Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC

May 1, 2008 **Vol. 15, No. 8**

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.

The Inside Story

News From CMS

- News Flash Messages from CMS…………………….. 3
- Psychological and Neuropsychological Tests Revised……………………………………………… 5
- Laboratory Competitive Bidding Demonstration…… 9
- Billing for the Oral Three Drug Combination Anti-Emetic (Aprepitant)- Revised.................................... 14
- Update to Audiology Policies.……….......................... 17
- Reporting a NPI for Ordering, Referring, Attending, Operating, Other, Service Facility for Medicare Claims- Revised…... 21
- Emergency Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB)............................ 23
- Processing of Drug Claims with the JW Modifier.…. 24
- Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update….. 25
- April 2008 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer Change…. 27
- April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications- Version 9.1…………….…. 30
- Zip Codes Requiring A Plus-Four Zip Code Extension…………………………………………… 32
- April 2008 Medicare Physician Fee Schedule Database (MPFSDB)- Update……………………… 34
- April 2008 Average Sales Price (ASP) Update…….. 38
- Long Term Care Hospital Prospective Payment System (LTCH PPS) Pricer Based on the SCHIP Extension Act of 2007 Changes…………………….. 42
- Skilled Nursing Facility (SNF) Inpatient Part A Billing for No-Payment and Medicare Advantage (MA) Claims………………………………………… 44

News From Cahaba GBA

- Schedule of Upcoming Events……………………..... 46
- Provider Contact Center Training Schedule…............ 46
- Provider Outreach & Education Advisory Group…... 47

Cahaba GBA Learning Corner……………........….. 48

Provider Contact Center Hours

The Medicare Part A Provider Contact Center may be reached Monday through Friday between the hours of 8:00 a.m. – 5.00 p.m. CST.

- 1-866-539-5598

The Interactive Voice Response (IVR) System is available from 6:00 a.m. - 11:00 p.m. Monday through Friday and can be accessed Saturdays from 6:00 a.m. - 6:00 p.m.

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

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

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Hospital Outpatient Prospective Payment System Fact Sheet

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

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.

Get the Flu Shot

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

Skilled Nursing Facility Consolidated Billing Web-Based Training Course

The Skilled Nursing Facility Consolidated Billing Web-Based Training Course (October 2007) can now be accessed at the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.hhs.gov/MLNGenInfo/ by scrolling down to "Related Links Inside CMS and selecting "Web Based Training (WBT) Modules." The course includes general information about Skilled Nursing Facilities (SNFs), SNF Consolidated Billing, and "under arrangement" agreements between Skilled Nursing Facilities and other providers or suppliers.

Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf or to order hard copies, please visit the MLN Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 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.)

Psychological and Neuropsychological Tests-Revised

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

MLN Matters Number: MM5204-Revised	**Related Change Request (CR) #:** 5204
Related CR Release Date: February 29, 2008	**Effective Date:** January 1, 2006
Related CR Transmittal #: R85BP	**Implementation Date:** December 28, 2006

Note: This article was revised on March 3, 3008, to reflect a revision made to CR 5204. The article was changed to correct a reference in the first paragraph of the Background section to section 1861 (s)(2)(c) of the Social Security Act . The correct section number is 1861 (s)(3). Also, the CR release date, transmittal number, and Web address for accessing CR 5204 were changed. All other information remains the same.

Provider Types Affected

Providers who bill Medicare carriers or Fiscal Intermediaries (FIs) for the provision of diagnostic psychological and neuropsychological tests.

Provider Action Needed

Effective January 1, 2006, carriers and FIs will pay (under the Medicare physician fee schedule (MPFS) database) for diagnostic psychological and neuropsychological tests that are within the CPT code range of 96101 through 96120.

What You Need to Know

The CMS announces the revision of the CPT codes for psychological and neuropsychological tests (codes 96101 through 96120) to include tests performed by technicians and computers (CPT codes 96102, 96103, 96119 and 96120) in addition to those performed by physicians, clinical psychologists, independently practicing psychologists and other qualified non-physician practitioners (as described in the 'Background' section below).

What You Need to Do

Make sure that your billing staffs are aware of the CPT code changes.

Background

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(3) of the Social Security Act, and payment for these tests is authorized under section 1842(b)(2)(A) of the Social Security Act.

The CPT codes for these tests are included in the range of codes from 96101 to 96120. The appropriate codes when billing for psychological tests are: 96101, 96102, 96103, 96105, 96110, and 9611; and when billing for neuropsychological tests are: 96116, 96118, 96119 and 96120. All of the tests under this CPT code range 96101-96120 are covered and indicated as active codes under the MPFS database.

More specifically, CR 5204, from which this article is taken, provides that (effective January 1, 2006) the CPT codes for psychological and neuropsychological tests include tests performed by technicians and computers (CPT codes 96102, 96103, 96119 and 96120) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified non-physician practitioners.

These changes, made in accordance with the final physician fee schedule regulation, were published in the Federal Register on November 21, 2005, at 70 FR 70279 and 70280 under Table 29 (AMA, Relative Value Update Committee (RUC) and Health Care Professional Advisory Committee (HCPAC) Recommendations and CMS Decisions for New and Revised 2006 CPT Codes).

You should be aware of some supervision requirements for diagnostic psychological and neuropsychological tests. First, under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision allow only physicians to provide the assigned level of supervision for such tests; however, for diagnostic psychological and neuropsychological tests, there is a regulatory exception that allows either a clinical psychologist (CP) or a physician to perform the assigned general supervision.

Moreover, non-physician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision requirements of the diagnostic psychological and neuropsychological tests benefit, that is, under the general supervision of a physician or a CP.

In fact, rather than providing them under the requirements for diagnostic psychological and neuropsychological tests, NPs and CNSs must perform such tests under the requirements of their respective benefit. Therefore, NPs and CNSs must perform them in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. Likewise, PAs must perform these tests under the general supervision of a physician as required for services furnished under the PA benefit.

To continue, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes (96105, 96110, and 96111) as “sometimes therapy” codes. However, when PTs, OTs and SLPs perform these three tests, they must do so under the general supervision of a physician or a CP.

You should also note that expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, which is the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Social Security Act. Further, the payment amounts that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings.

Remember that CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. And although Independently Practicing Psychologists (IPPs) are not required to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests. (An IPP is any psychologist who is licensed (or certified) to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. Examples of psychologists (other than CPs) whose psychological and neuropsychological tests are covered under the diagnostic tests provision

include, but are not limited to, educational psychologists and counseling psychologists.) Additionally, there is no authorization under Medicare law for payment for diagnostic tests when performed on an "incident to" basis.

Following is a summary of who may bill for diagnostic psychological and neuropsychological tests, and references for the review of qualifications, when appropriate.

Providers that May Bill for Diagnostic Psychological and Neuropsychological Tests

CPs	See qualifications under Chapter 15, section 160 of the *Medicare Benefits Policy Manual*.
NPs- –to the extent authorized under State scope of practice.	See qualifications under Chapter 15, section 200 of the *Medicare Benefits Policy Manual*.
CNSs –to the extent authorized under State scope of practice.	See qualifications under Chapter 15, section 210 of the *Medicare Benefits Policy Manual*.
PAs – to the extent authorized under State scope of practice	See qualifications under Chapter 15, section 190 of the *Medicare Benefits Policy Manual.*
Independently Practicing Psychologists (IPPs)	
PTs, OTs and SLPs	See qualifications under Chapter 15, sections 220-230.6 of the *Medicare Benefits Policy Manual.*

The Medicare Benefits Policy Manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS Web site.

Here are some other important things that you should know.

- The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Therefore, CPT psychological test code 96101 will not be paid if you include it in the bill for the same tests or services performed under psychological test codes 96102 or 96103.

  Similarly, CPT neuropsychological test code 96118 will not be paid when included in the bill for the same tests or services performed under neuropsychological test codes 96119 or 96120. Note, however, CPT codes 96101 and 96118 can sometimes be paid separately, when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.

- Under the MPFS, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes 96102 and 96119, when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being

administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.

- Fiscal intermediaries will continue to pay claims from providers of outpatient Part B therapy services (including physical therapy, occupational therapy, and speech-language pathology) for CPT codes 96105, 96110 and 96111 with revenue codes and corresponding therapy modifiers (42X with GP, 43X with GO, and 44X with GN, respectively).

- Finally, your carriers and fiscal intermediaries do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims to January 1, 2006; they will adjust claims that you bring to their attention.

Additional Information

You can find more information about Psychological and Neuropsychological Tests by reading CR 5204, located at http://www.cms.hhs.gov/Transmittals/downloads/R85BP.pdf on the CMS Web site. As an attachment to this CR, you will find updated relevant portions of Publication 100.02 (Medicare Benefit Policy Manual), Chapter 15 (Covered Medical and Other Health Services), Section 80.2 (Psychological Tests and Neuropsychological Tests).

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

Disclaimer

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

Laboratory 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: MM5359	**Related Change Request (CR) #:** 5359
Related CR Release Date: March 19, 2008	**Effective Date:** April 1, 2007
Related CR Transmittal #: R57DEMO	**Implementation Date:** April 2, 2007

Note: This article was changed on March 20, 2008, to reflect a change that was made to related CR 5389 on March 19, 2008. The CR was modified to delete a business requirement instructing carriers and A/B MACs deny claims with dates of service between April 1, 2007 and March 31, 2010 inclusive and with modifier "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA. Since that requirement was deleted, language regarding that denial requirement was deleted from the article. The CR release date, transmittal number and Web address for accessing CR 5389 were also changed. All other information remains the same. However, it is important to note that a more current article, MM5772, is now available regarding this demonstration at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5772.pdf on the CMS Web site. Where there is disagreement between this article and related CR 5359 and MM5772 and related CR 5772, the information in CR 5772 is more current and takes precedence over CR 5359.

Provider Types Affected

Physicians and hospitals (TOB 14X only) who bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

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

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and CR 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR 5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.

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

- Physician office laboratory (POL) testing and hospital outpatient testing are not included in the demonstration, except where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.

- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders
Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories
Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs **will not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 by $25,000 or more will be:

- Terminated from the demonstration project; and

- Will 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.

- Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories. Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners
Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Non-Winners
Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "non-winners."

Similarly, required bidders that do not bid will 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.

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 payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests
Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites
There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, 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. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

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

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration (“winners” and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code **96** (non-covered charges);

- Remark code **M114** (This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.); and

- Remark code **N83** (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., “snow birds”) according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R57DEMO.pdf on the CMS Web site.

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

Disclaimer

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Clarification on Billing for the Oral Three Drug Combination Anti-Emetic (Aprepitant)- Revised

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

MLN Matters Number: MM5655 Revised	**Related Change Request (CR) #:** 5655
Related CR Release Date: July 6, 2007	**Effective Date:** April 4, 2005
Related CR Transmittal #: R1281CP	**Implementation Date:** January 7, 2008

Note: This article was revised on March 18, 2008, to add clarifying language in the 'Provider Action Needed' section below and in the 'Background' section.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5655 which clarifies that hospital outpatient departments may bill the entire Tri-Pack of aprepitant, an oral anti-emetic drug given in conjunction w/ two other oral anti-emetic drugs to their FI or A/B MAC as part of a cancer chemotherapeutic regimen that includes the anti-emetic three drug combination.

What You Need to Know

If the 3-drug anti-emetic combination (Aprepitant, a 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron), and Dexamethasone (a cortico-steroid)) is administered to a beneficiary, the hospital may dispense the Tri-Pak of three days of aprepitant in the hospital outpatient setting; the Tri-Pak may then be billed to the FI as 57 units of J8501 (APREPITANT, 5mg, Oral), in addition to the other 2 drugs.

What You Need to Do

See the 'Background' and 'Additional Information' sections of this article for further details regarding this issue.

Background

CMS states that reimbursement will be provided for oral anti-emetic drugs when used as a full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen when the drugs are administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The oral three drug combination is:

- Aprepitant,
- A 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron), and

- Dexamethasone (a cortico-steroid).

Note that oral anti-emetic drug(s) should be prescribed only on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24-hour or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment.

The three drug combination protocol requires the first dose to be administered before, at, or immediately after the time of the anti-cancer chemotherapy administration. The second day, on which only aprepitant is given, is defined as "within 24 hours," and the third day, on which only aprepitant is given, is defined as "within 48 hours" of the chemotherapy administration. These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, critical access hospital, or skilled nursing facility), or through a supplier, such as a pharmacy. (See the revised *Medicare Claims Processing Manual*, Chapter 17, Section 80.2 (Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs which is attached to CR 5655.)

It has come to the attention of CMS that some Medicare contractors are denying payment for the entire Tri-Pak because two doses of the Tri-Pak (for days 2 and 3) are sent home with the beneficiary. This is a misinterpretation of CR 4301 (Billing for Take Home Drugs; http://www.cms.hhs.gov/Transmittals/Downloads/R882CP.pdf) which requires billing drugs that are for take home use only to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

The purpose of CR 5655 is to clarify that hospital outpatient departments may bill the entire Tri-Pack of aprepitant to their FI or A/B MAC as part of the three drug combination oral anti-emetic. If the 3-drug combination is dispensed with a Tri-Pak of aprepitant in a hospital outpatient setting; the entire Tri-Pak may be billed to the FI as 57 units of J8501 (APREPITANT, 5mg, Oral), and all of the drugs in the three drug combination must be billed in the same claim.

This clarification is needed to prevent incorrect denials of claims from hospital outpatient departments for Aprepitant for Chemotherapy-Induced Emesis, as spelled out in the National Coverage Determination (NCD), CR 3831 at http://www.cms.hhs.gov/Transmittals/downloads/R40NCD.pdf on the CMS Web site.

CR 5655 further instructs that:

- Your FI or A/B MAC is to accept claims for 57 units of Aprepitant (J8501) when dispensed to the beneficiary by the hospital in the form of a Tri-Pak;

- Coverage of aprepitant is dependent upon the beneficiary's receipt of a highly emetogenic anti-cancer chemotherapeutic agent;

- For dates of service on or after January 1, 2008, qualifying emetogenic anti-cancer chemotherapeutic agents are:

    - Carmustine, (J9050);

    - Cisplatin, (J9060, J9062);

    - Cyclophosphamide (J9070, J9080, J9091, J9092, J9093, J9094, J9095, J9096, J9097)

- Dacarbazine, (J9130, J9140)
- Mechlorethamine, (J9230)
- Streptozocin, (J9320);
- Doxorunicin, (J9000, J9001); and,
- Epirubicin, (J9178);

- Coverage of Aprepitant is as part of the three drug combination of:
  - Aprepitant (Emend®) (J8501);
  - A 5-HT3 antagnoist, e.g., Granisetron (Q0166), Ondansetron (Q0179), or Dolasetron (Q0180); and,
  - Dexamethasone, a cortico-steroid (J8540).

All of the drugs must be billed on the same claim.

Effective for dates of service April 4, 2005 through December 31, 2007, inclusive, the following HCPCS dispensed by non-OPPS (Outpatient Prospective APayment System) providers qualify the beneficiary to receive the 3 drug combination oral anti-emetic: J9050, J9060, J 9062, J9070, J9080, J9091m J9092, J9093, J9094, J9095, J9096, J9097, J9130, J9140, J9230, J9320, J9000, J9001, and J9178. For the same time period, the following HCPCS dispensed by OPPS provider qualify the beneficiary to receive the 3 drug anti-emetic: J9050, J9060, J9070, J9093, J9130, J9230, J9320, J9000, J9001, and J9178.

Note that CR 5655 instructs your Medicare FI or A/B MAC to adjust denied or partially denied aprepitant (J8501) claims if you bring such claims to the attention of your FI or A/B MAC within 6 months of the implementation date of January 7, 2008. During this period, the timely filing requirements will be bypassed, as needed, to complete the adjustment.

Additional Information

The official instruction, CR 5655, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1281CP.pdf on the CMS Web site. CR 5655 includes some billing examples.

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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Update to Audiology Policies

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: MM5717
Related CR Release Date: February 29, 2008
Related CR Transmittal #: R84BP and R1470CP
Related Change Request (CR) #: 5717
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians, non-physician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare Administrative Contractors (A/B MACs), carriers and Fiscal Intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5717, which alerts affected providers that there are updates to language in the *Medicare Benefit Policy Manual (MBPM)* Chapter 15, sections 80.3 and 230.3 and the *Medicare Claims Processing Manual (MCPM)* Chapter 12, section 30.3. These manual changes highlight coding issues, including auditory implants as auditory prosthetic devices, differentiate the functions of speech-language pathologists and audiologists in aural rehabilitation, and discuss policy related to automated hearing testing.

CR 5717 states that:

- Medicare pays for:
  - Audiological diagnostic tests under the benefit for "other diagnostic tests"; and
  - Audiological evaluations, which include tests of tinnitus, auditory processing and osseointegrated devices.
- Medicare does cover treatment for beneficiaries with disorders of the auditory systems as speech-language pathology services.
- Audiological tests may be ordered for any beneficiary when there is suspicion of impairment of the auditory systems, including tinnitus, auditory processing or balance.
- Audiological tests should not be ordered for the purpose of fitting or modifying a hearing aid.
- Audiological tests **are covered** and payable when performed by qualified audiologists.
- Medicare **does not cover audiological treatment**, including hearing aids.

Background

The sections of the *MBPM* concerning audiological services had not been updated since the manual was last published in 2003. Since that time, there have been requests for clarification of some of the language. You may review the details of these changes by looking at the revised manual sections, which are attached to CR 5717. The *MBPM* Chapter 15 Section 80.3 and Section 230.3 and the *MCPM* Chapter 12 section 30.3 are also attached to CR 5717.

Key Points

The revised *MBPM* Chapter 15 sections 80.3 and 230.3 and the revised *MCPM* Chapter 12 section 30.3 point out that audiologists and speech-language pathologists each furnish separate services to hearing impaired beneficiaries. Osseointegrated auditory implants are prosthetic devices. **Services using automated devices that do not require the skills of an audiologist are not covered services**. The following are the key points for specific requirements listed in the *MBPM* and the *MCPM*.

Under conditions already noted above, Medicare will pay as follows:

- Medicare will pay for appropriately provided audiological diagnostic tests depending on the reason for the test.
- Medicare will pay audiologists for the global service when audiologists perform both the technical and professional components of services that have both components. The most recent Medicare Physician Fee Schedule for pricing and supervision levels for audiology services may be reviewed at http://www.cms.hhs.gov/PFSlookup/01_Overview.asp#TopOfPage on the CMS Web site.
- Medicare will not include diagnostic analysis of implants, (such as cochlear, osseointegrated or brainstem implants, including programming or reprogramming following implantation) in the global fee for the surgery.
- Medicare will pay audiologists for the technical component of audiological tests when they perform only the technical component and a physician or qualified non-physician practitioner provides the professional component of services that have both components.
- Medicare will pay for osseointegrated prosthetic devices under provisions of the applicable payment system. Payment may differ depending upon whether the device is furnished on an inpatient or outpatient basis, by a hospital subject to the outpatient prospective payment system (OPPS), by a Critical Access Hospital (CAH), by a physician's clinic, or by a Federally Qualified Health Center (FQHC).
- Medicare will pay for timed codes 92620 and 92621 when billed for appropriately provided evaluation of auditory processing disorders.
- The timed code 92506 is one of the "always therapy" codes listed in the *MCPM* that must be furnished by a speech-language pathologist under the standards and conditions for speech-language pathology services (See also the *MBPM* Chapter 15, sections 220 & 230). Audiologists may not be paid for these codes.
- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a speech-language pathology benefit when furnished by a speech-language pathologist.

- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a diagnostic test benefit when furnished by an audiologist.

- Medicare will pay for appropriately provided speech-language pathology services after implantation of auditory devices.

- Medicare will pay for appropriately provided services of an audiologist for diagnostic evaluation of cochlear implants. At the time of issuance of CR 5717, the codes for diagnostic analysis of cochlear implants are 92601, 92602, 92603 and 92604.

Medicare will NOT pay for:

- Medicare will not pay for diagnostic evaluation of cochlear implants by speech-language pathologists, or others who are not audiologists, with the exception of physicians and non-physician practitioners who may personally provide the services that are within their scope of practice.

- Medicare will not pay for services documented as audiological services when they have been furnished through the use of computers that do not require the skills of an audiologist.

- Medicare will not pay audiologists for treatment services.

- Medicare will not pay for diagnostic audiological tests provided by technicians unless the order specifies each test individually. Note that technicians must meet qualifications determined by the Medicare contractor being billed, which will include, at a minimum, qualification requirements of state and/or local law and successful conclusion of a curriculum including both classroom training and supervised clinical experience administering the audiological service. (However, when the tests are done by an audiologist and the orders do not name specific tests, the audiologist may select the appropriate battery of tests.)

- Medicare will not pay for services that require the skills of an audiologist when furnished by an AuD 4th year student who is not qualified according to section 1861(ll)(3) of the Act.

- Medicare will not pay for audiological services incident to the service of a physician or non-physician practitioner.

- Medicare will not pay for the technical component of audiological diagnostic tests performed by a qualified technician unless the medical record contains the name and professional identity of the technician who actually performed the service and the physician or non-physician supervisor who provides the direct supervision has documented the clinical decision making and active participation in delivery of the service.

- Medicare will not pay for computer-controlled hearing tests that are screening tests, which do not require the skilled services of an audiologist and are not covered or payable using codes for diagnostic audiological testing. Examples include, but are not limited to, otograms and pure tone or immitance screening devices that do not require the skills of an audiologist.

Additional Information

There are actually two transmittals issued to your Medicare contractor for CR 5717. The first contains changes to the *MCPM* and is available at http://www.cms.hhs.gov/Transmittals/downloads/R1470CP.pdf on

the CMS Web site. The second has the changes to the *MBPM* and is available at http://www.cms.hhs.gov/Transmittals/downloads/R84BP.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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Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims- Revised

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

MLN Matters Number: MM5890 Revised	**Related Change Request (CR) #:** 5890
Related CR Release Date: January 18, 2008	**Effective Date:** May 23, 2008
Related CR Transmittal #: R235PI	**Implementation Date:** April 7, 2008

Note: This article was revised on March 5, 2008, to remove the parenthetical phrase of "MD and DO" from the note box on page 3. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

What You Need to Know

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

What You Need to Do

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

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The National Provider Identifier (NPI) final rule (45 CFR Part 162, CMS-045-F), published on January 23,

2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

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

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

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

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

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

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

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

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

The Social Security Act (§ 1848(c)(4) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services. Previously, payment files were issued to Medicare contractors based upon the November 1, 2007, Medicare Physician Fee Schedule Final Rule.

CR 5902 amends those payment files.

In summary, CR 5902 instructs your Medicare contractor to:

- Manually update their systems to reflect 5 base units for Current Procedural Terminology (CPT) code 01916; and

- Manually update their Healthcare Common Procedure Coding System (HCPCS) file to include the laboratory certification code (LC) 400 for CPT code 89060 on or after January 1, 2008.

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

Additional Information

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

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

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Additional Clarification to Chapter 17, Section 40, Regarding Processing of Drug Claims with the JW Modifier

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: MM5923	**Related Change Request (CR) #:** 5923
Related CR Release Date: February 5, 2008	**Effective Date:** January 1, 2008
Related CR Transmittal #: R1435CP	**Implementation Date:** January 7, 2008

Provider Types Affected

Physicians, providers and suppliers billing Medicare Contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for drugs or biologicals provided to Medicare beneficiaries.

Impact on Providers

When processing all drugs except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals, Medicare contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This modifier will provide payment for the discarded drug or biological.

Background

The Centers for Medicare & Medicaid Services (CMS) issued this CR 5923 to notify providers of the *Medicare Claims Processing Manual* update that clarifies the use of the JW modifier when processing all drugs except CAP drugs.

Additional Information

To see the official instruction (CR 5923) issued to your Medicare Carrier, DME/MAC, FI and/or A/B MAC, visit http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.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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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

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

MLN Matters Number: MM5942
Related CR Release Date: March 7, 2008
Related CR Transmittal #: R1475CP
Related Change Request (CR) #: 5942
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

CR 5942, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at http://www.wpc-edi.com/Codes. The Remittance Advice Remark Code Changes summarize the latest changes to these lists, as announced in CR 5942.

CMS has also developed a new tool to help you search for a specific category of code and that tool is available at http://www.cmsremarkcodes.info. Note that this web site does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR 5942) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf on the CMS Web site.

For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.

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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April 2008 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer Changes

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

MLN Matters Number: MM5965	**Related Change Request (CR) #:** 5965
Related CR Release Date: March 14, 2008	**Effective Date:** April 1, 2008
Related CR Transmittal #: R1479CP	**Implementation Date:** April 7, 2008

Provider Types Affected

Inpatient rehabilitation facilities (IRFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5965 which instructs Medicare contractors to install the April Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer.

What You Need to Know

CR 5965 updates the Fiscal Year 2008 (FY08) standard payment conversion factor from $13,451 to $13,034, effective for discharges on or after April 1, 2008, and it adds the default Case Mix Group (CMG) of A9999 as a valid CMG to allow "informational only" claims for Medicare Advantage (MA) patients to be processed, effective for discharges on or after October 1, 2006.

What You Need to Do

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

Background

The purpose of CR 5965 is to:

- Update the standard payment conversion factor per the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (Section 115), and

- Provide hospitals with a mechanism to submit "informational only" bills to Medicare for Medicare Advantage (MA) patients.

The following background is provided regarding these issues:

<u>Fiscal Year 2008 Standard Payment Conversion Factor (Effective October 1, 2007)</u>

On August 24, 2007, the Centers for Medicare & Medicaid Services (CMS) issued CR 5694 to outline the prospective payment rates applicable for Inpatient Rehabilitation Facilities (IRFs), effective for Fiscal Year

(FY) 2008. CR 5694 also instructed the standard system maintainer to install the new IRF Prospective Payment System (PPS) Pricer that contained updated FY 2008 rates, which set the standard payment conversion factor (also known as the standard Federal rate) at $13,451. You can review the MLN Matters article related to CR 5694 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5694.pdf on the CMS website.

"Informational Only" Billing for Medicare Advantage (MA) Patients (Effective October 1, 2006)
On July 20, 2007, CMS issued CR 5647 to require hospitals to submit "informational only" bills to their Medicare contractor for the MA patients they treat, in order for the days to be eventually captured in the Disproportionate Share Hospital (DSH) (or low income patient (LIP) for IRF) calculations. You can review the MLN Matters article related to CR 5647 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5647.pdf on the CMS website.

Standard Payment Conversion Factor Update
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 115) amended the Social Security Act (Section 1886(j)(3)(C)) to apply a 0.0 percent increase to payment rates for IRFs for part of FY 2008. You can find Section 1886(j)(3)(C) of the Social Security Act at http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the internet.

Note that the new rates will become effective for discharges occurring on or after April 1, 2008, and will apply to the last two quarters of FY 2008 (from April 1, 2008 through September 30, 2008).

Payment rates for the first two quarters of FY 2008 (from October 1, 2007 through March 31, 2008) will continue to be based on the 3.2 percent market basket increase that was implemented in the FY 2008 IRF PPS final rule (72 FR 44284). You can review 72 FR 44284 at http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf on the internet.

Effective April 1, 2008, the new IRF standard payment conversion factor will be $13,034. Applying this new standard payment conversion factor to the case-mix group relative weights published in the FY 2008 IRF PPS final rule (72 FR 44284, 44293 through 44297) results in the new IRF payment rates listed at: http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage on the CMS website. You can review 72 FR 44284 and 72 FR 44293 through 44297 at http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf on the internet.

Informational Only" Billing for MA Patients
For IRF "informational only" claims (Type of Bill 111 with a condition code 04) for MA patients with discharges on or after October 1, 2006, CMS is instructing IRFs to submit a default Case Mix Group (CMG) code of A9999.

Note: Prior to the implementation of this CR 5965, CMS has been instructing IRFs, on a case-by-case basis, to use any CMG until a default Health Insurance Prospective Payment System (HIPPS) code could be considered a valid CMG in the IRF Pricer software.

In summary, CR 5965 instructs your Medicare contractor to:

- Update the FY 08 standard payment conversion factor from $13,451 to $13,034, effective for discharges on or after April 1, 2008; and

- Add the default CMG of A9999 as a valid CMG to allow “informational only” claims for MA patients to be processed, effective for discharges on or after October 1, 2006.

In addition, CR 5965 instructs your Medicare contractor to install and pay IRF claims with the April 2008 IRF PPS Pricer.

Additional Information

The official instruction, CR 5965, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1479CP.pdf on the CMS website.

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April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1

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: MM5969
Related CR Release Date: March 25, 2008
Related CR Transmittal #: R1483CP

Related Change Request (CR) #: 5969
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 5969 and notifies providers that I/OCE Specifications Version 9.1, is effective April 1, 2008. Claims with dates of service prior to July 1, 2007 are routed through the non-integrated versions of the Outpatient Code Editor (OCE) software that coincide with the versions in effect for the date of service on the claim.

Background

This article is based on CR 5969 and informs providers that the I/OCE routes all institutional outpatient claims (including non-outpatient prospective payment system hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. This integration does not change the current logic that is applied to outpatient bill types that already pass through the Outpatient Prospective Payment System (OPPS) OCE software. It expands the software usage to include non-OPPS hospitals. The full specifications for the I/OCE as well as detailed lists of the APC (Ambulatory Payment Classifications), HCPCS (health care common procedure coding systems), CPT (Current Procedural Terminology) code changes, additions, and deletions are attached to CR 5969. The Web address for accessing CR 5969 is in the 'Additional Information' section of this article. Thus, we will not repeat all of those changes in this article. However, the key changes in the Version 9.1 of I/OCE are as follows:

Effective Date	Edit	Description of Change
04/01/2008	24	Modify the software to maintain/retain 28 prior quarters (7 years) of programs & codes in each release. Remove older versions with each release. (The earliest version date included in the April 2008 release will be 01/01/2001).
04/01/2008		Modify appendix D of I/OCE Specifications (attached to CR5969) to exempt codes with SI of "S" and "X" from the conditional bilateral discounting.

01/01/2008		Change HCPCS APC to "0" in the APC/ASC Return Buffer for all PH services on PHP claims.
04/01/2002		Add code 29086 to the list of cast procedures (code list for Antigens, splints & Casts)
01/01/2008		Modify/correct list of codes identified as partial hospitalization services for PHP claims
01/01/2008		Bypass edit 48 for rev code 0637. Assign edit 50 when submitted without a HCPCS code. Apply to OPPS & Non-OPPS claims.
		Make HCPCS/APC/SI changes as specified by CMS
	19, 20, 39, 40	Implement version 14.0 of the NCCI (National Correct Coding Initiative) file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
01/01/2007	22	Add new (genetic testing) modifier (8C) to the valid modifier list.
		Modify description of PHP code lists in appendix C - to include all PH services in list B, and make list A a subset of list B.
01/01/2008	78	Update nuclear medicine/radiopharmaceutical edit requirements.
01/01/2008	71	Update procedure/device edit requirements.
01/01/2008		Remove ASC procedure list – no longer needed to identify claims to be processed as 83X TOB.
		Added explanatory paragraphs, re antigens/splints/casts & CCI editing to the specifications document. Add appendix N, for requested code listings.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5969) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1483CP.pdf on the CMS Web site. To review the Outpatient Code Editor (OCE) web site you may refer to: http://www.cms.hhs.gov/OutpatientCodeEdit/ 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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Web site for Additions and Deletions of ZIP Codes Requiring a Plus Four ZIP Code Extension

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: MM5970	**Related Change Request (CR) #:** 5970
Related CR Release Date: March 21 2008	**Effective Date:** April 21, 2008
Related CR Transmittal #: R1480CP	**Implementation Date:** April 21, 2008

Provider Types Affected

Physicians, providers, and other health care providers submitting claims to Medicare Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs) or Regional Home Health Intermediaries (RHHIs) for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services.

Provider Action Needed

The ZIP code where services are rendered determines the payment locality for services paid under the MPFS and for anesthesia services. Certain ZIP codes fall into more than one payment locality and require a plus four ZIP code extension to ensure proper payment. (See the MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf on the CMS Web site for further details regarding ZIP code reporting.)

What You Need to Know

The CMS will begin posting additions and deletions to the list of ZIP codes that require a plus four ZIP code extension on their website. A complete list of all ZIP codes requiring a plus four ZIP code extension will also be posted.

What You Need to Do

Make certain your billing staffs are aware of these resources for checking plus four ZIP code extension requirements.

Key Points of CR 5970

- To access a file containing the quarterly additions and deletions to the list of ZIP Codes requiring a plus four extension refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Web site. The file is named “ZIP Code Changes” and can be found in the Downloads section of this web page.

- To access a file containing all ZIP Codes requiring a plus four extension, refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Web site. The file is named “ZIP Codes Requiring +4 Ext” and can be found in the Downloads section of this web page.

- Upon release of a new quarterly update, the previous quarter's additions and deletions are incorporated into the file name "ZIP Codes Requiring +4 Ext" file and are not included in the "ZIP Code Changes" file.

Additional Information

To see the official instruction (CR 5970) issued to your Medicare FI, carrier, A/B MAC or RHHI refer to http://www.cms.hhs.gov/Transmittals/downloads/R1480CP.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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April Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB)

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

MLN Matters Number: MM5980
Related CR Release Date: March 21 2008
Related CR Transmittal #: R1482CP
Related Change Request (CR) #: 5980
Effective Date: January 1, 2008
Implementation Date: April 7, 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 professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 5980 which amends payment files previously issued to Medicare contractors based upon the 2008 Medicare Physician Fee Schedule Final Rule. CR 5980 also includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

Background

Attachment 1 of CR 5980 contains changes included in the April Update to the 2008 MPFSDB, and CR 5980 can be reviewed at http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf on the CMS Web site. Specific changes are detailed in Attachment 1 of CR 5980 and are summarized as follows:

CPT/HCPCS Code Revisions

A number of CPT/HCPCS codes have been modified to reflect revised bilateral indicators, Relative Value Unit (RVU) revisions, or procedure status changes retroactive to January 1, 2008.

Reinstated "J" Codes

A number of "J" Codes (J7611 through J7614) are reinstated with a status indicator of "E" and the reinstated codes are effective for dates of service on or after April 1, 2008. Descriptors and payment indicators for the reinstated codes are in attachment 1 of CR 5980.

New "Q" Codes

There are several new "Q" codes (Q4096 through Q4098) with a status indicator of "E" and which are effective for dates of service on or after April 1, 2008. The codes with their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
Q4096	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF:RCO	VWF complex, not Humate-P
Q4097	Injection, Immune Globulin (Privigen), Intravenous, Non-Lyophilized (E.G., Liquid), 500 mg	Inj IVIG Privigen 500 mg

Q4098	Injection, Iron Dextran, 50 mg	Inj iron dextran
Q4099	Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms	Formoterol fumarate, inh

New Category II Codes for PQRI

There are new Category II codes for the PQRI for dates of service on or after April 1, 2008. These new codes and their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
0525F	Initial visit for episode	Initial visit for episode
0526F	Subsequent visit for episode	Subs visit for episode
1130F	Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of "red flags" (warning signs) AND assessment of prior treatment and response, AND employment status	Bk pain + fxn assessed
1134F	Episode of back pain lasting six weeks or less	Epsd bk pain for =< 6 wks
1135F	Episode of back pain lasting longer than six weeks	Epsd bk pain for > 6 wks
1136F	Episode of back pain lasting 12 weeks or less	Epsd bk pain for <= 12 wks
1137F	Episode of back pain lasting longer than 12 weeks	Epsd bk pain for > 12 wks
2040F	Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications	Bk pn xm on init visit date
2044F	Documentation of mental health assessment prior to intervention (back surgery or epidural steroid injection) or for back pain episode lasting longer than six weeks	Doc mntl tst b/4 bk trxmnt
3330F	Imaging study ordered	Imaging study ordered (bkp)
3331F	Imaging study not ordered	Bk imaging tst not ordered
3340F	Mammogram assessment category of "incomplete: need additional imaging evaluation", documented	Mammo assess inc xray docd
3341F	Mammogram assessment category of "negative", documented	Mammo assess negative docd
3342F	Mammogram assessment category of "benign", documented	Mammo assess bengn docd
3343F	Mammogram assessment category of "probably benign", documented	Mammo probably bengn docd
3344F	Mammogram assessment category of "suspicious", documented	Mammo assess susp docd
3345F	Mammogram assessment category of "highly suggestive of malignancy", documented	Mammo assess hghlymalig doc
3350F	Mammogram assessment category of "known biopsy proven malignancy", documented	Mammo bx proven malig docd
4240F	Instruction in therapeutic exercise with follow-up by the physician provided to patients during	Instr xrcz 4bk pn >12 weeks

	episode of back pain lasting longer than 12 weeks	
4242F	Counseling for supervised exercise program provided to patients during episode of back pain lasting longer than 12 weeks	Sprvsd xrcz bk pn >12 weeks
4245F	Patient counseled during the initial visit to maintain or resume normal activities	Pt instr nrml lifest
4248F	Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer	Pt instr–no bd rest>= 4 days
4250F	Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	Wrmng 4 surg – normothermia
5060F	Findings from diagnostic mammogram communicated to practice managing patient's on-going care within 3 business days of exam interpretation	Fndngs mammo 2pt w/in 3 days
5062F	Findings from diagnostic mammogram communicated to the patient within 5 days of exam interpretation	Doc f2fmammo fndng in 3 days
6040F	Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented	Appro rad ds dvcs techs docd
6045F	Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented	Radxps in end rprt4fluro pxd
7020F	Mammogram assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] entered into an internal database to allow for analysis of abnormal interpretation (recall) rate	Mammo assess cat in dbase
7025F	Patient information entered into a reminder system with a target due date for the next mammogram	Pt infosys alarm 4 nxt mammo

Revised Descriptors for PQRI Codes

Attachment 1 of CR 5980 also contains a list of editorial changes to the short and/or long descriptors for a number of PQRI codes.

Additional Information

The official instruction, CR 5980, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf on the CMS Web site.

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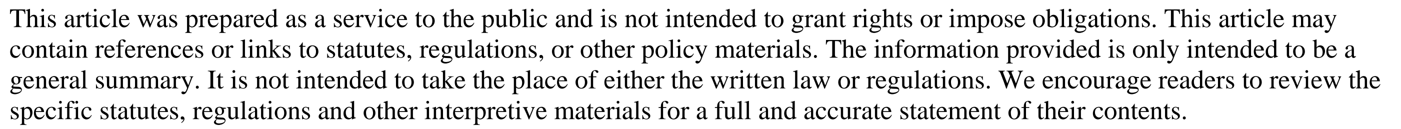

April 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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

MLN Matters Number: MM5982
Related CR Release Date: March 26 2008
Related CR Transmittal #: R1484CP
Related Change Request (CR) #: 5982
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by the CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all End-Stage Renal Disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to CMS. CMS then provides the quarterly data to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA; and,
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or,
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "Not Otherwise Classified, (NOC)" HCPCS codes.

ASP Methodology

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

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

- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits will not be updated in 2008**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.**

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

  On or after March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR 5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007

April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional Information

To see the official instruction (CR 5982) issued to your Medicare contractor visit http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.pdf on the CMS Web site.

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Changes to the Long Term Care Hospital Prospective Payment System (LTCH PPS) Pricer based on the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007

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: MM5955
Related CR Release Date: March 7, 2008
Related CR Transmittal #: R1474CP

Related Change Request (CR) #: 5955
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on CR 5955 which instructs that effective for discharges occurring on or after April 1, 2008, through June 30, 2008, the Federal rate for rate year (RY) 2008 will be $38,086.04, and the revised high cost outlier fixed-loss amount is $20,707.

Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted on December 29, 2007:

- Postponed implementation of a portion of the Short Stay Outlier (SSO) payment adjustment formula effective upon enactment for a period of 3 years, and

- Revised the Federal rate for RY 2008 by providing that the base (that is, Federal) rate for RY 2008 be the same as the base rate for discharges for the hospital occurring during the Rate year ending in 2007 (applicable to discharges occurring on or after April 1, 2008).

Note that CMS made the change to the SSO policy immediately, and the updated Long Term Care Hospital (LTCH) Pricer was in production within the Medicare claims processing system on January 28, 2008. In addition, Medicare contractors were instructed to reprocess SSO claims within 60 days.

The Federal rate for RY 2007 was $38,086.04. Consequently, the Federal rate for RY 2008 will also be $38,086.04 (effective for discharges occurring on or after April 1, 2008 and on or before June 30, 2008).

In order to maintain estimated total payments for high cost outlier cases at 8 percent of the estimated total payments, the revised high cost outlier fixed-loss amount is $20,707 (effective for discharges occurring on or after April 1, 2008 and on or before June 30, 2008). This is consistent with the existing regulations at 42 CRF 412.525(a).

Additional Information

The official instruction, CR 5955, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1474CP.pdf on the CMS Web site.

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Manual Updates to Chapter 6, Skilled Nursing Facility (SNF) Inpatient Part A Billing, for No-Payment and Medicare Advantage (MA) Claims

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

MLN Matters Number: MM5840	**Related Change Request (CR) #:** 5840
Related CR Release Date: December 14, 2007	**Effective Date:** October 1, 2006
Related CR Transmittal #: R1394CP	**Implementation Date:** March 17, 2008

Provider Types Affected

Skilled Nursing Facilities (SNFs) that bill Medicare Administrative Contractors (A/B MACs) or Fiscal Intermediaries (FIs) for SNF services provided to Medicare beneficiaries enrolled in traditional Medicare or a Medicare Advantage (MA) plan.

Impact on Providers

This article is informational in nature and meant to clarify existing Medicare policies.

Background

A SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of service but continue to reside in a Medicare-certified area of the facility. CMS maintains a record of all inpatient services whether covered or not to provide input to national healthcare planning and to keep track of the beneficiary's Part A benefit period.

Key Points

This article is based on CR 5840, which provides clarification to Chapter 6 of the *Medicare Claims Processing Manual*, SNF Inpatient Part A Billing. There is no change in policy. The key points clarified by CR 5840 are:

- If a facility has a separate, distinct non-skilled area or wing, then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no-payment bills would not be required. In addition, SNF consolidated billing legislation for therapy services would not apply to these beneficiaries.

- SNF providers are not required to submit no-payment bills for non-skilled beneficiary admissions.

- SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and drop to a non-covered level of care but continue to reside in a Medicare-certified area of the facility.

- Note that providers may bill benefits exhaust and no payment claims using the default HIPPS code of AAA00 in addition to an appropriate room and board revenue code only.

- SNF providers are not required to submit no-payment bills for beneficiaries that are in current Medicare Advantage (MA) plans and no longer require skilled care while still under the plan.

- If a beneficiary no longer requires skilled care under the MA plan, the SNF may discharge the patient using a patient status code of 04. If the beneficiary then requires skilled care again after a period of non-skilled care, the SNF should begin a new admission claim for Medicare to continue the spell of illness.

- When admitting an MA beneficiary, if a SNF is non-participating with the MA plan, the beneficiary must be notified of his or her status because he/she may be private pay in this circumstance, depending upon the type of MA plan in which the beneficiary is enrolled.

- No-payment bills may span both Medicare and the provider's fiscal year end dates.

Additional Information

To see the official instruction, CR 5840, issued to your Medicare FI or A/B MAC, go to http://www.cms.hhs.gov/Transmittals/downloads/R1394CP.pdf on the CMS Web site.

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

Disclaimer

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

Schedule of Upcoming Events
Medicare Part A

Date	Course/Event	Location
Thursday, May 1, 2008	Medicare 101: An Overview of Medicare Part A- Part I	Webinar
Thursday, June 26, 2008	Ask Cahaba A- Topic: May 2008 CERT Report	Teleconference
Tuesday, July 22, 2008	Medicare 101: Completing the UB04 Claim Form- Part II	Webinar
Wednesday, August 6, 2008	Ask Cahaba A- Topic: TBA	Teleconference

Please note: These events are for all Part A providers, except Home Health and Hospice.

For additional details and/or registration regarding any event above, please visit our site at www.cahabagba.com/apps/course_registration/ia/calendar.jsp.

Provider Contact Center Training Schedule

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
May 9, 2008	9:00 a.m.–11:00 p.m. CT
May 16, 2008	9:00 a.m.-11:00 p.m. CT
May 23, 2008	9:00 a.m.–11:00 p.m. CT

May Federal Holiday

In observance of the federal holiday, **Memorial Day, Monday, May 26, 2008**, the Provider Contact Center will not be available. The Fiscal Intermediary Standard System (FISS) will be available and providers can submit claims and receive reports electronically. The Interactive Voice Response (IVR) unit will also be available to providers to check beneficiary eligibility or the status of claims.

Provider Outreach & Education Advisory Group

As part of the contractor requirements mandated by the Centers for Medicare & Medicaid Services (CMS), Cahaba GBA is required to support and maintain a Medicare Part A, Provider Outreach and Education (POE) Advisory Group. Currently, we are in the process of accepting applications for vacant positions.

The primary function of the POE Advisory Group is to assist the Medicare Part A Fiscal Intermediary, Cahaba GBA, in the creation, implementation and review of provider education strategies and efforts. The POE Advisory Group provides input and feedback on training topics, provider/supplier education materials, and dates and location of provider education workshops and events. The POE Advisory Group also identifies provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff.

Contractor Responsibilities

1. Establish, recruit and maintain a POE Advisory Group.
    - Membership will be comprised of representatives of Medicare certified provider and professional organizations representing these certified providers.
    - Membership will be based on the type of care provided.
    - Members will be from different geographic areas, as well as from urban and rural locales.
    - Annual evaluation of group composition and participation.
2. Setup and arrange all meetings (3 or 4 times a year).
3. Handle meeting logistics.
4. Produce and distribute meeting agenda.
5. Document Advisory Group meeting outcomes and post on the Cahaba GBA Web site.
6. Implement educational outreach that results from the recommendations of the advisory groups that is within the contractor's management resources.

POE Advisory Group Members' Responsibilities

1. Attend and participate in a majority of scheduled POE meetings.
2. Identify and bring forth education needs indicated by industry trends and concerns.
3. Identify educational outreach activities to appropriately address concerns.
4. Assist the contractor with planning educational outreach through selection of topics, educational medium, and when appropriate, selection of the outreach site.

The focus of the POE Advisory Group meetings will be centered on the development and implementation of effective provider/supplier communication materials and strategies.

We are seeking individuals to fill vacant seats who are interested in this joint effort to commit to a minimum of one year of service. If you are interested in serving as a member on the POE Advisory Group, please complete the application and return to us within the next 30 days.

Cahaba GBA
Part A Provider Outreach and Education
Post Office Box 11465
Birmingham, Alabama 35202-1465
Or
Fax: (205) 220-0484

Cahaba GBA Learning Corner

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

- **"An Overview of the Medicare Part A Program"** Webinar
  Medicare 101: Part 1 of 2
  Date: May 1, 2008
  Time: 10:00 a.m. - 11:00 a.m. (Central Standard Time)
  Registration Deadline: April 25, 2008
  Intended Audience: Part A providers new to the Medicare program.
  Description: This educational event will provide participants with an overview of the Medicare Part A program and available Medicare Resources. The presentation is tailored to Medicare Part A providers and staff who have less than 25 full-time employees and who are new or have staff new to Medicare billing.

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.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/05/2007 Note: (New Code 11/05/2007)	YES
N431	Service is not covered with this procedure. Start: 11/05/2007 Note: (New Code 11/05/2007)	YES
N432	Adjustment based on a Recovery Audit. Start: 11/05/2007 Note: (New Code 11/05/2007)	YES

Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/05/2007
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who	11/05/2007

	knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/05/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/05/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/05/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/05/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/05/2007
N70	Consolidated billing and payment applies.	11/05/2007
N367	Alert: The claim information has been forwarded to a Consumer Account Fund processor for review.	11/05/2007
N377	Payment based on a processed replacement claim.	11/05/2007
N385	Notification of admission was not timely according to published plan procedures.	11/05/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.)	Deactivated eff. 05/01/2008

Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Medicare Initiated
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes

Code	Modified Narrative	Last Modification Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	04/01/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	04/01/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 | Stop: 05/23/2008 | Last Modified: 09/30/2007	04/01/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	04/01/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or	04/01/2008

	provider. Start: 01/01/1995 | Last Modified: 09/30/2007	
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
56	Procedure/treatment has not been deemed proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last	04/01/2008

	Modified: 09/30/2007	
61	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	04/01/2008

135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	04/01/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	04/01/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	04/01/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	04/01/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	04/01/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	04/01/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	04/01/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	04/01/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	04/01/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	04/01/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	04/01/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	04/01/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	04/01/2008
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	04/01/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	04/01/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last	04/01/2008

	Modified: 09/30/2007	
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	04/01/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	04/01/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	04/01/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	04/01/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	04/01/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008

182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	04/01/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	04/01/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	04/01/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	04/01/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	04/01/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	04/01/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	04/01/2008
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	04/01/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008

B16	New Patient qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	04/01/2008

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	04/01/2008
126	Deductible -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	04/01/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	04/01/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	04/01/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	04/01/2008