicare beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is furnished inpatient hospital services, inpatient critical access hospital services or long term care services. The benefit period ends with the close of the first period of 60 consecutive days thereafter on each of which he/she is neither an inpatient of a hospital or a critical access hospital nor an inpatient of a skilled nursing facility. The Social Security Act (Section 1812; http://www.ssa.gov/OP_Home/ssact/title18/1812.htm) further defines the scope of inpatient hospital benefits for Medicare beneficiaries and includes an additional provision regarding 60 nonrenewable lifetime reserve days (LRDs) which a beneficiary may draw upon if hospitalized for more than 90 days in a benefit period.

For inpatient hospital services furnished during a spell of illness, Medicare beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital). For the first 60 days of covered care during a spell of illness the beneficiary is not liable for paying a co-insurance.

For the 61st through the 90th day that beneficiaries receive inpatient hospital services (during a spell of illness), they are responsible for **a coinsurance amount equal to one-fourth (25 percent) of the inpatient hospital deductible per day.**

After the 90th day spent in the hospital during a spell of illness, beneficiaries may elect to use their 60 LRDs of coverage. Their **daily coinsurance amount is then equal to one-half (50 percent)** of the inpatient hospital deductible (42 CFR 409.83 (Inpatient hospital coinsurance); http://www.gpoaccess.gov/cfr/retrieve.html on the Internet).

In 2008, the inpatient hospital deductible is $1,024.00 per benefit period or spell of illness; therefore, beneficiaries pay the following daily coinsurance amounts for 2008:

- $256.00 a day for days 61-90 in an ACH **in each period**; and,
- $512.00 a day for days 91-150 **for each LRD used**.

Election Not to Use Lifetime Reserve Days (LRDs)

An election not to use LRDs may be made by the beneficiary (or by someone who may act on his or her behalf) at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described below in the Section II (Election Made Retroactively).

Hospitals are required to notify patients who have already used or will use 90 days of benefits in a benefit period that they can elect not to use their LRDs for all or part of a stay.

The hospital should give notice of the option to elect to not use LRDs **when the beneficiary has five regular coinsurance days left** and is expected to be hospitalized beyond that period. Where the hospital discovers **the patient has fewer than five regular coinsurance days left,** it should **immediately notify the patient of this option (if notice was not provided earlier.)**

The hospital should:

- Annotate its records at the time that it informed the patient of this option; and
- Make available an appropriate election statement or form to be included in the patient's hospital record if the patient elects not to use LRDs. (See the *Medicare Benefit Policy Manual* (Chapter 5, Section 40.1; http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf) for sample election format).

If a patient elects not to use LRDs, some of the hospital services may be covered by Medicare Part B. These covered Part B services are billed to the intermediary or A/B MAC on Form CMS-1450 or the electronic equivalent.

Note: A Medicare beneficiary who is **eligible for medical assistance (Medicaid) under a State plan should be advised that such assistance would not be available if the beneficiary elects not to use the LRDs**. However, this restriction on medical assistance payments does not apply to cases where the beneficiary is deemed to have elected not to use LRDs.

Beneficiary Deemed to Have Elected Not to Use LRDs

A Medicare **beneficiary will be deemed to have elected not to use LRDs** in the following situations:

1. The average daily charge for covered services furnished during a lifetime reserve billing period is **equal to or less than the coinsurance amount for LRDs; and**

   - The hospital is reimbursed on a cost reimbursement basis; **or**
   - The hospital is reimbursed under a prospective payment system (PPS) and LRDs are needed to pay for all or a portion of the outlier stay. (See Section IIIB (*Hospitals Reimbursed Under the Prospective Payment System*) below and the *Medicare Benefit Policy Manual* (Chapter 5, Section 10.2); http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf on the CMS Web site.)

2. **For the nonoutlier portion of a stay in a hospital** reimbursed under a PPS, if the beneficiary has **one or more regular days (non-LRDs) remaining** in the benefit period upon admission to the hospital [i.e. an acute care hospital (ACH), inpatient rehabilitation facility (IRF), and a normal stay under long term care hospital (LTCH) (i.e., not a short stay)]. (See *Section IIIB (Hospitals Reimbursed Under the Prospective Payment System*) below.)

3. **The beneficiary has no regular days available at the time of admission** to a hospital reimbursed under the prospective payment system and **the total charges** for which the beneficiary would be liable (if LRDs are not used) **is equal to or less than** the **charges for which the beneficiary would be liable** if LRDs were used (i.e., the sum of the coinsurance amounts for the LRDs that would be used **plus** the total charges for outlier days (if any) for which no LRDs would be available because LRDs are exhausted. (See *Section IIIB- Hospitals Reimbursed Under the Prospective Payment System* below.)

   Exception: Even though a beneficiary would otherwise be deemed to have elected not to use LRDs, they will not be so deemed where:

   - Benefits are available from another third party payer to pay some or all of the charges, and
   - The third party requires (as a condition for payment) that LRDs be used.

   In such cases, LRDs will be used unless the beneficiary specifically elects not to use them.

I. Election Made Prospectively

Ordinarily, an election **not to use LRDs will apply prospectively**. If the election is filed at the time of admission to a hospital, it may be made effective **beginning** with the **<u>first day of hospitalization</u>**, or **<u>any day thereafter</u>**. If the election is filed later, it may be made effective **beginning** with any day **<u>after the day it is filed</u>**.

II. Election Made Retroactively

A beneficiary **may retroactively elect not to use LRDs** provided when:

- The beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B, **and**

- The hospital agrees to accept the retroactive election.

In this case, the hospital will contact the fiscal intermediary (FI) for procedures for correcting any claims already submitted.

A retroactive election not to use the LRDs must be filed **within 90 days following the beneficiary's discharge** from the hospital unless:

- Benefits are available from a third party payer to pay for the services, and

- The hospital agrees to the retroactive election.

In this case, the beneficiary may file an election not to use the LRDs later than 90 days following discharge.

EXAMPLE 1

Prior to July 1, Mr. Jones had used 90 days of inpatient hospital services in a benefit period. Beginning July 1, he was hospitalized for 10 additional days in that same benefit period. He was informed of his election right on July 1 at the time of admission, and he indicated that he wanted to use his LRDs for that stay. One month after being discharged from the hospital, Mr. Jones informed the hospital's billing office that he now wished to save his LRDs for a future stay. Mr. Jones agreed to pay the hospital for the services he received during the 10 days of hospitalization which were not payable under Part B, and the hospital agreed to the request. He was permitted to file a retroactive election not to use his LRDs, effective July 1.

EXAMPLE 2

On July 1, Mrs. Smith was discharged from a hospital after being hospitalized for 105 days. The hospital billed Medicare for 90 regular days plus 15 LRDs. On October 20 (more than 90 days following discharge), Mrs. Smith learned that a private insurer could pay for the last 15 days of the stay. She informed the hospital that she wished to file a retroactive election not to use LRDs for the last 15 days of the stay. The hospital agreed to the request, and Mrs. Smith filed an election form. The hospital refunded the Medicare payment and billed the private insurer instead.

III. Period Covered by Election

A. Hospitals Not Reimbursed Under Prospective Payment System (PPS)

A beneficiary election not to use LRDs for a particular hospital stay:

- May apply to the entire stay, or
- May apply to a single period of consecutive days in the stay, but
- Cannot apply to selected days in a stay.

If an election not to use LRDs (whether made prospectively or retroactively) is made effective:

- beginning with the first day for which LRDs are available, it may be terminated at any time;

  (After termination of the election, all hospital days would be covered to the extent that LRDs are available. Thus, an individual who has private insurance that covers hospitalization beginning with the first day after 90 days of benefits have been exhausted, may terminate the election as of the first day not covered by the insurance plan.); or

- beginning with any day after the first day for which LRDs are available, it must remain in effect until the end of that stay unless the entire election is revoked in accordance with the Medicare Benefit Policy Manual (Pub. 100-02, Chapter 5, Section 40.2); http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf on the CMS Web site.

B. Hospitals Reimbursed Under Prospective Payment System (PPS)

- The rules described in Section IIIA above apply. In addition, for PPS discharges occurring on or after October 1, 1997, involving high cost outlier status, a beneficiary whose 90 days of benefits are exhausted before high cost outlier status is reached must elect to use LRDs for the hospital to be paid high cost outlier payments.

  High cost outlier status is reached on the day that charges reach the high cost outlier status for the applicable DRG for inpatient PPS and LTCH PPS or case-mix group (CMG) in the case of IRF PPS. Use of LRDs must begin on the day following that day, to permit payment for high cost outlier charges.

  If the beneficiary elects not to use LRDs where benefits are exhausted, the hospital may charge the beneficiary for the charges that would have been paid as a high cost outlier.

Additional Information

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site 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.

January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0-Revised

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: MM5865-Revised	**Related Change Request (CR) #:** 5865
Related CR Release Date: January 18, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1419CP	**Implementation Date:** January 7, 2008

Note: This article was revised on January 22, 2008, to reflect changes made to CR5865 as a result of legislation that required CMS to change the status indicator (SI) from K to H for brachytherapy and radiopharmaceutical codes for dates of service of January 1, 2008, through June 30, 2008. Relative changes were made in the table on pages 2-4 of this article. The CR release date, transmittal number and the Web address for accessing CR5865 were also changed.

Provider Types Affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5865 and notifies providers that the I/OCE Specifications Version 9.0, is effective January 1, 2008. Note that claims with dates of service prior to **July 1, 2007** are routed through the non-integrated versions of the OCE software that **coincide with the versions in effect for the date of service on the claim**.

Background

This article is based on Change Request (CR) 5865 and informs providers that the I/OCE routes all institutional outpatient claims (including non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. **This integration does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software**. It expands the software usage to include non-OPPS hospitals.

There are numerous changes/additions/deletions to diagnosis codes, Ambulatory Payment Classification (APC) codes, and Health Care Common Procedure Codes (HCPCS) in January 2008. All of the changes will not be detailed in this article. Instead, please see CR5865 for those details. CR5865 is available at http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf on the CMS Web site.

The key changes for the January 2008 I/OCE are as follows: (Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.)

Effective Date	Modification
01/01/08	Modify appendix D to prevent double discounting: 1. Replace discount formula #6 with formula #3 in applicable rows, to prevent application of both multiple procedures & terminated procedure discounting to the same procedure. 2. Create new discount formula #9 to replace discount formula #7 (to pay 100% of the APC rate, 50% x2, for a bilateral T procedure that is not the highest).
01/01/08	Discontinue use of discount formulae #6 and #7
01/01/08	Create new payment adjustment flag (PAF) 8: Item provided with partial credit to provider. 1. Assign to procedures subject to 50% of off-set, when modifier FC is present. 2. Reduce APC payment rate by 50% of offset amount before application of discounting logic.
01/01/08	Expand edit 75 to apply to modifier FC in addition to FB – to trigger if modifier FB or FC is appended to a code with status indicator (SI) other than S, T, X or V.
01/01/08	Expand use of SI of "Q" – to include other codes (not packaged services only) subject to SI change based on criteria.
01/01/08	Implement new 'composite' APC assignment logic as specified in appendix K and Appendix H-c of the I/OCE specifications attached to CR5865.
01/01/08	Implement 2-character payment adjustment flags, 91-99; use for composite APCs (see appendix G of CR5865).
01/01/08	Deactivate observation logic that is based on payable G0378 (appendix H-a).
01/01/08	Remove criterion for 'payable G0378' from G0379 processing (appendix H-b).
01/01/08	Implement logic for assignment of new composite APCs which include observation (appendix K)
01/01/08	Bypass edit 48 for rev code 0948.
01/01/08	Apply wound care logic to all revenue codes in the therapy series: 042x, 043x and 044x (not 04x0 only).
01/01/08	Modify PHP and MH per-diem logic (appendix C)- • Replace APC numbers with specified lists of codes o PH services = list of codes that count toward Partial Hospitalization APC o MH services = list of codes that are included in the Daily Mental Health services cap • Assign SI of 'N' to all codes that are packaged into APC 33 & 34 • Count multiple occurrences of OT (G0129) as separate units in determining "3 or more" for PHP
01/01/08	Modify the current special packaged codes logic to package only in the presence of codes with SI of S,T,V or X on the same date of service = "STVX-packaged" codes.
01/01/08	Expand special packaged codes logic to add codes that will be packaged in the presence of a code with SI of T on the same date of service = "T-packaged" codes.

08/01/00	Bypass edit 48 for rev codes 099x. Assign edit 9 (SI-E) if submitted without a HCPCS.
10/01/07	Rescind previous program modification - re-apply edit 71 to bill type 12x.
01/01/07	Modify the program to exclude bill type 12x from edit 77 (change effective date from 10/1 to **01/01/07**).
01/01/08	New edit 78 – Claim lacks required radiopharmaceutical (**RTP**). Assign to specified nuclear medicine procedure if no specified radiopharmaceutical on the claim.
01/01/08	Make Non-OPPS bill type 83x invalid for the I/OCE – assign claim processed flag of “1” (claim could not be processed, invalid bill type).
07/01/07	Modify the program to bypass edit 17 for bill type 85x. Modify the processing flow such that no values are returned for the following OPPS-related flags on Non-OPPS claims (OPPS flag = 2). Return blank fields in the APC/ASC Return buffer. • status indicator, • payment indicator, • discounting formula number, • line item denial or rejection, • packaging, • payment adjustment, • payment method, and • line item action. Return “0” in the payment APC/ASC field.
	Make HCPCS/APC/SI changes as specified by CMS
	Implement version 13.3 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999; 99143-99150), E&M (92002-92014, 99201-99499), or MH (90804-90911).
	Add new modifiers (FC, EA, EB, EC, KG, KK, KU, KW, KY, Q0, and Q1) and delete modifiers QA, QR, and QV as specified by CMS.
	Modify description for edit 75: Incorrect billing of modifier FB or FC.
10/01/07	Add new revenue code 0948 to the valid revenue code list, no pre-assigned SI.
	Modify description for SI ‘M’ (Service not billable to the FI/MAC)… also modify descriptions for SI A, and K, and N, and Q, and V, and Y.
	Rename OCE Overview as appendix L; Rename Summary of Modifications as appendix M.

Readers should also read through the specifications attached to CR5865 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.

Additional Information

For complete details regarding CR5865, please see the official instruction (CR5865) issued to your Medicare A/B MAC, RHHI, or FI. To view the instruction, visit http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition 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: SE0801	**Related Change Request (CR) #:** N/A
Related CR Release Date: N/A	**Effective Date:** N/A
Related CR Transmittal #: N/A	**Implementation Date:** N/A

Provider Types Affected

Providers billing Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs).

Provider Action Needed STOP – Impact to You

This Special Edition article is based on information from the Centers for Medicare & Medicaid Services (CMS) regulations and transmittals and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2008 (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) Effective Date: March 1, 2007 copyrighted by the American Hospital Association (AHA); NUBC UB-04 Version 2.00 Clarifications and Errata (as of 8/22/07). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

IMPORTANT: The NUBC is responsible for the maintenance and dissemination of guidance for the UB-04 code set. The CMS has provided a subset of information below for Medicare-participating providers. For greater detail, providers should visit http://www.nubc.org/ in order to purchase a UB-04 manual.

What You Need to Know

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle. It belongs in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.

What You Need to Do

See the Background section of this article for more details regarding instructions and clarifications for patient discharge status coding.

Background
This Special Edition article is being provided to help you determine the right discharge status code to use with your claims. Assigning the correct patient discharge status code is just as important as any other coding used when filing a claim and the same processes should be applied for patient discharge status codes as with any other coding. Choosing the patient discharge status code correctly avoids claim errors and helps you receive payment for your claim sooner.

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). The Centers for Medicare & Medicaid Services (CMS) requires patient discharge status codes for:

- Hospital Inpatient Claims (type of bills (TOBs) 11X and 12X);
- Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X);
- Outpatient Hospital Services (TOBs 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and,
- All Hospice and Home Health Claims (TOBs 32X, 33X, 34X, 81X and 82X).

It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

Identifying the appropriate patient discharge status code can sometimes be confusing, so be sure to read the Frequently Asked Questions (FAQ) Section at the end of this article for further guidance.

Patient Discharge Status Codes and Their Appropriate Use
The following describes patient discharge status codes and provides details regarding their appropriate use:

01 - Discharge to Home or Self Care (Routine Discharge)
This code includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care
This patient discharge status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with patient discharge status Code 63.

03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.
This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use code 61- Swing Bed. This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.

Code 03 should not be used if:

- The patient is admitted to a non-Medicare certified area.

04 - Discharged/Transferred to an Intermediate Care Facility (ICF)
Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:

- To designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification; or,
- For discharges/transfers to state designated Assisted Living Facilities (ALFs).

05 - Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List
Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of health care institutions.

NEW DEFINITION FOR PATIENT DISCHARGE STATUS CODE 05- Effective, per NUBC, on April 1, 2008

05 - Discharged/Transferred to a Designated Cancer Center or Children's Hospital
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html on the Internet.

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
This code should be reported when a patient is:

- Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) - whether home attendant, nursing aides, certified attendants, etc.;
- Discharged/transferred to a foster care facility with home care; and,
- Discharged to home under a home health agency with DME.

This code should not be used for home health services provided by a:

- DME supplier; or,
- Home IV provider for home IV services.

07 - Left Against Medical Advice or Discontinued Care
The important thing to remember about this patient discharge status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who leave before triage, or are triaged and leave without being seen by a physician; or,
- Patients who move without notice, and the home health agency is unable to complete the plan of care.

08 - Reserved for National Assignment
This patient discharge status code is reserved for national assignment.

09 - Admitted as an Inpatient to this Hospital
This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 - Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

20 - Expired
This code is used only when the patient dies.

21-29 - Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

30 - Still Patient or Expected to Return for Outpatient Services
This code is used when the patient is still within the same facility and is typically used when billing for leave of absence days or interim bills. It can be used for both inpatient or outpatient claims,

It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

On outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., Frequency Code 3: Interim - Continuing Claim).

31-39 - Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

Hospice Patient Discharge Status Codes - Hospice Claims Only (TOBs: 81X & 82X)
The following patient discharge status codes should only be used when submitting hospice claims:

- **40 - Expired at Home;** This code is for use only on Medicare and TRICARE claims for hospice care.
- **41 - Expired in a Medical Facility**, such as a Hospital, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Free-standing Hospice; and,
- **42 - Expired - Place Unknown**; This code is for use only on Medicare and TRICARE claims for hospice care.

43 - Discharged/Transferred to a Federal Hospital
This code applies to discharges and transfers to a government operated health care facility including:

- Department of Defense hospitals;
- Veteran's Administration hospitals; or
- Veteran's Administration nursing facilities.

This patient discharge status code should be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

The NUBC has also clarified that this code should also be used when a patient is transferred to an inpatient psychiatric unit of a Veterans Administration (VA) hospital.

44-49 Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

50 and 51 - Discharged/Transferred to a Hospice
These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.
The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following Hospice Levels of Care:

- Routine or Continuous Home Care. Patient discharge status **code "50: Hospice home"** should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.
- General Inpatient Care. Patient discharge status **code "51 Hospice medical facility"** should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- Inpatient Respite. Patient discharge status **code "51 Hospice medical facility"** should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care can not be determined. Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice "referral only," (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice (i.e. 01: home or self care, or 04: an intermediate care nursing facility, assuming it is not a Medicare SNF admission).

Additional Guidance on Use of Patient discharge status Code 50 or 51:

- Patient discharge status code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.

Patient discharge status code 51 should be used when a patient is:

- Discharged from acute hospital care but remains at the same hospital under hospice care,
- Transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:
    - The patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.
    - The patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.
    - Admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement to a designated hospice unit/bed.

52-60 - Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

61 - Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
This code is used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.

When a patient is discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Patient discharge status Code 61. Swing beds are not part of the post acute care transfer policy

62 - Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Distinct Part Units of a Hospital

Inpatient Rehabilitation Facilities (IRFs) (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

63 - Discharged/Transferred to Long Term Care Hospitals (LTCHs)

This code is for hospitals that meet the Medicare criteria for LTCH certification as follows: Long term care hospitals are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a long term care hospital. If you are not sure whether a facility is a long term care hospital or a short term care hospital, you should contact the facility to verify their facility type before assigning a patient discharge status code.

64 - Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare

Nursing facilities may elect to certify only a portion of their beds under Medicare, and some nursing facilities choose to certify all of their beds under Medicare. Still others elect not to certify any of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare certified beds, this code should be used. If any beds at the facility are Medicare certified, then the provider should use either Patient discharge status code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g. Veterans Administration Hospitals). In this case, see patient discharge status Code 43.

66 - Discharged/Transferred to a Critical Access Hospital (CAH)

Patient discharge status code 66 is used to identify a transfer to a critical access hospital (CAH) for inpatient care. Providers will need to establish a process for identifying whether a hospital is paid under the prospective payment system (PPS) or whether the facility is designated as a CAH.

Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with Patient discharge status Code 61.

67-69 - Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

NEW PATIENT DISCHARGE STATUS CODE 70 – Per NUBC, Effective April 1, 2008:

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008. (See code 05)

71-99 - Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

Patient Discharge Status Codes Affected by the Hospital Transfer Policies for Inpatient PPS and IRF PPS

The IPPS Acute to Acute Transfer policy applies to transfers coded with patient discharge status code 02 and applies to all DRGs and when the length of stay is less than the average length of stay for the DRG.

Under **Medicare's Post Acute Care Transfer Policy** (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post acute care transfer when the patient's discharge is assigned to one of the qualifying diagnosis-related groups (DRGs), and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (IPPS) (includes: inpatient rehabilitation facilities, long term care hospitals, psychiatric hospitals, cancer hospitals and children's hospitals);

- To a skilled nursing facility (not swing beds); and

- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

Note: A list of the FY2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That rule is available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf on the CMS Web site.

Based on the above, the IPPS Post-Acute Care Transfer Policy applies to claims coded with Patient discharge status Codes 03, 05, 06, 62, 63, and 65.

Inpatient Rehabilitation Facilities (IRFs) : 42 CFR 412.624(f) The following patient discharge status Codes are applicable under the IRF Transfer Policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

<u>NUBC Frequently Asked Questions (FAQs) and Answers</u>

1. **Q**: A patient is discharged from our facility (disposition code 01) and is to go to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, 01 or 02?

   A: Based on the information the hospital had at discharge, the patient was discharged to home (01). If your facility was unaware of the planned admission at the second facility, it is likely that you will have

to provide support for your coding decision when the fiscal intermediary receives the claim for admission to another hospital on the same day you discharged the patient.

2. **Q:** If a facility discharges a patient to a personal care home, which is similar to assisted living facilities, are they most appropriately coded as 01 or 04?

   A: If the personal care home is the person's place of residence, even temporarily, use code 01, discharged to home or self care.

3. **Q:** What discharge status code should be used when a patient is sent to another acute care facility for an outpatient procedure later in the day? This occurs when we do not have the equipment to perform the procedure and the intention is that the patient will not be returning to our facility after the procedure.

   A: Since this is a discharge to outpatient treatment, and it is expected that the patient will go home afterward, use discharge status 01, discharged to home or self care.

4. **Q:** We have a home health agency with DME. Often we find the orders reads "Home with Walker". We do not see a physician order for home health care nor has there been an assessment documented by the receiving home health nurse. The nursing discharges instructions check "home". Is the patient discharge status code still 06?

   A: No. "Home with walker" does not imply a discharge to home under care of organized home health service organization in anticipation of covered skilled care. Accordingly, code 01, discharged to home or self care (routine discharge) would be appropriate.

5. **Q:** What is the difference between residential care and assisted living care?

   A: In terms of patient discharge status codes, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike (01).

6. **Q:** An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient discharge status code would be appropriate?

   A: If the patient has not made a hospice election, and has a referral only, use Code 01, Discharged to home.

7. **Q:** A patient was discharged to home with home health services. Two days later the patient was readmitted to our hospital. We were notified by the discharge planner of the patient's readmission and the fact that home health services were not started for the patient and the discharge status code needed to be changed to 01. By the time of the discharge planner's notification, we had already submitted the patient's bill with the discharge status code of 06. In this instance what should the correct discharge status code be on this patient?

   A: To ensure accurate reimbursement and reporting, send a replacement claim with the correct discharge status code (01).

8. **Q:** What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

A: A rehabilitation unit that is part of a skilled nursing facility is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a Medicare-certified SNF in anticipation of skilled care, **use 03**. Status **code 03** is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.

9. **Q:** What is the appropriate patient discharge status code for a patient transferred from an acute care hospital to a nursing facility for a non-skilled/custodial/residential level of care? For example:

   The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.

   The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.

   The patient resides at a Medicare certified SNF but only receives non-skilled services.

   A: code 04, discharged/transferred to an intermediate care facility (ICF) would be the appropriate patient status discharge code for all of the examples above.

10. **Q:** If a patient is discharged from a hospital based Transitional Care Unit (i.e., skilled nursing unit) to the acute hospital under Observation Status, what is the Discharge Status for the TCU claim?

    A: Use **code 05**, discharged/transferred to another type of health care institution not defined elsewhere in this code list.

11. **Q:** If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

    A: code 06 would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:

    - **Condition Code 42** – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;

    - **Condition Code 43** – Continuing care not provided within prescribed post-discharge window.

12. **Q:** If a patient is discharged from an acute care hospital and PT/OT is arranged to be done in the home by a rehabilitation agency that is not affiliated with the home health care agency that made the arrangements, what is the appropriate code to use -- 01 or 06?

    A: If the therapy services are being provided under the home health benefit (e.g. Medicare Part A), **use code 06**; if the therapy is provided under the outpatient therapy benefit (e.g., Medicare Part B), use **code 01**.

13. **Q**: If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?

    A: Use **code 51** Hospice - medical facility

14. **Q:** What discharge status code should be used when a patient is discharged to a chemical dependency treatment facility that is not part of a hospital?

    A: If the chemical dependency treatment facility is not a psychiatric hospital or psychiatric distinct part unit of a hospital, and the patient is undergoing inpatient/residential treatment, use **code 05,** discharged/transferred to another type of health care institution not defined elsewhere in this code list. (**Note: The NUBC has approved the establishment of a new code (70) to take effect April 1, 2008 for other types of health care facilities not defined elsewhere in the code list.**).

Additional Information

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs

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: MM5699
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1412CP
Related Change Request (CR) #: 5699
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and A/B Medicare administrative contractors (A/B MACs)) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers

Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008.

Failure to report this information will result in your claim being returned as unprocessed. (**Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills.**) See the rest of this article for reporting details.

Background

Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: "*Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.*"

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for

ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

What You Need to Know
CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading.

    - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.

    - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-position numeric elements (10.50) are reported as 10.5.

      Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

    - Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.

    - When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (and only one) of the following three modifiers on the same line as the ESA HCPCS:

- EA: ESA, anemia, chemo-induced;
- EB: ESA, anemia, radio-induced; or
- EC: ESA, anemia, non-chemo/radio

- Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.

- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.

- Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using Reason Code 16, and Remarks Codes MA130 and N395

- Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information

For complete details regarding this CR please see the official instruction (CR5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated Carrier, and A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf on the CMS Web site.

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Use of an 8-Digit Registry Number on Clinical Trail Claims

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

MLN Matters Number: MM5790
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R310CP
Related Change Request (CR) #: 5790
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

Provider Action Needed

This article is based on Change Request (CR) 5790 that notifies providers and suppliers that Medicare claims forms will be modified to accommodate the 8-digit clinical trail number for claims that Medicare receives on or after April 1, 2008. Reporting this number is voluntary and claims submitted without the clinical trial number will be paid the same as claims containing a number. While reporting is voluntary, the number will assist the Centers for Medicare & Medicaid Services (CMS) in informing beneficiaries about the availability of clinical trials and to use claims information to inform coverage decisions. Be sure your billing staff is aware of this rule.

Background

The purpose of CR5790 is to instruct providers and suppliers on new, voluntary reporting for placing a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the Medicare National Coverage Determination Manual, Publication 100-03, section 310.1. That publication is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site. The clinical trial number that the CMS is requesting to be voluntarily reported is the number assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered by a sponsor or investigator. Information regarding NLM clinical trials is available at http://clinicaltrials.gov/.

CMS will use this number to identify all items and services provided to beneficiaries during their participation in a clinical trial. Furthermore, this identifier will permit CMS to meet the recommendations of the 2000 Institute of Medicine report that led to the Executive Memorandum to increase participation of Medicare beneficiaries in clinical trials and the development and implementation of the CMS clinical trials policy.

Recommendations from The White House Executive Memorandum included:

- Tracking Medicare payments;
- Ensuring that the information gained from the research is used to inform coverage decisions;

- Making certain that the research focuses on issues of importance to the Medicare population; and,
- Enabling CMS to better inform Medicare beneficiaries about the clinical studies available for their participation.

Key Points

- Claims submitted without the clinical trial number will be paid the same as claims containing a number.
- Institutional clinical trial claims are identified through the presence of all of the following elements:
    - Value Code D4 and corresponding 8-digit clinical trial number (when present on the claim);
    - ICD-9 diagnosis code V70.7;
    - Condition Code 30; and
    - HCPCS modifier Q1: outpatient claims only. (See MM5805 related to CR5805 for more information regarding modifier Q1.)
- Practitioner/DME clinical trail claims are identified through the presence of all of the following elements:
    - ICD-9 diagnosis code V70.7;
    - HCPCS modifier Q1; and
    - 8-digit clinical trial number (when present on the claim).
- On institutional claims, the 8-digit numeric clinical trial number should be placed in the value amount of value code D4 on the paper claim UB-40 (Form Locators 39-41) or in Loop 2300, HI – Value Information segment, qualifier BE on the 837I.
- On professional claims, the clinical trial registry number should be preceded by the two alpha characters of "CT" and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

Additional Information

You may see the official instruction (CR5790) issued to your Medicare A/B MAC, FI, DME/MAC, or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R310OTN.pdf on the CMS Web site. You may see the article related to the Q1 modifier, MM5805, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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New Healthcare Common Procedure Coding System (HCPCS) Modifiers when Billing for Patient Care in Clinical Research Studies

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: MM5805	**Related Change Request (CR) #:** 5805
Related CR Release Date: January 18, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1418CP	**Implementation Date:** April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

What Providers Need to Know

This article is based on Change Request (CR) 5805. The Centers for Medicare & Medicaid Services (CMS) is discontinuing the QA (FDA Investigational Device Exemption), QR (Item or Service Provided in a Medicare Specified Study), and QV (Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial) HCPCS modifiers as of December 31, 2007, and creating two new modifiers that will be used solely to differentiate between routine and investigational clinical services.

These new modifiers will be included in the 2008 Annual HCPCS Update and are effective for dates of service on and after January 1, 2008:

> **Q0** - Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Q0 replaces QA and QR.
>
> **Q1** - Routine clinical service provided in a clinical research study that is in an approved clinical research study. Q1 replaces QV.

Use these two new modifiers as follows:

Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved, or otherwise covered (or not covered) under Medicare.

Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent), clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers), and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).

Medicare contractors will not search their files to adjust affected claims processed prior to implementation of this change, but they will adjust such claims that you bring to their attention.

Note: If a Category A or B investigational device is used on the clinical trial, providers should continue to include the Investigational Device Exemption (IDE) in item 23 of the CMS-1500 claim form or the electronic equivalent. Also, your Medicare contractor will validate the IDE# number when it appears on the claim with the Q0 modifier and if the IDE# does not meet validation criteria, the claim will be returned as unprocessable.

Additional Information

You may see the official instruction (CR5805) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R1418CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)

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: MM5836
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1408CP

Related Change Request (CR) #: 5836
Effective Date: January 1, 2008
Implementation Date: February 11, 2008

Provider Types Affected

All physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided or supplied to Medicare beneficiaries.

What You Need to Know

CR 5836, from which this article is taken, modifies the Reconsideration Request Form that is included with the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations), to clarify the minimum set of elements on the form that you must complete in order for the request to be considered valid for reconsideration.

You should make sure that your billing staffs are aware that they must complete items 1, 2a, 6, 7, 11 & 12 on this Reconsideration Request Form.

Background

The Reconsideration Request Form modification that CR 5836 requires is necessary because the current Medicare manual instructions do not clearly identify all of the elements required for a reconsideration request to be considered valid in accordance with Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Section 405.964(b).

The modification to the form is as follows:

"Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12 but to help us serve you better, please include a copy of the redetermination notice with your request."

Those elements that, as a minimum, you must complete in the form are:

- 1. Name of Beneficiary
- 2a. Medicare Number
- 6. Item or service you wish to appeal
- 7. Date of the service (From and To dates)
- 11 Name of Person Appealing
- 12. Signature of Person Appealing/Date

Additional Information

You can find more information about the modification to the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) by going to CR 5836, located at http://www.cms.hhs.gov/Transmittals/downloads/R1408CP.pdf on the CMS Web site. The updated *Medicare Claims Processing Manual*, Chapter 29, Section 320.7 (Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)) is an attachment to that CR. The Reconsideration Request Form is also attached to CR5836.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Outpatient Therapy Caps With Exceptions Start January 1, 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: MM5871
Related CR Release Date: January 10, 2008
Related CR Transmittal #: R1407CP

Related Change Request (CR) #: 5871
Effective Date: January 1, 2008
Implementation Date: January 14, 2008

Provider Types Affected

Therapists and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MAC)) for therapy services for Medicare beneficiaries.

Provider Action Needed

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008, and clarifies the *Medicare Claims Processing Manual* regarding exceptions to outpatient therapy services.

On January 1, 2008, the financial limits on outpatient therapy services will be $1,810.00 for combined physical therapy and speech-language pathology services; and $1,810.00 for occupational therapy services.

You should make sure that your billing staffs are aware of these new outpatient therapy caps. You might also want to refer to the updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), for the complete documentation of the outpatient therapy services exceptions clarifications (which are summarized below). The complete revised manual sections are attached to CR5871, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R1407CP.pdf on the CMS Web site.

Background
The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital services. The 2006 Deficit Reduction Act enacted exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process through June 30, 2008. The dollar amount of the cap is updated annually in accordance with the Medicare Economic Index.

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008. Effective January 1, 2008, the financial limits on outpatient therapy services will be $1,810.00 for combined physical therapy and speech-language pathology services; and $1,810.00 for occupational therapy services. Exceptions are allowed for medically necessary outpatient therapy services.

The financial limits on outpatient therapy services over the last three years are displayed in Table 1.

Table 1
Financial Limits on Outpatient Therapy Services*

Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	$1,810.00	$1,810.00
2007	$1,780.00	$1,780.00
2006	$1,740.00	$1,740.00

Note: Medicare pays up to 80% of the limits after the deductible has been met.

The Medicare Summary Notice (MSN) message 38.18 has been updated to read:
"ALERT: Coverage by Medicare is limited to *$1,780.00 in 2007 and $1,810.00 in 2008* for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services."

CR 5871 also clarifies the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), regarding exceptions to outpatient therapy services (except when billed by outpatient hospitals). A summary of the major manual clarifications follows:

1. Section 10.2, Subsection B. Moratoria and Exceptions for Therapy Claims
   Future exceptions language added as follows:
   The cap exception for therapy services billed by outpatient hospitals was part of the original legislation (Balanced Budget Act of 1997), and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions, as they did for 2007 and as they again extended through June 30, 2008, as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

2. Section 10.2, Subsection C-1 Exceptions to Therapy Caps – General

When the exceptions process (as directed by legislation) is in effect the policies in this section apply. Further, with the exception of the use of the KX modifier, the guidance in this section applies to all therapy services addressed by this section.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

3. Section 10.2, Subsection C-2 Automatic Process Exceptions
   Beginning January 1, 2007, all exceptions are processed automatically. You should be aware that the term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception, itself, is automatic.

   In making a decision about whether to utilize the automatic process for exception, clinicians should consider, (among other considerations) whether services are appropriate to the patient's condition including the diagnosis, complexities and severity You should be aware that the list of the ICD-9 codes (for conditions and complexities that <u>might</u> qualify a beneficiary for exception to caps) that is found in the table in subsection 10.2 C-3 is only a guideline; and neither assures that services on the list will be excepted, nor limits the provision of covered and medically necessary services for conditions that are not on the list.

   Not all patients who have a condition or complexity on the ICD-9 code list are "automatically" excepted from therapy caps. You should see the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 230.3 (Practice of Speech-Language Pathology) for documenting the patient's condition and complexities. Note that Medicare contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical. Further guidance on billing therapy services are found in the Local Coverage Determinations of some contractors.

4. Subsection C-3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity

   Some Medicare contractors' local coverage determinations do not allow the use of some of the codes on the list in this Subsection to be in the primary diagnosis position on a claim. If your contractor has determined that these codes do not characterize patients who require medically necessary services, you may not use these codes. Rather, to describe the patient's condition, you must use a billable diagnosis code that your contractor allows.

   Medicare will apply therapy caps to services based on the medical necessity of the service for the patient's condition, not on the condition itself. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

   You may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list in this subsection. The diagnosis on this list may be put in a secondary position on the claim and/or in the medical records, as your contractor directs.

Additional Information
You can find more information about the outpatient therapy caps for 2008, and the *Medicare Claims Processing Manual* clarifications regarding exceptions to outpatient therapy services by going to CR 5871,

located at http://www.cms.hhs.gov/Transmittals/downloads/R1407CP.pdf on the CMS Web site. The updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) is an attachment to that CR.

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Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

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

MLN Matters Number: MM5890
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R23PI

Related Change Request (CR) #: 5890
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services or items furnished to Medicare beneficiaries.

Provider Action Needed

Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

What You Need to Know

CR 5890, from which this article is taken, provides that it is the claim/bill submitter‘s responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers NPIs for claims. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

What You Need to Do
Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

Background
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The National Provider Identifier (NPI) final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians (MD and DO) and the following non physician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter‘s responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information
You can find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare Claims by going to CR 5890, located at http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

Disclaimer
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Mammography: Change Certification-Based Action from Return to Provider (RTP)/Return as Unprocessable to Denial- Revised

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: MM5577 Revised	**Related Change Request (CR) #:** 5577
Related CR Release Date: December 7, 2007	**Effective Date:** April 1, 2008
Related CR Transmittal #: R1387CP	**Implementation Date:** April 7, 2008

Note: This article was revised on January 15, 2008, to correct the RA reason code for carriers/B MACs for claims that contain a film mammography HCPCS code and the facility is certified for digital mammography only (page 4). The correct RA code is 171 and not B6 as previously stated. All other information remains unchanged.

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs). carriers, and Part A/B Medicare Administrative Contractors (MACs) for mammography services.

What You Need to Know

CR 5577, from which this article is taken, instructs FIs, carriers and A/B MACs to deny claims for mammography services (rather than returning them as unprocessable) if the appropriate Food and Drug Administration (FDA) certification status is not listed on the FDA-created, CMS-supplied, Mammography Quality Standard Act (MQSA) data file.

You should make sure that your billing staffs list the FDA certification status as required.

Background

Depending on which contractor you bill, FIs and A/B MACs return to provider (RTP), and carriers or A//B MACs return as unprocessable, claims for mammography services when:

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim, and the facility is Food and Drug Administration (FDA) certified for only digital mammography;
- A digital mammography HCPCS code is submitted on a claim, and the facility is FDA certified for only film mammography; or
- Either a film or digital mammography HCPCS code is submitted (*carriers/B MACs only*) on a claim and there is no FDA certification number on the claim's Mammography Quality Standard Act (MQSA) data file.

In order to ensure that the facility has a right to appeal an inappropriate denial based on the status of its FDA certification, CR 5577, from which this article is taken, instructs Medicare FIs, carriers and A/B MACs to deny all claims for screening or diagnostic mammography services (rather than return them to the provider, or return as unprocessable to the supplier), if the appropriate FDA certification status is not listed on the

claim. Please note, however, that carriers and A/B MACs will continue to return the claim as unprocessable if the facility's FDA-assigned certification number is missing from the claim.

The MQSA requires that all facilities providing mammography services meet national quality standards, and provides the specific standards for those qualified to perform screening and diagnostic mammograms and how they should be certified.

The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities; and effective October 1, 1994, all facilities that provide screening and mammography services (except those in the Veterans Administration) must have an FDA-issued certificate to continue to operate.

In addition, Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000 provided new payment methodologies for both diagnostic and screening mammograms that use digital technology. Medicare pays for film mammography and digital mammography at different rates, and moreover, pays for a service only if the provider or supplier is certified by the Food and Drug Administration (FDA) to perform those types of mammograms for which payment is sought.

Medicare determines whether the mammography facility is certified to perform the mammography services billed by using data that the FDA sends to CMS on a weekly basis. This information indicates whether a mammography facility is certified to perform digital mammography.

To verify that the facility is certified by the FDA to perform mammography services, carriers/B MACs match the supplier's (i.e., independent facility) mammography certification number submitted on the claim to the 6-digit FDA-assigned certification number appearing on the file for the billing facility (in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF02 segment, where 01=EW segment) of the ASC X12 837 professional claim format, version 4010A1, for electronic claims). If the facility's FDA-assigned 6-digit number is not on the claim, the carrier/B MAC will return the claim as unprocessable using remittance reason code 16 (Claim/service lacks information which is needed for adjudication.) and remark code MA128 (Missing/incomplete/invalid FDA approval number.).

Intermediaries/A MACs identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform. Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:
    - Medicare Summary Notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility);
    - Remittance Advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service) and
    - RA remark code N110 (This facility is not certified for film mammography).

- Carriers/B MACs will verify that the FDA-assigned, 6-digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:

    - The facility's certification number submitted on the claim does not match the certification number on the MQSA file;

    - The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file; or

    - The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.

- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing); and RA reason code 125 (Payment adjusted due to a submission/billing error(s).) and remark code MA128 (Missing/incomplete/ invalid FDA approval number).

Further, Medicare contractors will use the FDA certification data to verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim.

They will deny the claim if the facility is not certified by the FDA to perform such service (if the HCPCS code on the claim, for either film or digital mammogram, does not match the type of certification indicated on the MQSA file).

In denying these claims because the facility is not certified by the FDA to perform <u>either</u> a screening or diagnostic mammography service, Medicare contractors will use:

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

- RA reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service), and

- Remark code N110 (This facility is not certified for film mammography).

- They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2. In this instance, carriers/B MACs will use RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility) and remark code N110 and FIs/A MACs will use reason code B7.

Similarly, Medicare contractors will deny the claim if it contains a digital mammography HCPCS code and the facility is certified for film mammography only. In denying these claims because the facility is not certified to perform digital mammography, they will again use MSN message 16.2. In this instance:

- Carriers/B MACs will use:

    - RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility); and,
    - Remark code N92 (This facility is not certified for digital mammography).

- FIs/A MACs will use reason code B7.

Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim, and will return claims to the supplier as unprocessable if it does not contain the facility's certification number.

Additional Information

You can find the official instruction, CR5577, issued to your carrier, FI, or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf on the CMS Web site. Additionally, you can find the revised sections of the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 18 (Preventive and Screening Services), Section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR5577.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

Disclaimer

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Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 and CMS-1450 Claims after NPI Required Date

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: MM5858	**Related Change Request (CR) #:** 5858
Related CR Release Date: February 1, 2008	**Effective Date:** Claims received on or after May 23, 2008
Related CR Transmittal #: R1432CP	**Implementation Date:** April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting CMS-1500 and CMS-1450 (UB-04) claims to Medicare carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Effective May 23, 2008, if you report a Provider Legacy Identifier on Medicare CMS-1500 or CMS-1450 (UB-04) claims, your contractors will return them as unprocessable.

What You Need to Know

CR 5858, from which this article is taken, announces that Provider Legacy Identifiers are not to be reported on Medicare CMS-1500 or Form CMS-1450 claims received on or after May 23, 2008 (the date at which the NPI is required to be reported on claims). After that date, claims containing Legacy Identifiers will be returned as unprocessable.

What You Need to Do

Make sure that your billing staffs are aware that effective May 23, 2008, only NPIs are to be reported on Medicare CMS-1500 and CMS-1450 claims.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other health care provider who conducts HIPAA standard electronic transactions. In accordance with this act, CMS began issuing NPIs on May 23, 2005.

Further, on April 2, 2007, the Department of Health and Human Services (DHHS) provided covered entities guidance regarding contingency planning for NPI implementation. In this guidance, as long as a health plan was compliant, meaning they could accept and send NPIs on electronic transactions, they could establish contingency plans to facilitate the compliance of their trading partners.
As a compliant health plan, on April 20, 2007 Medicare fee for service (FFS) established a contingency plan that followed this guidance. Since then, CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only;
- Medicare legacy only (PINs, UPINs, or National Supplier Clearinghouse number); and
- NPI and legacy combination.

CR 5858, from which this article is taken, announces that beginning on May 23, 2008, CMS requires the NPI to be submitted on the Form CMS-1500 and CMS-1450 paper claims; and legacy numbers will NOT be permitted on claims received on or after that date. Effective that date, Form CMS-1500 and CMS-1450 claims containing legacy identifiers will be returned as unprocessable, without appeal rights.

When returning these claims, your contractors will use an appropriate message and Remittance Advice Remark code, such as:

N257 Missing/incomplete/invalid billing provider primary identifier.

Note that contractors will not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, and other situations as allowed by CMS in the future). Such claims will be processed with established procedures for such claims.

Additional Information

You can find more information about the prohibition of Medicare fee for service legacy provider IDs on Form CMS-1500 and CMS-1450 claims after the NPI required date by going to CR 5858, located at http://www.cms.hhs.gov/Transmittals/downloads/R1432CP.pdf on the CMS Web site. You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), Section 10.4 (Items 14-33 - Provider of Service or Supplier Information) as an attachment to that CR.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare

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: MM5878	**Related Change Request (CR) #:** 5878
Related CR Release Date: February 1, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1433CP	**Implementation Date:** July 7, 2008

Provider Types Affected

Physicians and providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or Medicare Administrative contractors (A/BMAC)) for smoking and tobacco use cessation counseling.

Provider Action Needed

Effective for services on or after January 1, 2008, you must bill for smoking and tobacco use cessation counseling services with new CPT codes (99406 or 99407). If you bill using the former HCPCS codes (G0375 and G0376) for services provided after December 31, 2007, your claims will not be paid.

What You Need to Know

CR 5878, from which this article is taken, announces that the 2008 Medicare Physician Fee Database (MPFSDB) includes two new CPT codes for smoking and tobacco use cessation counseling services; replacing the temporary HCPCS G codes (G0375 and G0376) currently in use for billing these services. These new codes (effective on and after January 1, 2008) are:

- **99406** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes; and

- **99407** - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

What You Need to Do

Make sure that your billing staffs are aware of these newly required CPT codes for smoking and tobacco use cessation counseling services.

Background

CR 5878, from which this article is taken announces that the temporary HCPCS G codes G0375 and G0376, which are currently used to bill for Smoking and Tobacco Use Cessation Counseling services, are effective only through December 31, 2007.

They are being replaced by two new CPT codes (**99406** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes; and **99407** - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes). These new CPT codes, which are included in the 2008 Medicare Physician Fee Database (MPFSDB), become effective for claims with dates of service January 1, 2008 and later.

FIs, carriers, and A/B MACs will pay for counseling services billed with HCPCS codes G0375 and G0376 for dates of service performed on and after March 22, 2005 through Dec. 31, 2007 and with CPT codes 99406 and 99407 for dates of service on or after January 1, 2008.

Additional Information
You can find CR 5878 at http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf on the CMS Web site. You will find the updated *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 12.1(HCPCS and Diagnosis Coding), 12.2 (Carrier Billing Requirements), and 12.3 (FI Billing Requirements) as an attachment to that CR.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount

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: MM5895
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1423CP
Related Change Request (CR) #: 5895
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries and paid under the MPFS.

Provider Action Needed
This article is based on Change Request (CR) 5895 which contains summaries of the policy changes in the 2008 Medicare Physician Fee Schedule and the telehealth originating site facility fee for 2008. (Note: This CR does not include any changes that would be affected by recent legislation (i.e., 0.5 percent update to the conversion factor, changes to the geographic practice cost indices floor, etc. Information regarding these changes can be found in CR 5944, Legislative Change Affecting the 2008 Medicare Physician Fee Schedule (MPFS) and Extension of the 2008 Participation Open Enrollment Period.)

Background
The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1

of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2008.

The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 21, 2002 at $20.00.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3) at http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the internet). The MEI increase for 2008 is 1.8 percent.

For calendar year 2008, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is either 80 percent of the lesser of the actual charge or $23.35. Note: The beneficiary is responsible for any unmet deductible amount or coinsurance.

In summary, CR5895 instructs your Medicare contractor to:

- Pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 at 80 percent of the lesser of the actual charge or $23.35; and

- Consider payment for the following HCPCS codes only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per of the Social Security Act (Section 1862(a)(1)(A) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm):

HCPCS Code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes.
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes.

See the attachment to CR 5895, available at http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.pdf on the CMS Web site, for:

- A summary of significant issues discussed in CMS-1325-FC, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

Additional Information

The official instruction, CR5895, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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EMERGENCY -- Legislative Change Affecting the 2008 Medicare Physician Fee Schedule (MPFS), and Extension of the 2008 Participation Open Enrollment Period

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: MM5944
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R3120TN
Related Change Request (CR) #: 5944
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected
Physicians and other providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, and Medicare Administrative Contractors (A/B MAC)) for professional services paid under the MPFS.

What You Need to Know
CR5944, from which this article is taken, provides Medicare contractors with information about (and instructions for implementing) legislative changes to the 2008 MPFS, and about the extension of the Participation Open Enrollment period for 2008.

Effective for claims with dates of service January 1, 2008 through June 30, 2008, the update to the conversion factor will be 0.5%; and for claims with dates of service July 1, 2008 and after, will revert back to the previous payment methodology (the -10.1% update) that was outlined in the Final Rule, published in the Federal Register on November 27, 2007.

Additionally, the Centers for Medicare & Medicaid Services (CMS) has extended the 2008 Participation Open Enrollment period from December 31, 2007, to February 15, 2008 – therefore, it now runs from November 15, 2007, through February 15, 2008.

Background
The "Medicare, Medicaid, and SCHIP Extension Act of 2007" changes the rates of the 2008 Medicare Physician Fee Schedule (MPFS). CR5944 informs Medicare contractors of this legislative change to the 2008 MPFS; the release of the new MPFS files for them to load; the need to be ready to process beginning January 7, all claims with dates of service on or after January 1, 2008, which contain MPFS services; and the extension of the Participation Open Enrollment period for 2008.

MPFS Rate Change
Effective for claims with dates of service January 1, 2008, through June 30, 2008, the update to the conversion factor will be 0.5%.

It is important that you understand, however, that this new legislation only impacts the MPFS rates during the first half of 2008 (claims with dates of service January 1, 2008, through June 30, 2008). Claims with dates of service July 1, 2008 and after will revert back to the previous payment methodology (the -10.1% update) that was outlined in the Final Rule, published in the Federal Register on November 27, 2007.

Note: The legislation also extends the 1.0 floor on the work geographic practice cost index for six months, i.e., through June 30, 2008.

This MPFS rate change also impacts several other fee schedule rates which are MFPS-derived, including the anesthesia conversion factors, purchased diagnostic file, and ambulatory surgical center (ASC) facility rates; but does not impact services that are not paid under the MPFS (e.g., DME, clinical lab, etc.).

Physicians do not need to take any additional action in order for their claims to be paid at the new 0.5 percent rate. Medicare contractors are able to process claims for services paid under the Medicare Physician Fee Schedule that contain dates of service January 1 and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractors have been instructed to be ready to process all claims with 2008 dates of service with the new MPFS fees beginning January 7, 2008.

2008 Participation Open Enrollment Period Extension
Because this new legislation changes the 2008 MPFS rates, the CMS has extended the 2008 Participation Open Enrollment period from December 31, 2007, to February 15, 2008 – therefore, it now runs from November 15, 2007 through February 15, 2008.

The effective date for any Participation status change during the extension, however, remains January 1, 2008; and will be in force for the entire year. You should make your Participation decision for 2008 based on the two new fee rates (i.e., the 0.5% update that is effective January through June, and the -10.1% update that is effective July through December).

Note: CR5944 revises CR 5732 (Transmittal 1356 -- Calendar Year (CY) 2008 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures, dated October 19, 2007) to reflect the extension.

CR5944 also contains additional Medicare contractor instructions:

- Any contractor unable to meet the January 7, 2008 for processing claims date, can hold affected claims for up to 14 calendar days after receipt; but all held claims must be released for payment no later than January 15, 2008.

- Contractors will not automatically make adjustments for providers who change their Participation status after January 1, 2008 (you should begin billing claims according to the Participation decision that you have made). However, they will adjust claims based on Participation status changes that you bring to their attention.

- Your contractor will make the Participation Agreement available to you by placing it on their Web sites with Participation enrollment (and termination) instructions. They will mail (at no charge) hard

copies of the new 2008 MPFS, on request, to any physicians/practitioners who do not have Internet access and are unable to view the new fees on the contractor Web site. They will, however, charge a reasonable fee for mailing a hard copy of the 2008 MPFS to providers that do have Internet access, but who want a hard copy for convenience. Further, they will handle physicians/practitioners' requests for copies of the 2008 MPFS as customer services matters, and not as Freedom of Information Act (FOIA) requests; but will handle such requests from other members of the public as FOIA requests.

- Contractors will post the new fees on their Web sites as early as possible.

- Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

Additional Information

You can find the official instruction, CR5944, issued to your carrier, FI, RHHI, or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R312OTN.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases

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: MM5896	**Related Change Request (CR) #:** 5896
Related CR Release Date: February 1, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1426CP	**Implementation Date:** February 12, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5896 which provides instructions for the calendar year (CY) 2008 Payment Rate Increases for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services.

Background

In accordance with the Social Security Act (Section 1833(f) at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) the CMS is increasing the calendar year (CY) payment rates for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) effective for services on or after January 1, 2008, through December 31, 2008 (i.e., CY 2008) as follows:

- The Rural Health Clinics (RHCs) upper payment limit per visit is increased from $74.29 to $75.63. The 2008 rate reflects a 1.8 percent increase over the 2007 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by the Social Security Act (Section 1833(f)).

- The Federally Qualified Health Centers (FQHCs) upper payment limit per visit **for urban FQHCs** is increased from $115.33 to $117.41, and the maximum Medicare payment limit per visit **for rural FQHCs** is increased from $99.17 to $100.96. The 2008 FQHC rates reflect a 1.8 percent increase over the 2007 rates, in accordance with the rate of increase in the MEI.

To avoid any unnecessary administrative burden, Medicare contractors will not retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, they will adjust such claims that you bring to their attention. Also, they retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

Additional Information

The official instruction, CR5896, issued to your Medicare FI or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1426CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Modification of Payment Window Edits in the Medicare's Common Working File (CWF) to Look at Line Item Dates of Service (LIDOS) on Outpatient Claims

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

MLN Matters Number: MM5880
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1429CP
Related Change Request (CR) #: 5880
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Hospitals submitting outpatient claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for preadmission services provided to Medicare beneficiaries

Provider Action Needed
This article is based on Change Request (CR) 5880 which modifies the payment window edits in the CWF to look at the Line Item Dates of Service (LIDOS) of the outpatient bill.

What You Need to Know
Currently, CWF looks at the 'statement covers through' date of the outpatient claim. The modification of the payment window edits in the CWF is to look at the LIDOS of the outpatient bill. This will allow providers to more easily separate out the services that occur prior to the payment window. CR 5880 also incorporates a few missing revenue codes into the *Medicare Claims Processing Manual*.

What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Currently, the edits within Medicare's Common Working File (CWF) system look at the '*statement covers through date*' of outpatient claims in order to determine if the services fall within the payment window relative to an inpatient stay. Change Request (CR) 5880 modifies the payment window edits (both diagnostic and therapeutic) to look at the '*Line Item Dates of Service*' (LIDOS) of the outpatient bill instead of the '*statement covers through date*'. This modification will make it easier to distinguish between the

outpatient preadmission services that should bundled on the inpatient bill from those that may be reimbursed separately.

Effective for services on or after July 1, 2008, Medicare's CWF will reject services for payment when the outpatient service's LIDOS falls on the admission or any of the 3 days immediately prior to admission of the beneficiary to an IPPS (Inpatient Prospective Payment System) or Maryland waiver hospital or on the day of admission or one day prior to that admission for hospitals excluded from the IPPS, such as an inpatient rehabilitation or an inpatient psychiatric facility.

The payment window policy is a longstanding Medicare policy. The Social Security Act (Section 1886(a)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) and the Code of Federal Regulations (42CFR 412.2(c)(5) and 413.40(c)(2); see http://www.gpoaccesss.gov/cfr/retrieve/html) define the operating costs of inpatient services under the prospective payment system to include certain preadmission services furnished by the admitting hospital (or by an entity wholly owned or operated by the admitting hospital or by another entity under arrangements with the admitting hospitals). For details as to which services are considered preadmission services and should therefore be bundled into the inpatient bill, refer to the *Medicare Claims Processing Manual* (Chapter 3, Section 40.3), which is attached to CR5880.

In summary, CR 5880 instructs your Medicare contractor to:

- Modify all of the payment window edits to look at the outpatient service by the LIDOS;
- Remove revenue code 048X and replace with 0481, 0482, 0483, and 0489 in the diagnostic payment window edits; and,
- Include the following CPT codes for revenue codes 0481 and 0489: 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 in the diagnostic payment window edits. These CPT codes and their descriptors are included in the following table:

CPT Code	Descriptor
93501	Right heart catheterization
93503	Insertion and placement of flow directed catheter (e.g., Swan-Ganz) for monitoring purposes
93505	Endomyocardial biopsy
93508	Catheter placement in coronary artery (s), arterial coronary conduit (s), and/or venous coronary bypass graft (s) for coronary angiography without concomitant left heart catheterization
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93526	Combined right heart catheterization and retrograde left heart catheterization
93541	Injection procedure during cardiac catheterization for pulmonary angiography
93542	Injection procedure during cardiac catheterization for selective right ventricular or right atrial angiography
93543	Injection procedure during cardiac catheterization for selective left ventricular or left atrial angiography
93544	Injection procedure during cardiac catheterization for aortography
93556	pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)

93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/ or venous catheterization; with cardiac output measurement
93562	subsequent measurement of cardiac output

Additional Information
The official instruction, CR5880, issued to your Medicare FI and A/B MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1429CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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New Value Code to Report Patient Prior Payment

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

MLN Matters Number: MM5882
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1427CP
Related Change Request (CR) #: 5882
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries (FI) regional home health intermediaries (RHHI), or Medicare Administrative Contractors (A/B MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR 5882, from which this article is taken, announces the creation of a new value code for the Medicare Form UB-04 (CMS-1450). This new code, **Value Code FC – Patient Prior Payment**, will enable you to continue to report patient prior payments (the amount you received from the beneficiary toward payment of the submitted claim prior to the billing date).

Make sure that your billing staffs are aware of the creation of this new value code, and that they know to implement it effective July 1, 2008.

Background
Previous Medicare Form CMS-1450 billing instructions for form locator (FL) 54 allowed providers to report the total amount of payments toward deductibles and/or coinsurance that they had collected from a patient for all services other than inpatient hospitals or skilled nursing facilities (SNF). However, with the

implementation of the UB-04, the National Uniform Billing Committee (NUBC) eliminated "Patient" from FL 54; which is now used to report prior payer payments.

To enable Medicare providers to continue to report patient prior payments, the CMS asked the NUBC to create a value code for this purpose. NUBC approved this request on 11/14/2007; and CR 5882, from which this article is taken, announces the creation of this new value code: **Value Code FC – Patient Prior Payment.**

Effective July 1, 2008, you may use this value code to report patient prior payments.

Additional Information

You can find CR 5882 at http://www.cms.hhs.gov/Transmittals/downloads/R1427CP.pdf on the CMS Web site. There is also information in the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the Form CMS-1450 Data Set), on completing the UB-04. This manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the Special Edition (SE) Medicare Learning Network (MLN) Matters article entitled "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities", which was previously published in the September 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: SE0555	**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

This article was rescinded on August 9, 2007, due to a number of factors affecting NPI implementation, especially the contingency plan announced in MLN Matters article MM5595. For the latest NPI information, you can view all NPI related MLN Matters articles by going to http://www.cms.hhs.gov/NationalProvIdentStand/downloads/MMarticles_npi.pdf on the CMS Web site.

Additional Information

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Emergency Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB)

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: MM5902	**Related Change Request (CR) #:** 5902
Related CR Release Date: February 5 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1435CP	**Implementation Date:** January 7, 2008

Provider Types Affected

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries and paid under the MPFSDB.

Provider Action Needed

The article is based on Change Request (CR) 5902 which amends payment files that were issued to Medicare contractors based upon the November 1, 2007, Medicare Physician Fee Schedule (MPFS) Final Rule.

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services. Previously, payment files were issued to Medicare contractors based upon the November 1, 2007, Medicare Physician Fee Schedule Final Rule.

Change Request (CR) 5902 amends those payment files.

In summary, CR 5902 instructs your Medicare contractor to:

- Manually update their systems to reflect 5 base units for Current Procedural Terminology (CPT) code 01916; and
- Manually update their Healthcare Common Procedure Coding System (HCPCS) file to include the laboratory certification code (LC) 400 for CPT code 89060 on or after January 1, 2008.

Note: See Attachment 1 of CR 5902 for a list of detailed changes for certain CPT/HCPCS codes included in the Emergency Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB). The Web address for accessing CR5902 is in the next section of this article.

Additional Information

The official instruction, CR 5902, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1435CP.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Extension of the Dates of Service Eligible for the Physician Scarcity Area (PSA) Bonus Payment

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

MLN Matters Number: MM5937
Related CR Release Date: February 5 2008
Related CR Transmittal #: R1434CP
Related Change Request (CR) #: 5937
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, and other providers, who bill Medicare contractors (fiscal intermediaries (FI), carriers, or Medicare Administrative Contractors (A/B MAC)) for providing services to Medicare beneficiaries in designated physician scarcity areas.

What You Need to Know

CR 5937, from which this article is taken announces the extension of the physician scarcity area (PSA) bonus payment for dates of service through June 30, 2008. You should make sure that your billing staffs are aware of this PSA bonus payment extension.

Background

Section 413(a) of the Medicare Modernization Act of 2003 (MMA) required the Centers for Medicare & Medicaid Services (CMS) to pay a 5% bonus to physicians in a designated PSA for dates of service from January 1, 2005 through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended Section 1833(u)(1) of the Social Security Act, extending the payment of the PSA bonus for dates of service through June 30, 2008. CR 5937, from which this article is taken, announces this extension and provides Medicare contractors with implementing instructions.

Medicare contractors will continue to pay PSA bonuses for dates of service from January 1, 2005 through June 30, 2008, regardless of whether the bonus is requested through submission of a modifier or made through an automated payment based on ZIP code. The primary care and specialty care scarcity areas in effect on December 31, 2007 will be used for 2008 services. Fiscal Intermediaries (FI) and Medicare Administrative Contractors (A/B MACs) processing Part A claims will implement this CR on January 7, 2008, and carriers and A/B MACs Processing Part B claims will implement it 30 days from issuance;

Carriers and A/B MACs processing Part B claims will Identify claims that contain the AR modifier (physician providing services in a PSA) and are submitted with dates of service on or after January 1, 2008 and processed prior to this CR's implementation so that they may be included in the calculation in the first quarterly 2008 bonus payment. Additionally, when brought to their attention, carriers and A/B MACs processing Part B claims will re-open and re-process claims with these dates of service that are processed prior to the CR's implementation date in order to include the AR modifier and make the appropriate bonus payment.

Additional Information

You can find the official instruction, CR 5937, issued to your FI, carrier, or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1434CP.pdf on the CMS Web site. The updated *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Sections 250.2.1 (Billing and Payment in a Physician Scarcity Area (PSA)) and 250.2.2 (Zip Code Files); and Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners, Sections 90.5 (Billing and Payment in a Physician Scarcity Area (PSA)) and 90.5.2 (Identifying Physician Scarcity Area Locations) are attachments to that CR.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Hospital Outpatient Prospective Payment System Fact Sheet

The Hospital Outpatient Prospective Payment System Fact Sheet (revised January 2008), which provides general information about the Hospital Outpatient Prospective Payment System, ambulatory payment classifications, and how payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf.

If this URL does not take you directly to the fact sheet, please copy and paste the URL in your web browser.

April 2008 Update to the Medicare Code Editor (MCE) and Grouper

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: MM5876
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1411CP
Related Change Request (CR) #: 5876
Effective Date: Discharges on or after April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for services they provide to Medicare beneficiaries.

What You Need to Know

CR 5876, from which this article is taken, announces an April 2008 update to the Medicare Code Editor (MCE) and Grouper to accommodate the addition of the new Patient Status Discharge Code 70: "Discharges or Transfers to Other Types of Health Care Institutions not defined elsewhere in the UB-04 (CMS-1450) Manual Code List."

Hospitals should make sure their billing staffs are aware of these MCE and Grouper changes so that they can update their systems to incorporate them, as needed.

Background

Section 503(a) of Public Law 108-173, as part of the amendments related to recognizing new technology under the Inpatient Prospective Payment System (IPPS), included a requirement to update ICD-9-CM codes twice a year instead of the single yearly (October 1) update. This section amended section 1886(d) (5) (K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the

Secretary to adjust the payment (or diagnosis-related group classification) until the fiscal year that begins after such date."

However, while coding updates for April releases of MCE/Grouper will not adjust payment; for this April 2008 release, CMS needs to update the DRG software and other systems in order to recognize and accept the new patient status code of 70.

Additional Information

You can find more information about the April 2008 update to the MCE and Grouper by going to CR 5876, located at http://www.cms.hhs.gov/Transmittals/downloads/R1411CP.pdf on the CMS Web site.

You might also want to read the implementing instructions for Patient Discharge Status Code 70, which are discussed in MLN Matters Article MM5764 (**New Patient Status Discharge Code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List**) at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5764.pdf on the CMS Web site.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

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Line Item Billing Requirement for End Stage Renal Disease (ESRD) Claims- Revised

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: MM5039-Revised
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R1084CP
Related Change Request (CR) #: 5039
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Note: This article was revised on January 22, 2008, to add a references to related Change Requests (CR) 5768 (http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf and CR5545 (http://www.cms.hhs.gov/Transmittals/downloads/R1285CP.pdf. These CRs added to the requirements initiated in CR5039. The related MLN Matters articles may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5768.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5545.pdf on the CMS Web site. All other information remains the unchanged.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for ESRD services

Provider Action Needed STOP – Impact to You

This article is based on Change Request (CR) 5039, which provides updates to line item billing requirements for ESRD claims (Type of Bill 72X).

What You Need to Know

CR5039 instructs that line item billing is required for all ESRD claims with dates of service on or after April 1, 2007. Renal dialysis facilities are then required to bill all services with line item date of service detail, except supplies and Epoetin Alfa (EPO).

What You Need to Do

See the Background section of this article for further details regarding this change.

Background

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide, the Centers for Medicare & Medicaid Services (CMS) **requires that all outpatient claims contain a line item date of service for each revenue code billed on the claim**. CMS has completed implementation of line item billing for most institutional Part B claims and has encouraged renal dialysis facilities (RDFs) to begin line item billing. CMS has permitted RDFs to continue to roll-up the services provided through-out the month; and choose one date of service within the billing period on the claim to report all instances of each revenue code on a single line.

As a result, ESRD claims are currently being received and processed using both methods: line item billing; and services rolled-up for all instances of each revenue code.

The method of rolling up all instances of each revenue code on a single line does not provide the most accurate claims data since the claim is reporting that all of a given service is provided on the same date. **Inherent with this method of billing is an increase in the number of claims that cannot be processed to payment due to claims with overlapping dates of service**.

In these overlapping claim cases, RDFs must report service dates of other providers within the month they are billing using an occurrence span code 74 on the claim to prevent the overlap of the claims and allow both claims to be paid. RDFs have expressed to CMS that this is a difficult task because they are not always informed of the beneficiary receiving services performed by other providers.

The Medicare claims processing system has the ability to compare services on multiple claims to the line date that could prevent both the unnecessary suspension of claims for overlapping billing periods and the reporting of the occurrence span code 74 for the RDFs.

To apply this system functionality to the ESRD claims, the claim must provide the line item date of service detail for each service being billed on the claim. This is a substantial benefit that line item billing can provide for RDFs in submitting ESRD claims.

Benefits of Line Item Billing Include:

- More accurate and timely claim payments to providers;
- Less staff time needed to research dates of services performed by other providers;
- Clinical data will no longer need to be rolled up to accommodate the claims processing systems and therefore, will more closely match the claim record;
- More detailed claim data could be used to assist the CMS in future refinements to improve the accuracy and equity of ESRD payments; and
- HIPAA compliance for submitting the appropriate line item date of service for both the CMS and its providers is ensured.

Line Item Details

CR5039 instructs RDFs to:

- Bill a separate line item for each dialysis session performed, and
- Report the appropriate line item date of service to conform with the date the service was provided to the beneficiary. The units reported on the line for each date dialysis was performed should not exceed one.
- The use of occurrence span code 74 will not be necessary for ESRD claims with dates of service on or after April 1, 2007.
- Reporting value code 67 will not be required for ESRD claims with dates of service on or after April 1, 2007.

Medicare FIs will return to the provider any claims with dates of service on or after April 1, 2007, when:

- The claim contains units exceeding 1 reported on lines containing revenue codes 0821, 0831, 0841, or 0851.

Coding Adequacy for Hemodialysis
All claims billing for hemodialysis sessions must continue to report: Healthcare Common Procedure Coding System (HCPCS) code 90999 (unlisted dialysis procedure, inpatient or outpatient), and modifiers G1 through G6 used for reporting the urea reduction ratio (URR) for determining the adequacy of hemodialysis.

However, it is not required that it 90999 and a G1-G6 modifier be reported on every line item that contains a hemodialysis session.

Home Dialysis Under Method One
For intermittent home dialysis under method one, providers should submit a separate line item for each dialysis session using the dates in the pre-determined plan of care schedule provided to the beneficiary unless informed by the beneficiary that the schedule was changed.

In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.

For Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) under method one, providers should submit a separate line item for the dialysis for each day of the month.

If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay.

In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system will detect the overlapping dates and reject only the line item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.

Implementation
The implementation date for the instruction is April 2, 2007.

Additional Information
For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1084CP.pdf on the CMS Web site.

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Reminder of Appropriate Requests for Medicare Appeals

We have received numerous requests for Medicare appeals which do not meet Medicare guidelines for a valid appeal. As a result, this article serves to clarify when it is appropriate to submit an appeal request to Medicare.

Requests for a Medicare appeal are only appropriate when a claim has been denied by Medicare and the beneficiary or provider is disputing the denial. For example, a claim denied by Cahaba because it was determined that the services billed were not medically necessary, or did not meet other Medicare guidelines for coverage would be appropriate for appeal. Full denials will appear in the Fiscal Intermediary Standard System (FISS) status/location (S/LOC) D B9997. Partial denials will appear in FISS S/LOC P B9997, and can be distinguished from fully paid claims by accessing FISS Claim Page 02 and identifying the non-covered revenue code line. Press F2 to display MAP171D. Use the F6 key to scroll through and locate the non-covered revenue code line and the associated denial reason code. In addition, your remittance advice will contain reason codes and/or remarks codes when a claim has been fully or partially denied. The "Claim Adjustment Reason Code" field (RC) and "Remittance Advice Reason Code" fields (Rem) are available on the "All Claims" page of the Standard Paper Remittance Advice (SPR) and the "Single Claim" page of the Electronic Remittance Advice (ERA). A "Single Claim" page is available for each claim listed on the ERA. You can then look up the codes found in the "RC" and "Rem" fields using the WPC Web site at http://www.wpc-edi.com/products/codelists/alertservice to determine if appeal rights are available for the initial claim determination.

As a reminder, below is a list of situations in which it is never appropriate to submit an appeal request.

- Rejected claims (S/Loc R B9997)
- Claims paid in full (S/Loc P B9997)
- Claims which have never been submitted to Medicare
- Claims which are suspended (S/Loc S XXXXX where the Xs are various numbers and/or letter)

In addition, once a redetermination decision has a made for the first level of appeal, if the provider still disagrees with the denial, the provider's only recourse is to request the next level of appeal; the reconsideration. Additional documentation can be submitted with the reconsideration request submitted to the Qualified Independent Contractor (QIC).

Additional resources about the Medicare Appeals process can be found in the *Medicare Claims Processing Manual (CMS Pub. 100-4) Ch. 29 - Appeals of Claims Decisions,* or the Cahaba GBA Appeals Web page.

If you are unsure of whether a claim is appropriate to request an appeal, or have other questions about the Medicare Appeals process, please contact the appropriate Provider Contact Center.

Alabama Providers Reminder

Correct Claim Submission for Iron Sucrose Injection (Venofer)—HCPCS J1756

Medicare Part A data analysis identified underbilling of Iron Sucrose Injection—Venofer (HCPCS code J1756). Data revealed providers billing 1 - 20 units for each date of service. Venofer is available only in single dose vials (100 mg/5ml or 200 mg/10 ml). Based on the HCPCS Level II 2008 Expert, 1 revenue unit is equivalent to 1 mg of Venofer. Therefore, to prevent underbilling, when billing the standard recommended dose of Venofer (100 mg), report the units as 100 revenue units.

Venofer is indicated for the treatment of iron deficiency anemia in:

- Non-Dialysis Dependent – Chronic Kidney Disease (NDD- CKD) patients receiving or not receiving an erythropoietin
- Hemodialysis Dependent – Chronic Kidney Disease (HDD- CKD) patients receiving an erythropoietin.
- Peritoneal Dialysis Dependent – Chronic Kidney Disease (PDD- CKD) patients receiving an erythropoietin.

Medicare Forum

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

Q1. Will Medicare cover drugs that are usually considered self-administered in an emergency situation? For example, insulin is usually a self-administered drug but if the patient presents to the emergency room and is unresponsive and insulin is given to the patient, would it be covered in this situation?

A1. No. Self-administered drugs are statutorily noncovered regardless of the setting in which they are administered. When determining coverage for drugs, fiscal intermediaries adhere to the guidance of the carrier located within their jurisdiction. For the state of Iowa, the carrier is Noridian Administrative Services (NAS). For a list of self-administered drugs, refer to the NAS Web site at https://www.noridianmedicare.com/p-meda/coverage/sad.pdf. For the state Alabama, the carrier is Cahaba Government Benefit Administrators, LLC. For a list of self-administered drugs, refer to the Cahaba GBA Web site.

NOTE: The fiscal intermediary and carrier workloads for the state of Iowa are transitioning into an A/B Medicare Administrative Contractor (MAC) workload, which will be administered by Wisconsin Physician Services (WPS). You may need to check with WPS's Web site to obtain their listing of self-administered drugs.

The following is a correction to a Medicare Forum question/answer that was provided in the October 2007, *Medicare A Newsline*. The question is repeated, followed by the corrected answer.

Q2. We would like Cahaba to clarify the information given in the August 2007 Newsline in regards to CAH infusion billing. The question was asked: "If a patient receives either injections or infusions during the recovery process, is that considered as inherent to the procedure and therefore a separated injection or infusion code should not be charged?" In the answer is in item #2 it states that "Pain control is an inherent part of a procedure; therefore, the delivery and the medication (as well as the medication) are not separately billable". We understand why the administration of the drug would be included in the procedure but do not understand why the medication could not be billed separately. Not every patient receives pain medication and/or anti-nausea drugs as part of the recovery process. Can you please provide more information on this?

A2. As clarified by Cahaba's Contractor Medical Director, all services provided in a critical access hospital (CAH) (infusions and drugs) should be billed to Medicare.

March 2008 Education Events
To register go to the "Calendar of Educational Events" page on our Web site. Select the event title for registration instructions.

Online Courses

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.