Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC

April 1, 2008 **Vol. 15, No. 7**

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

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News Flash Messages from CMS For All Providers

Influenza Vaccine

It's Not Too Late to Give and Get the Flu Shot! In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Re-vaccination is necessary each year because flu viruses change each year. 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.

Test Your Medicare Claims Now

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.)

Skilled Nursing Facility Prospective Payment System Fact Sheet

The Skilled Nursing Facility Prospective Payment System Fact Sheet (October 2007), which provides the elements of the Skilled Nursing Facility Prospective Payment System, is now available in print format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network. To place your order, visit http://www.cms.hhs.gov/mlngeninfo/, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If the URL above does not take you directly to the MLN product ordering page, please copy and paste the URL in your web browser.

Quarterly Journal Ad

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

Revised Medicare Physician Fee Schedule Fact Sheet

The revised Medicare Physician Fee Schedule Fact Sheet (January 2008), which provides general information about the Medicare Physician Fee Schedule, can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf on the CMS Web site.

Implementation of the Medicare Clinical Laboratory Services Competitive Bidding Demonstration

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: MM5772
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R56DEMO
Related Change Request (CR) #: 5772
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected

Providers or suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs)) and/or order laboratory services for Medicare fee-for-service (FFS) beneficiaries under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project.

What You Need T Know

CR 5772, from which this article is taken, implements the CMS Medicare Clinical Laboratory Services Competitive Bidding Demonstration in the first Competitive Bidding Area (San Diego-Carlsbad-San Marcos, California metropolitan statistical area, or CBA1); and changes some of the demonstration's requirements that were stated in CR 5205, issued August 1, 2006, (see the MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5205.pdf on the CMS Web site) and superceded by CR 5359, issued November 1, 2006, (see the MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf on the CMS Web site).

Specifically, CR 5772 requires that:

- The demonstration covers tests provided to beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program who reside in the competitive bidding area (CBA1) during the 3-year demonstration period required bidders that do not bid, or bid and do not win, may serve as a reference laboratory to laboratories participating in the demonstration. However, they would not be allowed to bill Medicare directly for demonstration tests performed for Medicare FFS beneficiaries residing in the CBA.

- *Laboratories not required to bid*: These laboratories will be paid under the competitively set demonstration fee schedule for the duration of the demonstration.

    - CMS will exempt laboratories that supply less than $100,000 annually in demonstration tests to Medicare FFS beneficiaries residing in the CBA from submitting bids.

    - CMS will exempt laboratories providing services exclusively to beneficiaries entitled to Medicare by reason of end-stage renal disease (ESRD) from submitting bids. (Tests that are paid as part of the ESRD payment bundle are excluded from the demonstration.)

- CMS will exempt laboratories providing services exclusively to beneficiaries in nursing facilities or receiving home health services from submitting bids.

CR 5772 further announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008; and provides Medicare contractors detailed record layouts for the quarterly report and for listing laboratories in the CBA.

CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009.

Background
Section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to conduct a project to demonstrate the application of competitive acquisition for the payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

In this project, each of two demonstration sites (competitive bidding areas – CBA1 and CBA2) will run for three years with a staggered start of one year. It will cover certain "demonstration tests" furnished under Medicare Part B to any beneficiary enrolled in FFS Medicare who lives in the CBAs.

Competitively bid fees will be set for all tests paid under the Medicare Part B clinical laboratory fee schedule in these demonstration sites, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. In each CBA, the payment basis determined by the bidding will substitute for present payment under the existing clinical laboratory fee schedule.

CBAs will be defined geographically by ZIP codes, and will roughly correspond to a Metropolitan Statistical Area (MSA). Beneficiary residence status will be determined by information in the Medicare system as of the date the claim is processed, and review of a beneficiary's ZIP code of residence must reveal that it is included in the same listed CBA. CMS will provide Medicare contractors with a list of ZIP codes included in each MSA, which they will use to determine whether a beneficiary's residence is included in one of the CBAs.

Two previous CRs, 5205 and 5359 (issued August 1, 2006 and November 1, 2006, respectively), implemented the necessary system requirements to accomplish this project. CR 5772, from which this article is taken, establishes the project implementation dates; changes the requirements for referring and reference laboratory services, Skilled Nursing Facility (SNF) and Home Health services; and provides Medicare contractors a detailed record layout for the quarterly report, for listing laboratories in the CBA with their CB status.

The demonstration in CBA1 is scheduled to begin on July 1, 2008. CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009. You should note that multiple winners are expected in each CBA.

Note: Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Laboratory Categories
Under the demonstration, laboratories will be classified as either: 1) "Required bidders" (laboratories that are required to bid in the demonstration because (regardless of where they are located) they provide FFS beneficiaries residing in the CBAs "demonstration tests" that yield $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2006); or 2) "Non-required bidders" (laboratories whose payments for Medicare Part B (fee-for-service) payments for demonstration tests are below this $100,000 threshold.

"Non-required bidders" may choose to bid or not bid. Those that do not bid will be considered "passive" laboratories. Such passive laboratories, as well as "non-required bidders" who choose to bid (and win) and "required bidders" who win, (both labeled "winners") will be allowed to provide laboratory services to Medicare beneficiaries in the CBA and will be paid at the competitive bid rate for the demonstration tests paid under the Part B Clinical Laboratory Fee Schedule (CLFS), regardless of where the laboratory firm is located.

Conversely, "required bidders" and "non-required bidders" who bid and do not win (along with "required bidders" who do not bid) will be labeled "non-winners" under the demonstration. Medicare will not directly pay these "non-winner" laboratories (under either the Part B clinical laboratory fee schedule or the competitively bid price) for demonstration tests that they provide to beneficiaries residing in the CBAs for the duration of the demonstration (regardless of where the laboratory firm is located). Therefore, a passive laboratory that chooses to bid but does not "win" cannot participate in the demonstration in its "passive" status.

There are three types of passive laboratories: 1) "Passive-small business" (those with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBA); 2) "Passive-ESRD" – those that provide clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBAs); and 3) "Passive SNF/Home Health" – those that provide laboratory services exclusively to beneficiaries residing in nursing homes or are receiving home health services.

The "passive-small business" category of passive laboratories is subject to an annual payment ceiling of $100,000; however this payment ceiling threshold does not apply to the "passive ESRD" or "passive SNF/Home Health" laboratories. Further, you should note that the $100,000 threshold for "passive" laboratories does not include Medicare payment for tests excluded from the demonstration test list, services for beneficiaries residing in areas outside the CBA, or revenues from sources other than Medicare fee-for-service

You should also note that the $100,000 threshold does not apply to either the "passive ESRD" or passive SNF/Home Health laboratory categories.

In addition, in order to make it easier for nursing facilities to continue to provide continuity of care, CMS is exempting "passive SNF/Home Health" laboratories from being required bidders. Laboratories providing both Part A and Part B laboratory services to nursing facilities will be able to continue existing business relationships because they will not be at risk of losing Medicare Part A business as a result of the demonstration. They will be paid at the competitively set rate for demonstration tests otherwise paid under the Part B CLFS, and will also continue to receive payment for mileage, phlebotomy, and the existing payment under any schedule other than the Part B CLFS for those tests included in the demonstration.

You should also be aware that during the demonstration period, CMS will require that Medicare contractors monitor (and report to CMS quarterly):

- "Passive-small business" laboratories to ensure that their Medicare Part B annual payments for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the dollar threshold (so that they do not unfairly gain market share within the CBA). Passive laboratory firms exceeding their threshold limitations during the demonstration period will be converted to a "non-winner" status, and will be terminated from the demonstration project, and not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

  Note: All changes from a "passive" to a "non-winner" will be prospective to the next quarter.

- "Passive-ESRD" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries with ESRD residing in the demonstration sites; and

- "Passive SNF/Home Health" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries residing in nursing homes or are receiving home health in the demonstration sites.

<u>Project Implementation</u>
The project is being implemented in multiple phases. The first phase (analysis and design) was implemented in January 2007. The second phase (finalization of the requirements, coding development, testing and documentation) was implemented in April 2007.

CR 5772, from which this article is taken, announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008, and that the tentative start date for the demonstration in the second CBA is July 1, 2009.

During the second quarter of calendar year (CY) 2008, CMS will provide Medicare contractors with:

- Information that specifies (along with a few other required fields) the laboratories' names and Medicare provider numbers, address and zip code, demonstration status (winning, passive (SB, SNF/Home Health, ESRD), or non-winner) and each laboratory's payment history for services provided to beneficiaries' living within the first CBA1 as of CY 2006. This information will identify the laboratories eligible to participate in the demonstration ("winning" laboratories), the passive laboratories that are exempt from bidding in the demonstration due to their relatively small size as measured by annual Medicare payments or due to their status as an ESRD or SNF/Home Health laboratory, and those not selected to participate in the demonstration after unsuccessfully bidding ("non-winner" laboratories). The list will specify the name of the laboratory, address, ZIP code, Medicare provider number, and the laboratory's demonstration status. Any changes to a laboratory's status in this report will be handled on an ad hoc basis.

- A test version of the laboratory competitive bidding demonstration fee schedule file containing the demonstration fee amounts for the preliminary list of services that the demonstration covers. (This test file will be populated only with the data pertaining to CBA1.)

- Modifications to the existing 5-position national ZIP code pricing file for the laboratory competitive bidding demonstration. Also during the second quarter of CY 2008, CMS will provide the final version of the laboratory competitive bidding demonstration fee schedule file containing the Current

Procedural Terminology (CPT) codes of the services covered by the demonstration and fees for CBA1.

To determine the correct laboratory competitive bidding fee schedule amount, contractors will use the July 2008 version of the 5-position national ZIP code pricing file to locate the ZIP code of the beneficiary's residence and map the beneficiary locality designation (i.e., CBA1 or CBA2) to the matching locality on the laboratory competitive bidding demonstration fee schedule file.

Notes:

1. This mapping is for demonstration pricing purposes only, and will not be used to report the laboratory state locality information.
2. For claims within a local carrier's jurisdiction, carriers will continue to report the state locality of the billing laboratory as they do now for clinical laboratory services.

CR 5772 also contains the following details about the demonstration:

- Physician office laboratory (POL) testing and hospital-based laboratories that function as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital are included in the demonstration. A POL enrolled as an independent laboratory or a hospital-based laboratory furnishing laboratory services to non-patients are subject to the demonstration rules. Services provided by a POL and/or a hospital-based laboratory for their own patients are not included in the demonstration and will continue to be paid under the existing CLFS.

  Note:
  For hospital-based laboratories, only 14X Type of Bills submitted for non-patient laboratory services are covered under this demonstration.

- Hospital inpatient testing is covered by Medicare Part A, it is, therefore, exempt from the demonstration.

- Pap smears and colorectal cancer screening tests are excluded from this demonstration by statute.

- Requirements under the Clinical Laboratory Improvement Amendments (CLIA) program as mandated in section 353 of the Public Health Service Act are applicable.

- Claims for phlebotomy, Healthcare Common Procedure Coding System (HCPCS) code 36415 (Collection of venous blood by venipuncture) must identify the place of service (POS), e.g., Skilled Nursing Facility (POS 31), Home (POS 12), ESRD treatment facility (POS 65), Physician's office (POS 11) or Independent laboratory (POS 81). If the specimen is collected at an independent laboratory draw station, you should use POS 81. For this demonstration, when the specimen is collected at a hospital laboratory or draw station that is acting as an independent laboratory, you should indicate the place of service for CPT code 36415 as POS 81.

- Referring and reference laboratories may be paid under the demonstration with some restrictions:

- A winning or passive laboratory can refer out and bill for the reference laboratory service and be paid directly by Medicare;

- A reference laboratory that was required to bid in the competitive bidding process but was not a winner under the demonstration can perform reference laboratory services but cannot bill Medicare directly or bill the beneficiary; and

- A reference laboratory that was not required to bid in the competitive bidding process can choose to bill for services that other laboratories refer to them. However, these laboratories are restricted to receiving payment less than $100,000 a year (for demonstration tests provided to FFS beneficiaries residing in the CBA), and if they exceed the $100,000 limit, they will be considered a non-winner and Medicare payment will not be allowed.

- **Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare denies payment for the test, nor may they charge the beneficiary for such a test.** However, non-winners may continue to furnish tests (that are outside the scope of the demonstration) to beneficiaries residing within the CBA, receive Medicare payment for such tests, and may appeal denial decisions for these services.

- Effective for claims with dates of services between July 1, 2008 and June 30, 2011, Medicare contractors will pay competitive bidding demonstration fee schedule amounts for claims that winning and/or passive laboratories submit for demonstration-covered services (including reference laboratory services) provided to beneficiaries residing in the CBA1. Moreover, CMS is aware that the allowed amount under the demonstration could be less than the regular fee schedule allowed amount. Therefore, contractors will add the following message for a demonstration remittance advice:

  M114 – This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.

- Laboratory tests which are exempt from the demonstration (e.g., pap smears, colorectal cancer screening tests), as well as new procedure codes that are added subsequent to the start of the demonstration will be paid in accordance with the existing CLFS. Laboratory tests provided to beneficiaries enrolled in the Medicare Program other than FFS or residing outside the CBA will be paid in accordance with the existing Part B CLFS.

- Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will deny, and intermediaries will reject, claims submitted by non-winner laboratories for demonstration-covered services provided to beneficiaries residing in the CBA1, using the following remittance advice reason code and remark codes:

  Reason code 96 – Non-covered charge(s).

  Remark Code M114 - This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.

  Remark Code M115 (For carriers) – No appeal rights. This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

Remark Code N83 (For intermediaries) - No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

- Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will not reject claims with a modifier "90" (Reference (Outside) Laboratory) submitted by a winning or passive laboratory for demonstration-covered services provided to beneficiaries residing in the CBA1. However, they will reject claims from non-winning laboratories for demonstration covered services provided to such beneficiaries, even with modifier "90" present.

- Finally, all of the other business rules provided in CR 5205 and CR 5359 remain applicable, and are not changed by CR 5772.

Additional Information

You can find the official instructions given to your carrier, FI, or A/B MAC in CR 5772 located at http://www.cms.hhs.gov/Transmittals/downloads/R56DEMO.pdf on the CMS Web site. You might also want to look at MLN Matters article MM5359 (Laboratory Competitive Bidding Demonstration) which you can find at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf on the CMS Web site. (MM5359 superseded MM5205.)

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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Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

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: MM5818
Related CR Release Date: January 14, 2008
Related CR Transmittal #: R80NCD and R1413CP
Related Change Request (CR) #: 5818
Effective Date: July 30, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying Erythropoiesis Stimulating Agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

What You Need to Know

Following a National Coverage Analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a Decision Memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

CR 5818 communicates the NCA findings and the coverage policy in the National Coverage Determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007, do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

Background

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use
CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);

- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the,150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha;

- Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%);

- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;

- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose; and,

- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use
Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;

- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);

- Anemia of cancer not related to cancer treatment;

- Any anemia associated only with radiotherapy;

- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and,
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

  Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, the following policies [NCD 110.21] were used when we made this decision, and remittance reason code 50, These are non-covered services because this is not deemed a `medical necessity' by the payer. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21

Medicare Contractors shall not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information
This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR 5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available at http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf on the CMS Web site. The second transmittal revises the *Medicare Claims Processing Manual* and it is at http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf on the same 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 Bone Mass Measurement (BMM) Billing Requirements Issued in CR 5521

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: MM5847	**Related Change Request (CR) #:**5847
Related CR Release Date: January 18, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1416CP	**Implementation Date:** February 20, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Bone Mass Measurement (BMM) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5847 which clarifies the claims processing instructions contained in CR 5521. Only those business requirements changing from CR 5521 are listed in CR 5847, and the BMM benefit policy is not changing. The basic clarification is that Medicare allows codes other than CPT code 77080 (i.e., 76977, 77078, 77079, 77081, 77083, and G0130) to be paid even though claims for such services report both a screening diagnosis code and an osteoporosis code.

Background

The Social Security Act (Sections 1861(s)(15) and (rr)(1)) (as added by the Balanced Budget Act of 1997 (BBA; §4106)) standardize Medicare coverage of medically necessary BMMs by providing for uniform coverage under Medicare Part B. Effective for dates of service on and after January 1, 2007, the Calendar Year (CY) 2007 Physician Fee Schedule (PFS) final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry as it is not considered reasonable and necessary under the Social Security Act (Section 1862 (a)(1)(A)) . Finally, it required in the case of monitoring and confirmatory baseline BMMs, that they be performed with a dual-energy x-ray absorptiometry (axial) test.

CMS issued change request CR9 5521 (Transmittal 70; May 11, 2007) to provide benefit policy and claims processing instructions for BMM tests. CMS has learned that the updated policy described in CR 5521 is not being implemented uniformly and some covered services are being denied in error.

You can review the MLN Matters article related to CR 5521 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5521.pdf on the CMS Web site. CR 5847 clarifies the claims processing instructions contained in CR 5521 and lists only those business requirements changing from CR 5521. The key clarifications are as follows, effective for dates of services on and after January 1, 2007, the following apply to BMM:

- Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in section 80.5.5 of the *Medicare Benefit Policy Manual*, which may be found at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.

- Medicare Contractors will pay claims for screening tests when coded as follows:
    - Contains Current Procedural Terminology (CPT) procedure code 77078, 77079, 77080, 77081, 77083, 76977 or G0130, and
    - Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Contractors are to maintain local lists of valid codes for the benefit's screening categories.
- Contractors will deny claims for screening tests when coded as follows:
    - Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, but
    - Does not contain a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Dual-energy x-ray absorptiometry (axial) tests are covered when used to monitor FDA-approved osteoporosis drug therapy subject to the 2-year frequency standards described in section 80.5.5 of the *Medicare Benefit Policy Manual*.
- Contractors will pay claims for monitoring tests when coded as follows:
    - Contains CPT procedure code 77080, and
    - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code.
- Contractors will deny claims for monitoring tests when coded as follows:
    - Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, and
    - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code, but does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the Medicare contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Single photon absorptiometry tests are not covered. Contractors will deny CPT procedure code 78350.

Note: As mentioned, these are clarifications and the BMM benefit policy is not changing. Also, note that while Medicare contractors will not search their files to reprocess claims already processed, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 5847, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1416CP.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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Use of Healthcare Common Procedure Coding System (HCPCS) V2787 When Billing Approved Astigmatism-Correcting Intraocular Lens (A-C IOLs) in Ambulatory Surgery Centers (ASCs), Physician Offices, and Hospital Outpatient Departments (HOPDs)

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: MM5853
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1430CP
Related Change Request (CR) #:5853
Effective Date: January 1, 2008
Implementation Date: March 3, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on CR 5853 which provides instructions regarding the use of HCPCS Code V2787 when billing for intraocular lens procedures and services involving recognized Astigmatism-Correcting Intraocular Lens (A-C IOLs) and taking place in Ambulatory Surgery Centers (ASCs), Physician Offices, or Hospital Outpatient Departments (HOPDs).

What You Need to Know

Effective for dates of service January 1, 2008, and later, when providing services to a Medicare beneficiary that involve the insertion of recognized A-C IOLs, and the service/procedure takes place in an ASC, HOPD, or physician office, then HCPCS Code V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. V2788 should not be used to report non-covered charges of the A-C IOLs on or after January 1, 2008.

What You Need to Do

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

Background

CMS previously announced in CR 5527 (Transmittal 1228, April 27, 2007) a new administrator ruling regarding the insertion of astigmatism-correcting intraocular lens (A-C IOLs) following cataract surgery. In that CR, CMS provided payment policies and billing instructions for services related to Intraocular Lens (IOL) procedures preformed with approved conventional IOLs or Astigmatism-Correcting Intraocular Lens (A-C IOLs) in Ambulatory Surgery Centers (ASCs), Hospital Outpatient Departments (HOPDs), or Physician offices. In addition, that CR instructed providers to:

- Bill the non-covered charges of the A-C IOL functionality of the lens using HCPCS Code V2788 when inserting an A-C IOL, and

- Continue to bill HCPCS Code V2632, as appropriate, for the charges associated with the insertion of a conventional lens or the conventional functionality when an A-C IOL was inserted.

You can review CR 5527 at http://www.cms.hhs.gov/transmittals/downloads/R1228CP.pdf on the CMS Web site and its corresponding MLN Matters article, MM5527, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf on the CMS Web site.

CR 5853 instructs that, effective for dates of service on or after January 1, 2008, services provided to Medicare beneficiaries involving the insertion of a recognized A-C IOL in an ASC, HOPD, or physician office, HCPCS Code V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens.

Note that (effective for dates of service on or after January 1, 2008) HCPCS Code V2788:

- **Is no longer valid** to report non-covered charges associated with the **A-C IOL**, **but**

- **Continues to be valid** to report non-covered charges associated with the **Posterior Chamber IOL (P-C IOL)**.

Physician offices should continue to bill HCPCS Code V2632 for the payable conventional IOL functionality of the A-C IOL. The payment for the conventional lens portion of the A-C IOL lens continues to be bundled with the facility procedure payment for ASCs and HOPDs.

As of March 3, 2008, your Medicare contractor(s) will accept HCPCS Code V2787 for dates of service on or after January 1, 2008 to report non-covered charges incurred for services provided to a Medicare beneficiary involving the insertion an A-C IOL in a physician's office, an ASC facility, or a hospital outpatient setting. The annual HCPCS update will include the definition of HCPCS Code V2787 as follows:

HCPCS Code	Descriptor
V2787	Astigmatism correcting function of intraocular lens. Non-covered by Medicare statue.

When Medicare denies A-C IOLs billed with V2787, they will return remittance reason code 96 (Non-covered charges) and remark code N425 (Statutorily excluded service(s)) or they may use reason code 204 (This service/equipment/drug is not covered under the patient’s current benefit plan).

Note that your Medicare contractor will not search their files to reprocess claims for HCPCS Code V2787 that may have been denied prior to the implementation date for this change. However, they will adjust such claims if you bring them to the contractor’s attention.

Additional Information

The official instruction, CR 5853, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1430CP.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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Clinical Lab: New Automated Test for the Automated Multi-Channel Chemistry Code (AMCC) Panel Payment Algorithm

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: MM5874	**Related Change Request (CR) #:**5874
Related CR Release Date: February 15, 2008	**Effective Date:** July 1, 2008
Related CR Transmittal #: R83BP	**Implementation Date:** July 7, 2008

Provider Types Affected

All physicians and providers, who submit claims for the AMCC to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and Fiscal Intermediaries (FIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

CMS issued CR 5874 to alert providers that existing current procedural terminology (CPT) code 82330, Calcium; ionized is being paid as in individual test and was not included in the AMCC Panel Payment Algorithm. That changes effective July 1, 2008.

What You Need to Know

Effective July 1, 2008, CPT 82330 will become an automated chemistry test within the AMCC Panel Payment Algorithm for payment purposes.

What You Need to Do

Make certain your office staffs are aware of this change.

Background

Effective January 1, 2008, the CPT Editorial Panel created a new code 80047 *Basic metabolic panel (Calcium, ionized)* which is an automated multi-channel chemistry (AMCC) code and is currently included in the automated multi-channel chemistry code (AMCC) Panel Payment Algorithm. The new code 80047 is comprised of eight component test codes (see table below). Also, new code 80047 is not a replacement for code 80048 *Basic metabolic panel*. Both codes 80048 and 80047 are included in the 2008 clinical laboratory fee schedule.

Key Points

- In order to determine payment for the new code 80047 using the AMCC Panel Payment Algorithm, existing code 82330, Calcium; ionized, will be added as an AMCC panel code.

- Payment code ATP23 has also been included in the clinical laboratory fee schedule data file to correspond to the AMCC panel code addition.

- The CPT code 80047 Basic metabolic panel (Calcium, ionized) is comprised of:

  - Calcium; ionized (82330);
  - Carbon dioxide (82374);
  - Chloride (82435);
  - Creatinine (82565);
  - Glucose (82947);
  - Potassium (84132);
  - Sodium (84295); and,
  - Urea Nitrogen (BUN) (84520).

For ESRD dialysis patients, CPT code 82330 *Calcium; ionized* will be included in the calculation for the 50/50 rule (Pub 100-04, Chapter 16, Section 40.6). When CPT code 82330 is billed as a substitute for CPT code 82310, *Calcium; total*, it should be billed with modifier CD or CE. When CPT code 82330 is billed in addition to CPT 82310, it should be billed with CF modifier.

Note that, in accordance with the *Medicare Claims Processing Manual*, section 40.6.1, the new panel code 80047 cannot be billed for services ordered through an End Stage Renal Disease (ESRD) facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel. The *Medicare Claims Processing Manual* is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.

Additional Information

To see the official instruction (CR5874) issued to your Medicare Carrier, FI, or A/B MAC, refer to http://www.cms.hhs.gov/Transmittals/downloads/R83BP.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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Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

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: MM5897	**Related Change Request (CR) #:**5897
Related CR Release Date: February 5, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1437CP	**Implementation Date:** May 5, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on CR 5987 which notifies Medicare contractors of an increase in the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2008. **The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2008 is $110.00. The amount remaining in controversy requirement for requests made on or after January 1, 2008 is $120.00. For Federal District Court review, the amount remaining in controversy goes from $1,130.00 for requests prior to January 1, 2008 to $1,180.00 for requests on or after that date.**

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for annual reevaluation (beginning in 2005) of the dollar amount in controversy required for an Administrative Lay Judge (ALJ) hearing and Federal District Court review.

CR 5897 revises the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29, Section 330.1 and Section 345.1) to update the Amount In Controversy (AIC) required for an ALJ hearing or Federal District Court review. As of January 1, 2008, the amount remaining in controversy must be at least $120.00 for an ALJ hearing or at least $1,180.00 for a Federal District Court review requested on or after January 1, 2008.

Additional Information

The official instruction, CR 5987, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1437CP.pdf on the CMS Web site.

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Update to Common Working File (CWF) Edits 7284 and 7548

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: MM5907	**Related Change Request (CR) #:**5907
Related CR Release Date: February 8, 2008	**Effective Date:** July 1, 2008
Related CR Transmittal #: R1446CP	**Implementation Date:** July 7, 2008

Provider Types Affected

Indian Health Service (IHS) or Tribal Hospitals billing Medicare contractors (Medicare Administrative Contractors (A/B MACs) or Fiscal Intermediaries (FIs)) for services provided to American Indian/Alaskan Native (AI/AN) Medicare beneficiaries admitted to an IHS/Tribal facility for social reasons.

Impact on Providers

CMS issued CR 5907 in order to clarify instructions for IHS or Tribal Hospitals regarding payment methodology for social admissions and outpatient services rendered at separate facilities.

Background

CR 3452, Transmittal 596 issued on June 24, 2005 implemented instructions to edit IHS and tribal facility claims for social admissions. A related MLN Matters article may be reviewed by going to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3452.pdf on the CMS Web site.

Key Points of CR 5907

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, Type of Bill (TOB) 12X during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13X or 72X. The CWF returns an A/B crossover edit and an IUR is created in any of these situations.

- The IUR 7284 is created for TOB 12X with an IHS provider number when the date of service on the claim is equal to or overlaps a claim in history with TOB 13X or 72X.
- The IUR 7548 is created for TOB 12X with an IHS provider number with a line item date of service is equal to or the day following the discharge date on a TOB 11X.
- The IURs 7284 or 7548 are bypassed when the beneficiary was not entitled to Medicare Part A at the time the services on TOB 12X were rendered.

Additional Information

To see the official instruction (CR 5907) issued to your Medicare FI or A/B MAC, refer to http://www.cms.hhs.gov/Transmittals/downloads/R1446CP.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 to CR 5744 - Payment Allowance Update for the Influenza Virus Vaccine CPT 90660 and further instruction regarding the Pneumococcal Vaccine Current Procedural Terminology (CPT) 90669

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: MM5910	**Related Change Request (CR) #:**5910
Related CR Release Date: February 22, 2008	**Effective Date:** January 1, 2008 except as noted in article
Related CR Transmittal #: R1461CP	**Implementation Date:** No later than March 24, 2008

Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FIs), carriers, or A/B MACs) for providing influenza and pneumococcal vaccines to Medicare beneficiaries.

What You Need to Know

CR 5910, from which this article is taken, clarifies CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP)), released October 26, 2007. It provides Medicare contractors additional instructions regarding the pediatric pneumococcal vaccine CPT code 90669, and the updated payment allowance for the nasal influenza virus vaccine CPT code 90660.

The Medicare Part B payment allowance for CPT 90660 is $22.031, effective September 19, 2007. Make sure that your billing staffs are aware of these CPT code updates.

Background

CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP)), released October 26, 2007; provided the payment allowances for Pneumococcal Vaccine Current Procedural Terminology (CPT) codes 90732 and 90669, and Influenza Virus Vaccines CPT codes 90655, 90656, 90657, 90658, and 90660).

CR 5910, from which this article is taken, augments CR 5744 by providing additional instructions regarding pediatric pneumococcal vaccine CPT code 90669, and the updated payment allowance for the nasal influenza virus vaccine CPT code 90660. These changes are:

- **CPT Code 90669 – Effective January 1, 2008**, FIs, carriers, and A/B MACs will accept claims containing 90669 for pneumococcal vaccine. In order to facilitate appropriate payment for CPT code 90669 (Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use), carriers and A/B MACs will use a payment indicator of "1" and the deductible indicator of "1". Institutional providers should bill HCPCS code G0009 when billing for services on or after January 1, 2008, for the administration of CPT code 90669.

- **CPT Code 90660** - On September 19, 2007, the Food and Drug Administration (FDA) approved FluMist for the 2007-2008 influenza season. Thus, your FI, carrier, or A/B MAC may cover CPT 90660 (FluMist, a nasal influenza vaccine) if it determines that its use is medically reasonable and necessary for the beneficiary. The Medicare Part B payment allowance for CPT 90660 is $22.031, effective September 19, 2007, except where the vaccine is furnished in the hospital outpatient department. This supersedes the allowance figure provided in CR 5744.

  Note: All other instructions in CR 5744 remain in effect.

Please note that, except when the vaccine is furnished in the hospital outpatient department, the Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95% of the average wholesale price (AWP), as reflected in the published compendia payment for the vaccine is based on reasonable cost.

Also note that annual Part B deductible and coinsurance amounts do not apply; and that all physicians, non-physician practitioners, and suppliers who administer the influenza virus and pneumococcal vaccinations must take assignment on the claim for the vaccine.

Finally, your Medicare contractor will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims that you bring to their attention.

Additional Information

You can find more information about the additional information regarding CPT codes 90669 and 90660 by going to CR 5910, located at http://www.cms.hhs.gov/Transmittals/downloads/R1461CP.pdf on the CMS Web site.

You might also want to review the MLN Matters article related to CR 5744. You can find that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf on the CMS Web site.

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Claim Status Category Code and Claim Status Code Update

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

MLN Matters Number: MM5947
Related CR Release Date: February 29, 2008
Related CR Transmittal #: R1468CP
Related Change Request (CR) #:5947
Effective Date: April 1, 2008 7
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on CR 5947 which indicates there have been updates to the Claim Status Category Codes and Claim Status Codes.

What You Need to Know

All code changes approved during the October 2007 meeting of the national Code Maintenance Committee have been posted at http://www.wpc-edi.com/content/view/180/223/ and will become effective April 1, 2008.

What You Need to Do

See the Background section of this article for further details.

Background

The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers, including Medicare, to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee. These codes are used in the X12 276/277 Health Care Claim Status Request and Response format to explain the status of submitted claim(s).

The decisions about additions, modifications, and retirement of existing Claim Status Category and Claim Status codes made at the October 2007 meeting of the national Code Maintenance Committee were posted at http://www.wpc-edi.com/content/view/180/223/ on November 5, 2007. These updates are effective April 1, 2008 and are to be used in editing of all X12 276 transactions processed by Medicare contractors on or after April 7, 2008.

Additional Information

To see the official instruction (CR 5947) issued to your Medicare FI, carrier, DME MAC, or A/B MAC, refer to http://www.cms.hhs.gov/Transmittals/downloads/R1468CP.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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January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Manualization

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: MM5946	**Related Change Request (CR) #:** 5946
Related CR Release Date: February 8, 2008	**Effective Date:** January 1, 2008 7
Related CR Transmittal #: R1445CP and R82BP	**Implementation Date:** March 10, 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 services paid under the OPPS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5946 which describes updates to both the *Medicare Claims Processing Manual* and the *Medicare Benefits Policy Manual* in order to clarify existing CMS OPPS policy. Much of this information has been conveyed previously by CR5912, which is discussed in MLN Matters article MM 5912 at http://ww.cms.hhs.gov/MLNMattersArticles/downloads/MM5912.pdf on the CMS Web site.

Background

This article is based on CR 5946 which is quite lengthy and includes important changes regarding certain OPPS issues. Those details will not be repeated in this article, but they are available in CR 5946 at http://www.cms.hhs.gov/Transmittals/downloads/R82BP.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R1445CP.pdf on the CMS Web site. Many of the changes to the *Medicare Claims Processing Manual* are being made simply to manualize changes already conveyed by CR 5912, which is summarized by MLN Matters article MM5912 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5912.pdf on the CMS Web site. The changes to both manuals are summarized in the remainder of this article.

Medicare Claims Processing Manual Updates

Key changes to this manual are summarized as follows:

Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 10

This section was modified to identify the five (5) composite APCs that are effective for services furnished on or after January 1, 2008 in the following table:

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT codes 55875 and 77778 on the same date of service
8002	Level I Extended Assessment and Management Composite	1) eight or more units of Healthcare Common Procedure Coding System (HCPCS) code G0378 are billed-- ● On the same day as HCPCS code G0379*; or ● On the same day or the day after CPT codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after 99284, 99285 or 99291; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0033. For the list of mental health services to which this composite applies, see the IOCE supporting files for the pertinent period.

*Payment for direct admission to observation care (HCPCS code G0379) is made either under APC 604 (Level 1 Hospital Clinic Visits) or APC 8002 (Level I Extended Management and Assessment Composite) or is packaged into payment for other separately payable services. See section 290.5.2 for additional information and the criteria for payment of HCPCS code G0379.

** For additional reporting requirements for observation services reported with HCPCS code G0378, see section 290.5.1 of this chapter.

Note: See Addendum A at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site for the national unadjusted payment rates for these composite APCs.

Other changes were made to Chapter 4, Section 10, to:

- Further explain the calculation of APC payment rates;
- Emphasize the importance of reporting all HCPCS codes and all charges for all services because of the packaging of certain items and services under the OPPS;
- Explain the combinations of packaged services of different types that are furnished on the same date of service; and,
- Further clarify outlier adjustments.

Chapter 4, Section 20.5.1.1 - Packaged Revenue Codes
The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services (with new revenue codes ***bolded*** and ***italicized***) are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, ***0273***, 0275, 0276, 0278, 0279, 0280, 0289, ***0343, 0344***, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, , 0681, 0682, 0683, 0684, 0689, 0700, ***0709***, 0710, **0719**, 0720, 0721, ***0732***, 0762, ***0801, 0802, 0803, 0804, 0809***, 0810, 0819, ***0821, 0824, 0825, 0829***, and 0942.

Chapter 4, Section 20.5.1.4 - Revenue Codes for "Sometimes Therapy" Services
This section was added to show that certain wound care services described by CPT codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care.

Hospitals receive separate payment under the OPPS when they bill for certain wound care services that are furnished to hospital outpatients independent of a certified therapy plan of care.

When billing for wound care services under the OPPS that are furnished independent of a certified plan of care, providers should neither attach a therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech language pathology) to the wound care CPT codes nor report their charges under a therapy revenue code (that is, 042x, 043x, or 044x), to receive payment under the OPPS.

Chapter 4, Section 61.4 - Billing and Payment for Brachytherapy Sources
This new section contains information regarding billing for brachtherapy sources (e.g. brachytherapy devices or seeds, solutions), which are paid separately from services to administer and deliver brachytherapy in the OOPS, per section 1833 T)(2)(H) of the Social Security Act. This payment for brachytherapy sources reflects the number, isotope, and radioactive intensity of devices furnished, as well as stranded versus non-stranded configuration of sources.

The list of separately payable sources is found in Addendum B of the most recent OPPS annual update published in the Federal Register, as well as in the recurring update notifications of the current year for billing purposes.(See Addendum B at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site) New sources meeting the OPPS definition of a brachytherapy source may be added for payment beginning any quarter, and the new source codes and descriptors are announced in the recurring update notifications.

Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid "per source" based on the number of units of the source HCPCS code reported, including the billing of the number of sources within a stranded configuration

of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

Brachytherapy sources eligible for separate billing and payment must be radioactive sources, meaning that the source contains a radioactive isotope. Separate brachytherapy source payments reflect the number, isotope, and radioactive intensity of sources furnished to patients, as well as stranded and non-stranded configurations.

A hospital may report and charge Medicare and the Medicare beneficiary for all brachytherapy sources that are ordered by the physician for a specific patient, acquired by the hospital, and used in the care of the patient. Specifically, brachytherapy sources prescribed by the physician in accordance with high quality clinical care, acquired by the hospital, and actually implanted in the patient may be reported and charged. In the case where most, but not all, prescribed sources are implanted in the patient, CMS will consider the relatively few brachytherapy sources that were ordered but not implanted due to specific clinical considerations to be used in the care of the patient and billable to Medicare under the following circumstances. The hospital may charge for all sources if they were specifically acquired by the hospital for the particular patient according to a physician's prescription for the sources that was consistent with standard clinical practice and high quality brachytherapy treatment, in order to ensure that the clinically appropriate number of sources was available for the implantation procedure, and they were not implanted in any other patient. Those sources that were not implanted must have been disposed of in accordance with all appropriate requirements for their handling. In general, the number of sources used in the care of the patient but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the patient. Under these circumstances, the beneficiary is liable for the copayment for all the sources billed to Medicare.

Providers should report charges related to supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways:

- Report the charge separately using CPT code 77790 (Supervision, handling, loading of radiation source), in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source; or,

- Include the supervision, handling, and/or loading charges as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.

Do not bill a separate charge for brachytherapy source storage costs. These costs are treated as part of the department's overhead costs.

Chapter 4, Section 200.4 Billing for Amniotic Membrane
This section was added to show that hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used. A specific procedure code associated with use of amniotic membrane tissue is CPT code 65780 (Ocular surface reconstruction; amniotic membrane transplantation). Payment for the amniotic membrane tissue is packaged into payment for CPT code 65780 or other procedures with which the amniotic membrane is used.

Chapter 4, Section 200.5 – Billing and Payment for Cardiac Rehabilitation Services
This section was added to reflect the National Coverage Determination for cardiac rehabilitation programs, which requires that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise,

education, and counseling. See the *National Coverage Determination (NCD) Manual*, Section 20.10, for more information. (This manual is available at http://www.cms.gov/Manuals/IOM/list.asp on the CMS Web site.) A cardiac rehabilitation session may include more than one aspect of the comprehensive program. For CY 2008, hospitals will continue to use CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services. However, effective for dates of service on or after January 1, 2008, hospitals may report more than one unit of HCPCS code 93797 or 97398 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the cardiac rehabilitation services provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

Chapter 4, Section 200.6 - Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, beginning January 1, 2008, the OPPS recognizes two parallel G-codes (HCPCS codes G0396 and G0397) to allow for appropriate 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.

Contractors shall 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 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 Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

Chapter 4, Section 200.7.1 Cardiac Echocardiography Without Contrast

This section instructs hospitals to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

Chapter 4, Section 200.7.2 Cardiac Echocardiography With Contrast
This section instructs hospitals to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 200.7.2 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms.

Table 200.7.2 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor
C8921	Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; complete
C8924	Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study
C8925	Transesophageal echocardiography (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiography (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

Chapter 4, Section 200.8 – Billing for Nuclear Medicine Procedures
Effective January 1, 2008, the I/OCE will begin editing for the presence of a diagnostic radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Hospitals should begin including diagnostic radiopharmaceutical HCPCS codes on the same claim as a nuclear medicine procedure beginning on January 1, 2008. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service. More information regarding these edits is available at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.

Chapter 4, Section 290, subsections dealing with Observation Services
These sections have been revised to add clarifications and updates related to the reporting hours of observation and billing and payment for observation. Note that general standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

Also, observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level emergency department visit (Level 4 or 5), critical care services, or direct admission as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about payment for extended assessment and management composite APCs, see Chapter 4, Section 10.2.1 (Composite APCs) of the *Medicare Claims Processing Manual*.

APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The Integrated Outpatient Code Editor (I/OCE) evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time
   a) Observation time must be documented in the medical record.
   b) A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
   c) A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
   d) The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services
   a) The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
      - An emergency department visit (CPT code 99284 or 99285) or
      - A clinic visit (CPT code 99205 or 99215); or
      - Critical care (CPT code 99291); or
      - Direct admission to observation reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.

   b) No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

3. Physician Evaluation
   a) The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
   b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that observation services will be packaged or will meet the criteria for extended assessment and management composite payment.

Only observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct admission to observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in CR 4047, Transmittal 763, issued on November 25, 2005. The MLN Matters article related to that CR is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4047.pdf on the CMS Web site.

If a claim for services providing during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and

payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

Direct admission to observation care continues to be reported using HCPCS code G0379 (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

Payment for direct admission to observation will be made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite) or packaged into the payment for other separately payable services provided in the same encounter. The criteria for payment of HCPCS code G0379 under either APC 0604 or APC 8002 include:

- Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service; and.
- No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only direct admission to observation services billed on a 13X bill type may be considered for a composite APC payment.

When services are not covered as observation services, hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the *Medicare Benefit Policy Manual*, Chapter 6, Section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care. That manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site.

Chapter 16, Section 40.3 - Hospital Billing Under Part B

This section was updated to include information related to billing certain Part B services. Specifically, if a hospital bills claims for both hospital outpatient and non-patient laboratory tests on different dates of service, it should prepare two bills: one for the outpatient (13X type of bill) laboratory test and the other for the non-patient laboratory specimen (14X type of bill) tests. The hospital includes laboratory tests provided to hospital outpatients on the same bill with other hospital outpatient services to the same beneficiary, unless it is billing for non-patient laboratory specimen tests provided on a different day from the other hospital outpatient services, in which case it submits a separate bill for the non-patient laboratory specimen tests.

For all hospitals except CAHs and Maryland waiver hospitals, if a patient receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. However if the non-CAH or Maryland waiver hospital only collects or draws a specimen from the beneficiary and the beneficiary does not also receive hospital outpatient

services on that day, the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non- patient on the 14x bill type.

For CAHs, payment for clinical diagnostic laboratory tests is made at 101 percent of reasonable cost only if the individuals are outpatients of the CAH (85X type of bill), as defined in 42 CFR 410.2, and are physically present in the CAH at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present at the CAH (non-patients 14X type of bill) when the specimens are collected are made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act. See also 42 CFR 413.70(b)(iii). Similarly, for Maryland waiver hospitals, the waiver is limited to services to inpatients and registered outpatients as defined in 42 CFR 410.2. Therefore payment for non-patients (specimen only, TOB 14X) who are not registered outpatients at the time of specimen collection will be made on the clinical diagnostic laboratory fee schedule.

Chapter 17, Section, 90.2 - Drugs, Biologicals, and Radiopharmaceuticals
This chapter was revised to include the following:

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals
Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Payment for drugs, biologicals, and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via CRs that are known as Recurring Update Notifications. The latest payment rates associated with each APC and HCPCS code may be found in the most current Addendum A and Addendum B, respectively, which can be found under the CMS quarterly provider updates on the CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp.

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals
Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. For the process and information required to apply for transitional pass-through payment status for drugs,

biologicals, and radiopharmaceuticals, go to the main OPPS Web page, currently at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site to see the latest instructions.

Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates at http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp on the CMS Web site.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or below the applicable drug packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug packaging threshold are paid separately through their own APCs.

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

2. Diagnostic Radiopharmaceuticals

Beginning in CY 2008, payment for non pass-through diagnostic radiopharmaceuticals is packaged into the payment for the associated nuclear medicine procedure.

Beginning January 1, 2008, the I/OCE will begin requiring claims with separately payable nuclear medicine procedures to include a diagnostic radiopharmaceutical. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service. More information regarding these edits is available at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS Web site.

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for non pass-through therapeutic radiopharmaceuticals at charges adjusted to cost From January 1, 2008 through June 30, 2008. Beginning July 1, 2008, payment for separately payable therapeutic radiopharmaceuticals under the OPPS will be made on a prospective basis with payment rates based upon mean costs from hospital claims data, unless otherwise required by law.

Medicare Benefit Policy Updates

The key new/revised sections of the *Medicare Benefit Policy Manual* that are conveyed by in CR 5946 are intended to clarify existing policy regarding the OPPS. Basically, these clarifications are in the following areas:

- Chapter 6 (Hospital Services Covered under Part B), Section 20 (Outpatient Hospitals Services). The subsections that are new or revised include discussions on:

- Limitations of coverage of certain services to hospital outpatients and an exception to the limitation;
    - Definitions of outpatient, encounter, and diagnostic services;
    - Outpatient diagnostic services;
    - Outpatient Therapeutic Services; and Outpatient observation services.

- Chapter 6, Section 70.5, which clarifies policy regarding laboratory services furnished to non-hospital patients by the hospital laboratory.

The actual revisions to this manual are available as an attachment to the CR 5946, Transmittal R82BP, which is at http://www.cms.hhs.gov/Transmittals/downloads/R82BP.pdf on the CMS Web site

Additional Information

The official instruction, 5946, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed by looking at two transmittals. The first transmittal has the changes to the *Medicare Claims Processing Manual* and is at http://www.cms.hhs.gov/Transmittals/downloads/R1445CP.pdf on the CMS Web site. The second transmittal contains the changes to the *Medicare Benefit Policy Manual* and it is at http://www.cms.hhs.gov/Transmittals/downloads/R82BP.pdf on the same 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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Quarterly Provider Update

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

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

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

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

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

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Electronic Claim Status Requests (X12 276) and National Provider Identifiers (NPIs)

This article serves as a reminder that, effective May 23, 2008, all electronics claim status requests submitted using the electronic data interchange (EDI) standards (X12 276) must use the Health Insurance Portability and Accountability Act (HIPAA) mandated NPI. Any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number will be returned to the provider.

In addition, as of May 23, 2008, all claims status responses (X12 277 transactions) will contain only NPIs. However, if your legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response since it is not possible to determine which of the multiple NPIs apply to the legacy number used to submit the X12 276 transaction.

For additional information, refer to the Medicare Learning Network (MLN) Matters article MM5726 "Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers (NPIs)", which was published in the December 1, 2007, *Home Health & Hospice Medicare A Newsline*.

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Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for FY 2008

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

MLN Matters Number: MM5898	**Related Change Request (CR) #:**5898
Related CR Release Date: February 22, 2008	**Effective Date:** July 1, 2008
Related CR Transmittal #: R1459CP	**Implementation Date:** July 7, 2008

Provider Types Affected

Comprehensive Outpatient Rehabilitation Facilities (CORFs) billing Medicare contractors (Medicare Administrative Contractors (A/B MACs), and Fiscal Intermediaries (FIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The CMS issued CR 5898 to bring attention to the implementation of the new claims processing requirements for CORF provider claims (bill type 75X) as a result of the FY 2008 Medicare Physician Fee Schedule (MPFS) final rule.

What You Need to Know

The MPFS specifies changes applicable to CORF billing. Read the "Key Points" section of this article so that you are aware of the billing requirements for CORF 75X bill types.

What You Need to Do

Make certain your billing staffs are aware of these changes as claims that do not follow the instructions will be returned to you.

Key Points of CR 5898

Allowable Revenue Codes on CORF 75X Bill Types - Effective July 1, 2008, the following revenue codes are allowable for reporting CORF services on 75X bill types:

0270	0274	0279	029X
0410	0412	0419	042X
043X	044X	0550	0559
0560	0569	0636	0771
0900	0911	0914	0919

Note: Billed revenue codes not listed in the above list will be returned by Medicare systems. See Chapter 25, Completing and Processing the CMS-1450 Data Set, for revenue code descriptions. Chapter 25 may be reviewed at http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf on the CMS Web site.

- **Billing for Social Work and Psychological Services in a CORF** - CORF providers should bill social work and psychological services using only CPT code 96152; Health and Behavior Intervention, Each 15 Minutes, Face-to-Face; Individual. CPT 96152 may only be billed with revenue code 0560, 0569, 0900, 0911, 0914 and 0919.

- **Billing for Respiratory Therapy Services in a CORF** - CORF providers should bill respiratory therapy services with revenue codes 0410, 0412 and 0419 only.

- **Billing for CORF Nursing Services** – CORF nursing services should be billed with HCPCS code G0128 with revenue codes 0550 and 0559 only. (The requirement to use HCPCS G0128 is not a new requirement for 2008.)

- **Payment of Drugs, Biologicals, and Supplies in a CORF** –

    - Influenza, Pneumococcal, and Hepatitis B vaccine administrations should be billed with revenue code 0771 for which Medicare will pay based on the Medicare Physician Fee Schedule amount for CPT 90471.

    - HCPCS G0128 should no longer be used for billing the vaccine administration in the CORF setting.

    - CORFs should not bill for supplies they furnish when those supplies are part of the practice expense for that service. Under the MPFS, nearly all these expenses are taken into account in the practice expense relative values. However, CORFs may bill separately for certain splint and cast supplies, represented by HCPCS codes Q4001 through Q4051, when furnishing a cast/strapping application service in the CPT code series 29000 through 29750.

Claims for services rendered on or after July 1, 2008 submitted by CORFs via the 75X bill type that do not comply with these revised requirements will be returned to the CORF.

Additional Information
To see the official instruction (CR 5898) issued to your Medicare FI, or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1459CP.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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Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services- Revision

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

MLN Matters Number: MM5684 **Revision**
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R47GI

Related Change Request (CR) #: 5684
Effective Date: September 17, 2007
Implementation Date: September 17, 2007

Note: CR5 684 was rescinded and replaced by CR 5833. To view the MLN Matters article related to CR 5833, go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5833.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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Refinements in Cost Reporting Due to CMS's Revised Procedures for Recalibrating DRG Relative Weights Under the Inpatient Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) issued the Transmittal 321 of the Medicare One-Time Notification Manual, (CMS Pub. 100-20), Change Request (CR) 5928.

MLN Matters Number: N/A	**Related Change Request (CR) #:** 5928
Related CR Release Date: February 29, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R321CP	**Implementation Date:** March 31, 2008

SUMMARY OF CHANGES: The purpose of this CR is to inform the fiscal intermediaries and Medicare administrative contractors of the hospital/medical association's initiative on encouraging hospitals to modify their cost reporting practices with respect to costs and charges, in an effort to improve the consistency of the cost-based IPPS DRG relative weights. We agree that it would be beneficial for hospitals to consistently report costs and charges in their appropriate cost centers, and in a manner that is consistent with the way in which charges are grouped in the Medicare Provider and Review (MedPAR).

GENERAL INFORMATION

A. Background: In the FY 2007 Final Rule (71 FR 47882), CMS began to implement significant revisions to Medicare's inpatient hospital rates by basing the relative weights on hospitals' estimated costs rather than on charges. The Medicare Provider and Review (MedPAR) files and the Medicare cost report are the data sources utilized to develop the cost based weights.

Some industry groups have expressed concerns about potential bias in cost weights due to "charge compression," which is the practice of applying a lower percentage markup to higher cost services and a higher percentage markup to lower cost services. There is concern that cost-based weights may undervalue high cost items and overvalue low cost items if a single cost-to-charge ratio (CCR) is applied to items of widely varying costs in the same cost center (e.g., for medical supplies and devices).

CMS commissioned RTI International (RTI) to conduct a study on charge compression. The RTI's draft interim report was posted on the CMS Web site https://cms.hhs.gov/reports/downloads/Dalton.pdf in March 2007. The RTI report made several recommendations, including a short-term recommendation to expand the number of distinct hospital department CCRs from 13 to 19.

In the FY 2008 IPPS proposed rule (72 FR 24712), CMS did not propose to implement RTI's short-term recommendation for FY 2008 to expand the number of national CCRs from 13 to 19, although CMS solicited public comments on this issue. After considering the public comments, CMS added two national CCRs for a total of 15 CCRs.

The comments received on the proposed rule from several hospital and medical associations included recommendations on how the impact of charge compression might be mitigated through improvement in cost reporting by hospitals. A workgroup convened by the American Hospital Association, the Association of American Medical Colleges, and the Federation of American Hospitals found that CMS groupings of hospital charges on MedPAR differ from how hospitals group Medicare charges, total charges, and overall costs on their cost reports. This mismatch between MedPAR charges and cost report CCRs can distort DRG weights. For example, the workgroup found that reporting of chargeable medical supplies costs and charges on the cost report (line 55 of Worksheets C, Part I and D-4) to be a significant problem area because some

hospitals report chargeable medical supply charges and costs in various ancillary departments on the cost reports, but report those charges on the medical supplies revenue code on the claim.

These hospital/medical associations have launched an educational campaign to encourage hospitals to report costs and charges, particularly for supplies, in a way that is consistent with the way that charges are grouped in MedPAR. Their suggestions include that hospitals should adopt an approach of classifying all billable medical supply costs and charges to line 55 of the cost report and mapping the 27X Revenue Summary codes from the Provider Statistical and Reimbursement Report (PS&R) only to line 55.

Therefore, the purpose of this Change Report is to inform the fiscal intermediaries and Medicare administrative contractors of the hospital/medical associations' initiative on encouraging hospitals to modify their cost reporting practices with respect to costs and charges, in an effort to improve the consistency of the cost-based IPPS DRG relative weights. CMS agrees that it would be beneficial for hospitals to consistently report costs and charges in their appropriate cost centers, and in a manner that is consistent with the way in which charges are grouped in MedPAR.

B. Policy: The Provider Reimbursement Manual (PRM), Part I, §2202.4 requires that costs and charges for a given service be matched and placed in the same cost center. Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Furthermore, it states that charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. Transmittal 18 of the hospital cost report will reaffirm this policy through the instruction in §3620 for Worksheet C, on which charge ratios are calculated.

Section 2203 of the PRM I states that in order to assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reporting, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

C. Reporting and Review

Providers may submit cost reports with cost and charges grouped differently than in prior years, so long as the cost and charges are properly matched and Medicare cost reporting instructions are followed. Medicare contractors shall not propose adjustments that regroup costs and charges merely to be consistent with previous year's reporting if the costs and charges are properly grouped on the as-filed cost report. In addition, prior approval from the Medicare contractor is not needed to regroup billable medical supply costs and charges to lines 55 because this is not a change in cost finding methodology. Medicare contractors shall be vigilant to ensure that the costs of items and services are not moved from one cost center to another without moving the corresponding charges. Contractors shall use the applicable desk review thresholds to determine whether a limited or a full desk review needs to be performed on the as-filed cost reports. Contractors shall determine the level of review needed to resolve any material variance noted during the completion of the ADR section of the full desk review. If the contractor suspects that the cost-to-charge ratio reported for any cost center is unreasonable, the contractors can add steps to the limited desk review program to ensure proper matching of cost and charges.

Additional Information
This transmittal can be found on the CMS Web site at
http://www.cms.hhs.gov/transmittals/downloads/R321OTN.pdf.

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

Update to the Common Working File (CWF) to Allow the Posting of Skilled Nursing Facility (SNF) and Swing Bed (SB) Claims to the Beneficiary's Spell of Illness When Qualifying Stay Criteria are Not Met

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: MM5872
Related CR Release Date: February 15, 2008
Related CR Transmittal #: R1450CP
Related Change Request (CR) #:5872
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected

Providers submitting Skilled Nursing Facility (SNF) and Swing Bed (SB) 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

CR 5872 modifies Medicare's Common Working File (CWF) to allow the posting of SNF and SB claims to the beneficiary's spell of illness dates when no prior qualifying stay or readmission exists. Medicare will only update the spell of illness dates for claims that do not meet the qualifying stay criteria. Benefit days will not be deducted from the beneficiary.

Background

SNF providers are required to submit claims to Medicare for beneficiaries who receive a skilled level of care. This includes beneficiaries who do not meet the qualifying stay or transfer criteria. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to update the beneficiary's spell of illness in the CWF. Currently, claims that are denied due to not meeting the prior qualifying stay criteria are not updating the beneficiary's spell of illness in the CWF. Therefore, CR 5872 modifies the CWF to allow these claims to update the beneficiary's spell of illness dates.

Additional Information

The official instruction, CR 5872, issued to your Medicare FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1450CP.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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National Provider Identifier (NPI) and Reason Code 32000

When claims are submitted with only the NPI number, and the provider's NPI applies to various sub-units (e.g., psychiatric unit, rehabilitation unit), the claim may go to the Return to Provider file with reason code 32000. Reason code 32000 will apply when the Fiscal Intermediary Standard System (FISS) is unable to determine the type of claim being submitted. For example, a provider that uses one NPI and submits inpatient hospital and psychiatric claims will receive reason code 32000 because both claims are submitted with the type of bill 11X and FISS is unable to determine whether to process the claim as an inpatient or psychiatric claim.

To correct claims in RTP with reason code 32000, enter your Medicare provider (Oscar/legacy) number in the "Oscar" field on the FISS Claim Page 01. To avoid claims from going to RTP with reason code 32000, report the Oscar/legacy number when you initially submit your claim. Providers may also consider submitting an application with the National Plan and Provider Enumeration System (NPPES) to obtain an individual NPI for each sub-unit.

Provider Contact Center – Availability

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

CSR Training Date	Time
April 11, 2008	9:00 a.m.–11:00 p.m. CT
April 25, 2008	9:00 a.m.–11:00 p.m. CT

Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **April 30, 2008,** for the quarter ending **March 31, 2008**.

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

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

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

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

Or, if sending overnight:

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

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

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

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

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

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

Follow-Up Questions from the February 19, 2008, "FISS 301: The Billing World Series" Webinar

The following questions were received during the February 19, 2008, "FISS 301: The Billing World Series" Webinar. We are publishing the responses so that all providers have access to this information.

Q1: What action should I take to include administration charges on influenza immunization claims, which were submitted without them?

A1: The claims will need to be adjusted to add this information. If the claims were submitted using a roster bill, you will still need to adjust each individual claim to add these charges on claim page 02. Information for adjusting claims using FISS can be found in the "Claims Corrections Menu" section of the *FISS Reference Guide*.

Q2: How do we reflect multiple liability records (value code 47) listed for the beneficiary on Medicare claims?

A2: If all records are liability (value code 47), where someone else is liable for the beneficiary's injuries or are for the beneficiary's own uninsured or underinsured motorist coverage, select one record to report on claim pages 03, 05 and 06. The information regarding the remaining records should be entered in "Remarks" on claim page 04.

Q3: Where can I find a listing of the relationship codes entered on claim page 05?

A3: Access the Medicare Claims Processing Manual (Pub. 100-04, Ch. 25, §75.51) for a listing of these codes. Cahaba GBA's "Medicare Secondary Payer (MSP) Billing" quick reference tool provides this information on page 8.

Q4: Where can we find more information about adjusting claims that rejected because we were unaware of an MSP record?

A4: The Cahaba "Medicare Secondary Payer Adjustments" Web page provides information about submitting an adjustment when your claim was paid or denied because of an MSP record.

Q5: How do we report that the insurer applied payment to the beneficiary's deductible for a working aged record?

A5: To report this situation to Medicare using FISS, on claim page 01, enter:

- Occurrence code 24 with the date of the EOB where the primary insurance applied the amount to the deductible;
- Value code 12 with the dollar amount of $0.00.

On claim page 03, enter the insurer as primary using a payer code "C", and also include the name of the worked aged insurance on line A of the "Payer" field (FL 50). Enter other data elements on claim pages 05 and 06 as required by conditional MSP payment request. You will also need to add "Remarks" on claim page 04 indicating the primary insurer applied the full allowance to the deductible.

Q6: How do we report that the Explanation of Benefits (EOB) received from a working aged insurer reflected that the services weren't covered?

A6: To indicate this situation using FISS, on claim page 01, enter:

- Occurrence code 24 with the date of the EOB where the services were not covered;
- Value code 12 with the amount of $0.00 to reflect no payment was received.

Q7: If the MSP record is more than 10 years old, is it still valid?

A7: Determining the validity of MSP records is the responsibility of the Coordination of Benefits Contractor (COBC). Cahaba cautions providers that open MSP records posted to the beneficiary's eligibility file will impact claims that are submitted by providers for Medicare payment. Therefore, providers are encouraged to work with Medicare beneficiaries and the COBC when they become aware of MSP records that may no longer be valid. Please access the CMS "Contacting the COB Contractor" Web page for more information.

Q8: How should we submit information to Medicare for a liability Medicare Secondary Payer (MSP) situation if the "holder" of the insurance is a business and not an individual?

A8: If a liability insurance is not tied to an individual, the Medicare claim should be submitted using the business name that's on record. In addition, we encourage providers to ensure that the "Remarks" entered on claim page 04 reflect the MSP record is tied to the business and not an individual.

April 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.