

# Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



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



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### Key for Icons:

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

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## **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](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) on the CMS Web site.



## **Clinical Laboratory Fee Schedule Fact Sheet**

The Clinical Laboratory Fee Schedule Fact Sheet, which provides general information about the Clinical Laboratory Fee Schedule, coverage of clinical laboratory services, and how payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at [http://www.cms.hhs.gov/MLNProducts/downloads/clinical\\_lab\\_fee\\_schedule\\_fact\\_sheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf). The Clinical Laboratory Fee Schedule Fact Sheet, is also available in print format. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”



## **Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart**

The revised Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart (January 2008), which provides Medicare claims processing information related to SNF spells of illness, can be accessed at <http://www.cms.hhs.gov/MLNProducts/downloads/SNFspellIllnesschrt.pdf> on the CMS Web site.



## **Newly Redesigned DMEPOS Competitive Bidding Web Page**

This dedicated web page provides one-stop shopping for Medicare providers, suppliers and referral agents who want the most current and reliable information on this new program. Features include links to policy information such as the Metropolitan Statistical Areas and Product Categories included in Round One, Federal regulations, notices and manual instructions, provider educational products and resources, Frequently Asked Questions, and more. You can see the latest announcements and communications sent to the Medicare provider community here as well. The web address is <http://www.cms.hhs.gov/DMEPOSCompetitiveBid>. We encourage you to bookmark this NEW page as we will continue to post new information and resources!



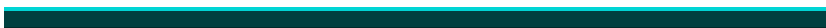
## **Medicare Guide to Rural Health Services Information**

The April 2008 version of the Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians, which contains rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005, is now available in downloadable format from the CMS Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf>.



## **New Program for Purchasing DMEPOS for Medicare Patients**

Effective July 1, 2008, Medicare will begin implementation of a new program for purchasing DMEPOS for Medicare patients. For Medicare beneficiaries whose permanent residence is in 1 of the 10 Metropolitan Statistical Areas (MSAs) affected by the first phase of this program, only contract suppliers, in most instances, will be eligible to provide competitive bid items and receive payment from Medicare. While new payment rules may not impact referral agents directly, they may impact your patients. For more information on this program, please refer to MLN Matters articles located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0805.pdf>, <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0806.pdf>, <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0807.pdf>, or visit the CMS Web site at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/>.





## Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2007 PQRI Feedback Reports will be made available in mid-July on a secure website. More information on how to access 2007 PQRI Participant Feedback Reports will be posted at <http://www.cms.hhs.gov/pqri> on the CMS Web site. CMS will begin testing eleven new quality measures for possible adoption in the PQRI program in future years. To learn more about how you can help CMS test these measures, visit <http://www.cms.hhs.gov/pqri> on the CMS Web site and select the “Measures/Codes” link on the left side of the page. And as a reminder, all educational resources about the 2008 PQRI are available on the dedicated PQRI webpage on the CMS Web site. To access this web page, visit <http://www.cms.hhs.gov/pqri>.



## Heparin Products and Heparin Flush Solutions

Please help the Food and Drug Administration (FDA) spread the word about recalls of injectable heparin products and heparin flush solutions that may be contaminated with oversulfated chondroitin sulfate (OSCS). Affected heparin products have been found in medical care facilities in one state since the recall announcement. Although product recall instructions were widely distributed, they may not have been fully acted upon at all sites where heparin is used. There have been reports of deaths associated with allergic or hypotensive symptoms after heparin administration (see FDA link at [http://www.fda.gov/cder/drug/infopage/heparin/adverse\\_events.htm](http://www.fda.gov/cder/drug/infopage/heparin/adverse_events.htm) on the Internet).



## Medicare Disproportionate Share Hospital Fact Sheet

The April 2008 version of the Medicare Disproportionate Share Hospital Fact Sheet is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at [http://www.cms.hhs.gov/MLNProducts/downloads/2008\\_mdsh.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/2008_mdsh.pdf). This fact sheet provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.





## **Average Sales Price (ASP) Updates**

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:** MM5798

**Related Change Request (CR) #:** 5798

**Related CR Release Date:** May 23, 2008

**Effective Date:** June 23, 2008

**Related CR Transmittal #:** R1513CP

**Implementation Date:** June 23, 2008

## **Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

## **Provider Action Needed**

This article is based on Change Request (CR) 5798 and provides you with updates and additions to language in the *Medicare Claims Processing Manual* relating to the ASP drug pricing and payment methodology. This article is informational to advise providers that the information is now in the Medicare manual and this information has been supplied in prior MLN Matters articles.

## **Key Points**

The Centers for Medicare & Medicaid Services (CMS) provides an ASP file to each FI, carrier, DME MAC, and A/B MAC for pricing drugs. Each FI, carrier, DME MAC, and A/B MAC must accept the ASP files made available by CMS for pricing bills/claims for any drug identified on the price files as these files **are the single national payment limit** established by CMS.

- The payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any earlier publication.

## **ASP Payment Methodology**

- The ASP methodology is based on quarterly data submitted to CMS by manufacturers and the updated and new guidelines established that relate to ASP pricing, payment methodology, and exceptions, are stated in Chapter 17, Section 20 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS Web site.
- The absence or presence of a Healthcare Common Procedure Coding System (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. Your local Medicare contractor processing the claim will make these determinations.

- The vast majority of drugs and biologicals not priced on a cost or prospective payment basis will be priced based on the ASP methodology.
- Pricing for compounded drugs is done by your local contractor.
- End Stage Renal Disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), will be priced based on the ASP methodology.
- 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.
- The payment allowance limits for ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP.
- For the purposes of identifying “single source drugs” and “biological products” subject to payment under Section 1847A, generally CMS (and its contractors) will utilize a multi-step process, in which CMS considers:
  1. The Food & Drug Administration (FDA) approval;
  2. Therapeutic equivalents as determined by the FDA; and
  3. The date of first sale in the United States.
- For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are 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, the payment limit for a biological product or single source drug will be based on the pricing information for products marketed or sold under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment, which may be made operational through use of “not otherwise classified” HCPCS codes.

### **Exceptions to the ASP Payment Methodology**

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a reasonable charge or prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia.
- The 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 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 Not Otherwise Classified (NOC) Pricing File, other than new drugs 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 OPSS 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 the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS Web site, for calculating the AWP, but substitutes WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC.
- Carriers, DME MACs, and A/B MACs will develop payment allowance limits for covered drugs when CMS does not supply the payment allowance limit on the ASP drug pricing 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 Not Otherwise Classified (NOC) Pricing File, are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Carriers will 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. Please refer to Chapter 17, Section 90.2 of the Medicare Claims Processing Manual regarding radiopharmaceuticals furnished in the hospital outpatient department.

### **Additional Information**

You may see the official instruction (CR 5798) issued to your Medicare contractor by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1513CP.pdf> on the CMS Web site. The ASP methodology files are posted at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> 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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## **New Chapter in Medicare Claims Processing Manual for Independent Diagnostic Testing Facilities (IDTF)**

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:** MM5815

**Related Change Request (CR) #:** 5815

**Related CR Release Date:** May 16, 2008

**Effective Date:** June 16, 2008

**Related CR Transmittal #:** R1504CP

**Implementation Date:** June 16, 2008

### **Provider Types Affected**

Independent Diagnostic Testing Facilities (IDTFs) submitting claims to Medicare Administrative Contractors (A/B MACs) Fiscal Intermediaries (FIs) or carriers for services provided to Medicare beneficiaries.

### **Impact on Providers**

Change Request (CR) 5815 alerts providers to the fact that information from the *Medicare Program Integrity Manual*, Chapter 10, **regarding claims processing instructions for IDTF's is being excerpted and added to Medicare Claims Processing Manual via Chapter 35**—a new chapter in the *Medicare Claims Processing Manual*. Currently, the *Medicare Claims Processing Manual* does not have claims processing instructions for IDTFs and this CR notifies providers of the availability of this information in that manual. No changes in policy are conveyed in CR 5815.

### **Key Points of CR 5815**

Providers note that information regarding IDTF claims processing has been excerpted from the *Medicare Program Integrity Manual*, chapter 10, and moved to the *Medicare Claims Processing Manual*, chapter 35, which is a new chapter. The new chapter 35 is available as an attachment to the official instruction of CR 5815. The new chapter contains information on the following:

- General coverage and payment policies applicable to IDTFs;
- Medicare's definition of an IDTF;
- Claims processing instructions with emphasis on:
  - Billing issues;
  - Transtelephonic and electronic monitoring services; and
  - Slide preparation facilities and radiation therapy centers.
- Ordering of tests;
- Purchased diagnostic tests;
- Interpretations of tests performed off the premises of the IDTF; and
- Restrictions that do not allow billing for strictly therapeutic procedures.

**IDTFs are reminded that the National Provider Identifier (NPI) of the ordering physician must be supplied in box 17B of the CMS-1500 form and in the appropriate loop of the ANSI X12 837P electronic claim format, effective for services on or after May 23, 2008.**


**Additional Information**

To see the official instruction (CR 5815) issued to your Medicare Carrier, FI, or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1504CP.pdf> on the CMS Website. As already mentioned, the new Chapter 35 of the *Medicare Claims Processing Manual* is attached to CR5815.

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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## **Phase 1 of Manual Revisions to Reflect Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005- 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:** MM5978-**Revised**      **Related Change Request (CR) #:** 5978  
**Related CR Release Date:** May 9, 2008      **Effective Date:** June 9, 2008  
**Related CR Transmittal #:** R1502CP      **Implementation Date:** June 9, 2008

**Note:** This article was revised on June 12, 2008, to reflect updated information as a result of the release of CR 6119 by the Centers for Medicare & Medicaid Services (CMS). CR 6119 added further sections to the *Medicare Claims Processing Manual* and the MLN Matters article related to CR 6119 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6119.pdf> on the CMS Web site.

This phase includes important information about the processes that suppliers should follow when making their grandfathering decisions prior to July 1, 2008

### **Provider Types Affected**

Medicare DMEPOS suppliers that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) that refer or order DMEPOS for Medicare beneficiaries are affected.

### **What You Need to Know**

CR 5978, from which this article is developed, adds Chapter 36 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) to the *Medicare Claims Processing Manual*.

This chapter manualizes policies and instructions for Medicare Contractors on the DMEPOS Competitive Bidding Program. This first installment provides a general overview and guidance for Medicare Contractors and suppliers on this program.

Subsequent installments will provide additional instructions and guidelines.

This article complements MLN Matters SE0805, SE0806, and SE0807, which already cover many of the sections of Chapter 36 being added to the *Medicare Claims Processing Manual*.

### **Background**

Medicare payment for most DMEPOS is currently based on fee schedules. However, Section 1847 of the Social Security Act (the Act), as amended by Section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates a competitive bidding program to replace

the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

The Centers for Medicare & Medicaid Services (CMS) issued the regulation for the Medicare DMEPOS Competitive Bidding Program (published on April 10, 2007 (72 Federal Register 68 (10 April 2007) pp. 17991-18090)). This regulation is available at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid> on the CMS Web site.

CMS encourages readers of this article to also review MLN Matters article MM 6119, which describes additional sections of Chapter 36 of the *Medicare Claims Processing Manual*. (The article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6119.pdf>). The new sections added via CR 6119 all apply to the competitive bidding program. The topics added include the following:

- Payment for rental of inexpensive or routinely purchased DME;
- Payment for oxygen and oxygen equipment and changing suppliers for oxygen and oxygen equipment;
- Payment for capped rental DME items and changing suppliers for capped rental DME items;
- Payment for purchased equipment and for repair and replacement of beneficiary-owned equipment;
- Payment for enteral nutrition equipment and maintenance and servicing of that equipment;
- Traveling beneficiaries and transfer of title of oxygen equipment or capped rental items for traveling beneficiaries;
- Advance Beneficiary Notice (ABN) information pertaining to upgrades under the competitive bidding program; and
- Billing procedures related to downcoding under the competitive bidding program.

## **Key Information in CR 5978**

### **Contract Supplier Requirements**

Chapter 36 documents contract supplier requirements. For example:

- A contract supplier is required to furnish items under its contract to any Medicare beneficiaries who maintain a permanent residence in or visit the competitive bidding area (CBA).
- Competitively bid items must be provided by a contract supplier unless an exception applies.
- Contract suppliers will be paid for DMEPOS competitively bid items based on bids submitted by qualified DMEPOS suppliers. These payments will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services from qualified suppliers.

- To be considered for participation as a contract supplier in the Medicare DMEPOS Competitive Bidding Program, suppliers must submit a bid for each product category in each CBA that they want to furnish to Medicare beneficiaries. DMEPOS suppliers must submit a bid amount for every item within a product category.

Contract supplier requirements and responsibilities are specified in Chapter 36 and include topics such as: who is eligible to submit bids; small supplier contract suppliers and networks; prescriptions for particular brand, item or mode of delivery; reports; change of ownership; billing privileges, and accreditation. This article will provide detail on some of these provisions, but impacted providers and suppliers should review the official manual revisions contained in CR 5978, as well as in the recently released CR 6119.

### **Noncontract Suppliers That Elect To Become “Grandfathered” Suppliers: Notice to Beneficiaries**

A “**Grandfathered**” supplier means a noncontract supplier that chooses to continue to furnish grandfathered items to a beneficiary in a CBA to whom the supplier had furnished the items prior to implementation of the competitive bidding program.

A noncontract supplier that elects to become a grandfathered supplier is responsible for **notifying all its Medicare customers** residing in CBAs to whom it supplies items identified in Section 20.6.1 of the new manual Chapter 36. This chapter is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1502CP.pdf> on the CMS Web site.

**NOTE: As discussed in the expanded Section 20.6.1 attached to CR 6119**, this notification should only be sent to beneficiaries who the supplier is currently serving and who maintain a permanent residence in a CBA. The list of zip codes for each CBA, the list of the HCPCS for competitively bid items, and the single payment amounts for these items are located in public use files on the CBIC website at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home> or at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/> on the CMS Web site.

The beneficiary notification should include the following:

- It should state that the supplier is offering to continue to furnish rental DME, oxygen and oxygen equipment and/or related accessories and supplies that it is currently furnishing to the beneficiary (i.e., before the start of the competitive bidding program) and to provide these items to the beneficiary for the remainder of the rental period.
- It should state that the supplier is offering to continue to furnish rental DME and/or oxygen and oxygen equipment that it had been furnishing to the beneficiary before the start of the competitive bidding program and to provide these items for the remainder of the rental period.
- It should state that the beneficiary has the choice to continue to receive a grandfathered item from the grandfathered supplier or to elect to begin receiving the item from a contract supplier after the competitive bidding program begins.
- It should provide the supplier’s telephone number so the beneficiary or caregiver may call and notify the supplier of his/her election.
- The supplier should provide the written notification to the beneficiary at least 30 days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

- The supplier should receive an election from a beneficiary and maintain a record as to whether the beneficiary chose to continue to receive the item from a grandfathered supplier, chose to go to a contract supplier to receive the item or did not respond.
- The supplier should inform the beneficiary of the end date of service and that arrangements will be made to pick-up the item within 10 days of picking up the item.

Sample election/notification letters are available at <http://www.dmecompetitivebid.com>.

### **Noncontract Suppliers That Do Not Elect To Become “Grandfathered” Suppliers: Notice to Beneficiaries**

A noncontract supplier that elects not to become a grandfathered supplier as defined above should provide **notification to the beneficiary** stating the supplier will not continue to furnish, after the start of the Medicare DMEPOS Competitive Bidding Program, the competitively bid item(s) that the beneficiary has been receiving from the supplier.

**NOTE: As mentioned in the updated section 20.6.1 attached to CR 6119**, this notification should only be sent to beneficiaries who the supplier is currently serving and who maintain a permanent residence in a CBA. The list of zip codes for each CBA, the list of the HCPCS for competitively bid items, and the single payment amounts for these items are located in public use files on the CBIC Web site at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home> or at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/> on the CMS Web site.

The notification should include the following:

- It should state that the supplier will not continue to furnish rental DME and/or oxygen and oxygen equipment that it had been furnishing to the beneficiary **after** the start of the competitive bidding program and that the beneficiary will need to select a contract supplier to continue to receive these items.
- It should inform the beneficiary of the start of the competitive bidding program and the date the supplier plans to pick up the item.
- It should inform the beneficiary that he/she may obtain further information on the program by calling 1-800-Medicare or accessing <http://www.medicare.gov> on the Internet.
- The supplier should provide this written notification to the beneficiary 30 days before the start date for the Medicare DMEPOS Competitive Bidding Program.
- The supplier should inform the beneficiary of the end date of service and that arrangements will be made to pick-up the item within 10 days of picking up the item.

Sample election/notification letters are available at <http://www.dmecompetitivebid.com>.

## Picking Up Equipment

Under no circumstances may the supplier discontinue services by picking up a medically necessary item(s) prior to the end of a month for which the supplier is eligible to receive a rental payment, even if the last day ends after the start date of the Medicare DMEPOS Competitive Bidding Program. A noncontract supplier may only pick up medically necessary oxygen equipment or capped rental DME prior to the start of the competitive bidding program or prior to the end of the month for which the supplier is eligible to receive payment if the beneficiary relocates his/her permanent residence outside the CBA and outside the normal service area of the supplier.

The pick up by the noncontract supplier and the delivery by the contract supplier of the equipment should occur on the same day and month as the item rental anniversary date. The anniversary date is the day of the month on which the item was first delivered to the beneficiary.

In all cases, CMS expects the contract supplier to consult with the noncontract supplier to obtain the anniversary date. The noncontract supplier should work with the contract supplier so that there is no break in service or furnishing of medically necessary items. CMS expects the contract supplier and the current supplier will work together to make arrangements suitable to the beneficiary's needs.

- **Examples: Using July 1st as the beginning date of the Medicare DMEPOS Competitive Bidding Program:**
  - A. If a beneficiary's last anniversary date before the beginning of the competitive bidding program is **June 29**, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28th. The noncontract supplier must not pick up the equipment prior to July 29th. In this case, the current supplier would pick up its equipment, on July 29th, and the contract supplier would deliver its equipment on July 29th.
  - B. If a beneficiary's anniversary date is **July 1st**, the beginning date for the competitive bidding program, the noncontract supplier must not pick up the equipment before July 1st and must not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1st and must submit a claim for this month.

For capped rental DME or oxygen and oxygen equipment, the noncontract supplier is responsible for submitting a claim for any rental period that begins prior to the start of the competitive bidding program.

## Exceptions

Medicare DME MACS will continue to apply all existing instructions for DMEPOS unless otherwise noted in CR 5978. In general, noncontract suppliers will not be paid for furnishing DMEPOS competitively bid items to beneficiaries in a CBA.

Only a contract supplier is eligible for Medicare payment for competitively bid items furnished to a Medicare beneficiary within a CBA, unless an exception applies. For example:

1. A noncontract supplier that has a valid National Supplier Clearinghouse (NSC) number may receive a Medicare secondary payment for a competitively bid item furnished to a beneficiary residing in a CBA if the beneficiary is required to use that supplier under his/her primary insurance policy.
2. A grandfathered supplier may continue to furnish a grandfathered item to a beneficiary residing in a CBA. Grandfathered items are limited to inexpensive or routinely purchased items furnished on a rental basis; items requiring frequent and substantial servicing; oxygen and oxygen equipment; and capped rental items furnished on a rental basis.
3. A physician, treating practitioner, physical therapist in private practice or occupational therapist in private practice may furnish certain competitively bid items in a CBA if certain requirements are met.

### **Important Note Regarding Rented Enteral Nutrition Infusion Pumps**

The grandfathering option does **NOT** apply to enteral nutrition equipment. In accordance with current instructions in Section 30.7.1 of Chapter 20 of the *Medicare Claims Processing Manual*, payment for rental of enteral infusion pumps is limited to a total of 15 months during a period of medical need. The supplier that collects the last month of rental (i.e., the 15th month) is responsible for ensuring that the beneficiary has a pump for the duration of medical necessity and for maintenance and servicing of the pump during the duration of therapy. Therefore, if a supplier is currently furnishing an enteral nutrition infusion pump to a Medicare beneficiary in a CBA on a rental basis and has not been awarded a contract to furnish enteral nutrients, supplies, and equipment, the supplier must either:

1. Inform the beneficiary if they are in rental months 1 thru 14 that they will need to contact a contract supplier for this product category to arrange for continuation of all of their enteral nutrition services; or
2. Inform the beneficiary if they are beyond rental month 15 that they will continue to furnish and maintain the pump for the duration of medical necessity, but that the beneficiary will need to contact a contract supplier to arrange for continuation of the services of furnishing the enteral nutrients and supplies.

With regard to scenario number 1 above, under no circumstances may the supplier discontinue services by picking up a medically necessary item(s) prior to the end of a month for which the supplier is eligible to receive a rental payment, even if the last day ends after the start date of the Medicare DMEPOS Competitive Bidding Program. The pick up by the noncontract supplier and the delivery by the contract supplier of the equipment should occur on the same day and month as the item rental anniversary date. The anniversary date is the day of the month on which the item was first delivered to the beneficiary. In all cases, CMS expects the contract supplier to consult with the noncontract supplier to obtain the anniversary date.

With regard to both scenarios above, the noncontract supplier should work with the contract supplier so that there is no break in service or furnishing of medically necessary nutrients, supplies, and equipment. CMS expects the contract supplier and the current supplier will work together to make arrangements suitable to the beneficiary's needs.

### **Payment**

- The Medicare payment amount for competitively bid items is based on the CBA in which the beneficiary maintains a permanent residence.

- Medicare will make payment for competitively bid items on an assignment-related basis equal to 80% of the applicable single payment amount.

### **Prescription for Particular Brand, Item, or Mode of Delivery**

As discussed in section 30.4 on the manual section added in CR 6119, contract suppliers are not required to furnish a specific brand name item or mode of delivery to a beneficiary unless prescribed by a physician or treating practitioner to avoid an adverse medical outcome. A physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) may prescribe, in writing, a particular brand of a competitively bid item or mode of delivery for an item if he or she determines that the particular brand or mode of delivery is necessary to avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

This documentation should include the following:

- The product's brand name or mode of delivery;
- The features that this product or mode of delivery has versus other brand name products or modes of delivery; and
- An explanation of how these features are necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

1. Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
2. Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
3. Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

### **Other Provisions Already Covered in Special Edition MLN Articles SE0805, SE0806, SE0807, and MM6119**

- Medicare will pay mail order contract suppliers the single payment amount for furnishing competitively bid mail order diabetic testing supplies to Medicare beneficiaries residing in the CBAs for which they have contracts. All mail order diabetic supplies suppliers must use the HCPCS modifier KL on each claim to indicate that the competitively bid item was furnished on a mail order basis. The modifier must be used for both competitive bidding and non-competitive bidding mail order diabetic supplies claims. Suppliers that furnish mail order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to penalties under the False Claims Act.
- Medicare will pay the fee schedule amount for non-mail order diabetic testing supplies to Medicare enrolled suppliers for the State where the beneficiary maintains a permanent residence.

- Medicare allows for the repair and replacement of parts for beneficiary-owned items by any Medicare enrolled supplier. **Note:** *Labor to repair equipment is not subject to competitive bidding and will be paid according to Medicare's general payment rules.*
- Competitive bidding applies to skilled nursing facilities (SNFs) and nursing facilities (NFs) to the extent that their residents receive competitively bid items under Medicare Part B. SNFs and NFs have the option to bid for, and be awarded contracts to be "specialty suppliers" that only furnish competitively bid items to their own residents or become a regular contract supplier that furnishes competitively bid items to beneficiaries throughout a CBA. If a SNF or NF is not a contract supplier (either a specialty contract supplier or a regular contract supplier), it must use a contract supplier for its CBA to furnish competitively bid items to its residents.
- Except where an exception applies, a beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a CBA, unless the beneficiary has signed an advance beneficiary notice (ABN). ABN forms are available at [http://www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp) on the CMS Web site.
- As related in CR 6119, home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding Program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a CBA. If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

### **Important Previously Issued Capped Rental Instructions**

All suppliers should pay attention to the new Chapter 36, Sections 20.6.4 (Transfer of Title for Oxygen Equipment and Capped Rental DME) and 20.6.5 (Capped Rental DME Furnished Prior to January 1, 2006). Previously, CR5010 detailed the changes in the payment for oxygen equipment and capped rental equipment as a result of the Deficit Reduction Act (DRA) of 2005. The MLN Matters article on that issue, MM5010, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5010.pdf> on the CMS Web site.

CR 5461 covered changes in maintaining and servicing capped rental DME and oxygen equipment as a result of the DRA, especially requirements for maintenance of capped rental DME furnished PRIOR TO January 1, 2006. These items are subject to the capped rental payment rules in effect prior to the changes made by the DRA. For such items, the supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and its maintenance and servicing after the 15--month period. This requirement is not eliminated by the competitive bidding program and applies to contract and noncontract suppliers whether or not the noncontract supplier is a grandfathered supplier. The MLN Matters article related to CR 5461 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5461.pdf> on the CMS Web site.

### **Additional Information**

You can find more information about the payment changes for DMEPOS items as a result of the DMEPOS competitive bidding program and the Deficit Reduction Act of 2005 by going to CR 5978, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1502CP.pdf> on the CMS Web site.

You will find the updated *Medicare Claims Processing Manual* Chapter 36 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) as an attachment to that CR.

CR 6119 is also available at <http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf> on the CMS Web site

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/> on the CMS dedicated website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

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

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## **Clinical Laboratory Fee Schedule - Medicare Travel Allowance Fees for Collection of Specimens**

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:** MM5996

**Related Change Request (CR) #:** 5996

**Related CR Release Date:** May 30, 2008

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1524CP

**Implementation Date:** June 30, 2008

### **Provider Types Affected**

Clinical laboratories submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory services provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 5996 which clarifies payment of travel allowances, either on a per mileage basis (P9603) or on a flat rate basis (P9604) for Calendar Year (CY) 2008.

### **What You Need to Know**

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

### **What You Need to Do**

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

### **Background**

Part B of Medicare covers 1) a specimen collection fee and 2) a travel allowance for a laboratory technician to draw the specimen from either a nursing home patient or homebound patient, and payment is made based on the clinical laboratory fee schedule. (See [Section 1833\(h\)\(3\) of the Social Security Act](#)). Furthermore, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover estimated travel costs of collecting the specimen (including the laboratory technician's salary and travel expenses), and Medicare contractors have the discretion to choose:

- Either a flat rate or a mileage basis, and
- How to set each type of allowance.

The per flat rate trip basis travel allowance (P9604) is \$9.55, and the per mile travel allowance (P9603) is \$0.955 cents per mile and is used in situations where the average trip to the patients' homes is:

- Longer than 20 miles round trip, and

- To be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

The per mile allowance rate of \$0.955 cents per mile was computed using the Federal mileage rate of \$0.505 cents per mile for automobile expenses plus an additional \$0.45 cents per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum of \$0.955 cents per mile if local conditions warrant it.

The standard mileage rate for business is based on a study of the fixed and variable costs of operating an automobile, and the study is conducted on an annual basis for the Internal Revenue Service (IRS). CMS reviews the minimum mileage rate and updates it in conjunction with the clinical laboratory fee schedule as needed.

Under either method (i.e., flat rate allowance or per mile travel allowance), when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip (for both Medicare and non-Medicare patients) either at the time the claim is submitted by the laboratory or when the flat rate is set by the Medicare contractor.

**Note:** Because of confusion that some laboratories have had regarding the per mile fee basis and the need to claim the minimum distance necessary for a laboratory technician to travel for specimen collection, some Medicare contractors have established local policy to pay based on a flat rate basis only.

At no time will a laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

### **Additional Information**

The official instruction, CR 5996, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1524CP.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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## Date of Service (DOS) for Clinical Laboratory and Pathology Specimens

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:** MM6018

**Related Change Request (CR) #:** 6018

**Related CR Release Date:** May 23, 2008

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1515CP

**Implementation Date:** January 5, 2009

### Provider Types Affected

Providers who submit claims to Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs) or carriers, for laboratory tests, or the technical component of physician pathology services, provided to Medicare beneficiaries.

### Impact on Providers

This article is based on Change Request (CR) 6018 alerting providers that the Centers for Medicare & Medicaid Services (CMS) revised the Date of Service (DOS) policy for clinical laboratory tests and added the technical component of physician pathology service effective January 1, 2009. These changes were announced in the final Medicare physician fee schedule rule published in the Federal Register on November 27, 2007 (42 CFR § 414.510).

### Key Points of CR 6018

The DOS policy as specified in 42 CFR § 414.510 for either a clinical laboratory test or the technical component of physician pathology service is as follows:

- **General Rule:** The DOS of the test/service must be the date the specimen was collected.
- **Variation:** If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

**The following two exceptions apply to this DOS policy** for either a clinical laboratory test or the technical component of physician pathology service:

#### 1. DOS for Tests/Services Performed on Stored Specimens:

In the case of a test/service performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test/service must be the date the test/service was performed only if:

- The test/service is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;

- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.

## **2. DOS for Chemotherapy Sensitivity Tests/Services Performed on Live Tissue:**

In the case of a chemotherapy sensitivity test/service performed on live tissue, the DOS of the test/service must be the date the test/service was performed only if:

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

For purposes of applying the above exception, a “chemotherapy sensitivity test” is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents. CMS identifies such tests through program instructions issued to the Medicare contractors.

### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 6018) issued to your Medicare FI, A/B MAC, or carrier. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1515CP.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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## July Quarterly Update for 2008 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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:** MM6022

**Related Change Request (CR) #:** 6022

**Related CR Release Date:** May 23, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1516CP

**Implementation Date:** July 7, 2008

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6022, which provides the quarterly update to the July 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staffs are aware of these changes.

### Background

This recurring update notification, CR 6022, provides specific instructions regarding the July quarterly update for 2008 for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is available at [http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp).

### Key Points

- The following Healthcare Common Procedure Coding System (HCPCS) codes were added to the HCPCS file effective January 1, 2008 and the fee schedule amounts for these HCPCS codes may be established as part of this update and are effective for claims with dates of service on or after January 1, 2008.

Code	Description	Code	Description
A5083	Continent device, stoma absorptive cover for continent stoma.	E0856	Cervical traction device, cervical collar with inflatable air bladder.
E2227	Manual wheelchair accessory,	E2228	Manual wheelchair accessory,

	gear reduction drive wheel, each.		wheel braking system and lock, complete, each.
E2397	Power wheelchair accessory, lithium-based battery, each.	L3927	Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), without joint/spring, extension/flexion (e.g. static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment.
L7611	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric.	L7612	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric
L7613	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	L7614	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric
L7621	Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined	L7622	Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined.

- The above codes were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for these codes with dates of service on or after January 1, 2008 that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.
- The fee schedule amounts for the following codes are being revised as part of this quarterly update to correct fee schedule calculation errors and the revised fee schedule amounts will be added to the fee schedule file as part of this update.

<b>Code</b>	<b>Description</b>	<b>Code</b>	<b>Description</b>
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands. Turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment.	L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material straps, custom fabricated, includes fitting and adjustment.
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment.		

- Your Medicare contractor will adjust previously processed claims for codes L3905, L3806 and L3808 with dates of service on or after January 1, 2008 if they are resubmitted for adjustments.
- HCPCS code K0672 (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) was added to the HCPCS file effective April 1, 2008.
- The fee schedule amounts for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g. Mask)) were inadvertently dropped from the January 2008 DMEPOS fee schedule file and the file was subsequently revised to add the fee schedule amounts for code E0461.

### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 6022) issued to your Medicare contractor. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1516CP.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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## **Instructions for Institutional Providers and Suppliers Billing Self-Referred Mammography Claims Regarding the Attending/Referring Physician National Provider Identifier (NPI)**

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:** MM6023

**Related Change Request (CR) #:** 6023

**Related CR Release Date:** May 30, 2008

**Effective Date:** May 23, 2008

**Related CR Transmittal #:** R1519CP

**Implementation Date:** June 30, 2008

### **Provider Types Affected**

Institutional providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for self-referred mammography services provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 6023 which provides National Provider Identifier (NPI) instructions for institutional providers and suppliers billing for self-referred mammography services. Do not use the surrogate unique physician identification number (UPIN) of “SLF000” on claims effective May 23, 2008.

### **What You Need to Know**

Providers of mammography services are instructed to report their own facility NPI in the attending physician NPI field in cases where the service is self-referred by the patient (beneficiary) and no attending/referring physician NPI is available.

### **What You Need to Do**

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

### **Background**

Effective May 23, 2008, covered health care providers, suppliers and health plans (other than small plans) are required to use National Provider Identifiers (NPIs). In reviewing the Medicare program’s business needs in preparation for the implementation of the NPI, the CMS identified that clarifying instructions are needed for institutional and supplier billing of self-referred mammography services.

The *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) indicates that a doctor’s prescription or referral is not necessary for screening mammography services to be covered. In self-referral cases, an NPI for an attending/referring physician is not available to the institution or supplier providing the mammography service. CR6023 modifies that instruction to alleviate this in self-referral cases.

In the past, Medicare Fiscal Intermediaries (FIs) instructed providers to use the surrogate UPIN of “SLF000” in the Attending Physician UPIN field on the institutional claim form. Since UPINs will no

longer be accepted on Medicare claims after May 23, 2008, an alternate means of identifying self-referral is needed.

Therefore, CR 6023 clarifies how providers and suppliers will reflect this situation on Medicare claims submitted on or after May 23, 2008, as follows:

- Institutional providers submitting claims for self-referred mammography services will duplicate the institution's own NPI in the attending physician NPI field on their claims; and
- Suppliers submitting claims for self-referred mammography services will duplicate the supplier's own NPI in the attending/referring physician NPI field on their claims.

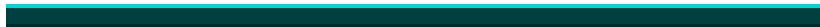
### **Additional Information**

The official instruction, CR 6023, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1519CP.pdf> on the CMS Web site.

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## **Inappropriate Denials of Claims for Percutaneous Transluminal Angioplasty (PTA) of Carotid Arteries Concurrent with Stenting Based on Facility Recertification Due Dates**

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:** MM6046

**Related Change Request (CR) #:** 6046

**Related CR Release Date:** June 6, 2008

**Effective Date:** March 17, 2005

**Related CR Transmittal #:** R349OTN

**Implementation Date:** July 7, 2008

### **Provider Types Affected**

Physicians and hospitals who submit claims to Medicare Carriers, Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for PTA services provided to Medicare beneficiaries.

### **What Providers Need to Know**

Be aware that the CMS using Change Request (CR) 6046 reminds providers and Medicare contractors that certifying and recertifying facilities for Medicare payment is solely under CMS jurisdiction. When CMS certifies a facility, the facility name and effective date appear on a list of approved facilities located at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp> on the CMS Web site. If CMS disapproves a facility at any time, that facility is placed on a separate list of formerly approved facilities indicating the time period during which the facility was certified (also accessible on the above-noted website). Therefore, **as long as a facility appears on the approved list, it is considered certified by CMS whether or not recertification is in pending status.** Your Medicare contractors are expected to consult the two facility lists in determining certification status and they **should not deny claims based on any other certification factors such as erroneously applied expiration date edits.**

All requirements contained in CR 3811 and CR 5660 remain in effect. You may review related articles MM5660, which clarifies the national coverage determination (NCD) policy for PTA at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5660.pdf> on the CMS Web site, and MM3811, which outlines the initial NCD policy for PTA at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf> on the CMS Web site.

### **Background**

This article is based on CR 6046 and in this article CMS states that it has come to their attention that some contractors are misapplying the initial certification and recertification requirements contained in CR 3811 and CR 5660, respectively, thereby inappropriately denying claims when a facility is not immediately recertified at the end of a 2-year period.

Effective March 17, 2005, CMS revised the NCD for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent for certain beneficiaries at high risk for carotid endarterectomy. On April 22, 2005, CMS issued change request (CR) 3811 to implement NCD 20.7, which included detailed steps facilities must follow to become certified by CMS to perform this procedure.

On April 30, 2007, as a result of a request for reconsideration of NCD 20.7, CMS posted a final decision that the current coverage policy would remain unchanged. CR 5660 was subsequently released on September 12, 2007, reiterating its decision. CR 5660 also made clarifying revisions to NCD 20.7 which

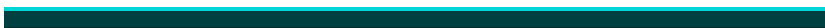
included additional, detailed recertification steps a facility must follow every 2 years in order to maintain Medicare coverage of carotid artery stenting (CAS) procedures.

### **Additional Information**

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

### **Disclaimer**

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## **July 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:** MM6049

**Related Change Request (CR) #:** 6049

**Related CR Release Date:** June 6, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1529CP

**Implementation Date:** July 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 6049, from which this article is taken, instructs Medicare contractors to download and implement the July 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised April 2008, January 2008, January 2007, April 2007, July 2007, and October 2007 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 average sales price (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 the CMS, which CMS then provides (quarterly) 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 are not being 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 OPPTS 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 the Medicare Claims Processing Manual, 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 OPPTS 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 June 16, 2008, the July 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 June 16, 2008, the July 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 CR6049 for the dates of service noted in the following table:

<b>Payment Allowance Limit Revision Date</b>	<b>Applicable Dates of Service</b>
July 2008 ASP and ASP NOC files	July 1, 2008 through September 30, 2008
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

**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 6049) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R1529CP.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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## July 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2

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:** MM6080

**Related Change Request (CR) #:** 6080

**Related CR Release Date:** May 30, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1523CP

**Implementation Date:** July 7, 2008

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6080 which provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the July, 2008, I/OCE that will be used for processing Outpatient Prospective Payment System (OPPS) and Non-OPPS claims from hospital outpatient departments, Community Mental Health Centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

### Background

Change Request (CR) 6080 informs providers and the Fiscal Intermediaries (FIs) and A/B MACs that the I/OCE is updated for July 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

Claims with dates of service prior to July 1, 2007 are routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

CR 6080 provides the I/OCE instructions and specifications that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The I/OCE instructions are attached to CR 6080 and will also be posted at <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS website.

CR 6080 also includes as an attachment with detailed lists of the ambulatory payment classifications (APC), health care common procedure coding systems (HCPCS), and Current Procedural Terminology (CPT) code changes, additions, and deletions. We will not repeat all of those changes in this article. However, the key modifications of the OCE for the July 2008 release (V9.2) are summarized in the table below.

In the table note that:

- Highlighted sections indicate change from the prior release of the software; and
- Some IOCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

Effective Date	Edit	Summary of Change
7/1/08	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 July 2008 release will be 4/1/01).
7/1/08	50	Change disposition for edit 50 to RTP (Return to Provider).  <b>Note: The IOCE change to RTP this claim will no longer trigger an initial determination. The provider should bill statutorily excluded services as noncovered and affix liability with the GY modifier (beneficiary liable).</b>
<b>4/1/01</b>		Exclude denied or rejected lines from PHP (Partial Hospitalization Program) processing and from Daily Mental Health assignment criteria.
		Make HCPCS/APC/SI changes as specified by CMS.
	19, 20, 39, 40	Implement version <b>14.1</b> 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).
<b>1/1/08</b>	17	Remove codes 92621 and 92627 from the Inherently bilateral list – change bilateral indicator to ‘0’.
7/1/08	15	Change all max units to zero for all codes that currently have max unit values other than zero.
<b>1/1/08</b>	78	Update nuclear medicine/radiopharmaceutical edit requirements.
<b>7/1/08</b>	71/77	<b>Update procedure/device edit requirements.</b>
7/1/08	22	<b>Add new modified CG (“Policy criteria applied”) to the valid modifier list.</b>
		Documented some ‘general programming notes’ that were in effect but not previously documented.
		Documented the exclusion of denied or reject lines from composite criteria.
		Clarified the text in appendix D that includes some non-type T procedures in bilateral procedure discounting.
		Modify description for SI “H” – “Pass-through device categories”.
		Modify description for SI “K” – Non pass-through drugs and biologicals, therapeutic radiopharmaceutical, brachtherapy sources, blood and blood products.
		Create a 508 Compliant version of the document (modify as necessary) – for publication on CMS Web site.

**Additional Information**

The official instruction, CR 6080, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1523CP.pdf> on the CMS Web site.

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## Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2008

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

**MLN Matters Number:** MM6084

**Related Change Request (CR) #:** 6084

**Related CR Release Date:** May 30, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1523CP

**Implementation Date:** July 7, 2008

### Provider Types Affected

Clinical diagnostic laboratories billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (AB MACs)).

### Provider Action Needed

This article is based on Change Request (CR) 6084 which announces the changes that will be included in the July 2008 quarterly release of the edit module for clinical diagnostic laboratory services. The last quarterly release of the edit module was issued in April 2007. CR 6084 incorporates all changes from April 2007 to the present and has no other changes.

### Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Chapter 16, Section 120.2; see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the CMS Web site the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 6084 announces changes to the laboratory edit module for changes in laboratory NCD code lists for July 2008 as described below. These changes become effective for services furnished on or after July 1, 2008. Contractors are not required to search their files to adjust affected claims between the July 1, 2007, and the July 1, 2008, quarterly clinical lab edit module updates.

### CR 6084 reports the following changes effective July 1, 2008:

#### For HIV Testing:

- Add ICD-9-CM codes 079.83 and 288.66 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (190.14) NCD.
- Modify the descriptor for Current Procedural Terminology (CPT) code 86701 in the HIV Testing (190.14) NCD to read “Antibody; HIV-1.”

- Modify the descriptor for CPT code 86702 in the HIV Testing (190.14) NCD to read “Antibody; HIV-2.”
- Modify the descriptor for CPT code 86703 in the HIV Testing (190.14) NCD to read “Antibody; HIV-1 and HIV-2, single assay.”

#### **For Blood Counts:**

- Add ICD-9-CM codes 388.45, 389.05, 389.06, 389.13, 389.17, 389.20, 389.21, 389.22, V25.04, V26.41, V26.49, V26.81, V26.89, V49.85 and V72.12 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes 389.2, V26.4 and V26.8 from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Modify the descriptor for ICD-9-CM code 389.14 to read “Central hearing loss” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD;
- Modify the descriptor for ICD-9-CM code 389.18 to read “Sensorineural hearing loss, bilateral” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD; and
- Modify the descriptor for ICD-9-CM code 389.7 to read “Deaf, non-speaking, not elsewhere classifiable” from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

#### **For Prothrombin Time:**

- Add ICD-9-CM codes 415.12, 789.51, 789.59, V12.53, and V12.54 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.
- Delete ICD-9-CM code 789.5 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.

#### **For Serum Iron Studies:**

- Add ICD-9-CM codes 233.30, 233.31, 233.32, and 233.39 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM code 233.3 from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

#### **For Glycated Hemoglobin/Glycated Protein:**

- Add ICD-9-CM codes 258.01, 258.02 and 258.03 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- Delete ICD-9-CM code 258.0 from the list of ICD-9-CM codes covered by Medicare for Glycated Hemoglobin/Glycated Protein (190.21) NCD.

#### **For Thyroid Testing:**

- Add ICD-9-CM codes 255.41, 255.42, 258.01, 258.02, 258.03, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

- Delete ICD-9-CM codes 255.4, 258.0, 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

#### **For Gamma Glutamyl Transferase:**

- Add ICD-9-CM codes 359.21, 359.22, 359.23, 359.24 and 359.29 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM code 359.2 from the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

#### **For Hepatitis Panel/Acute Hepatitis Panel:**

- Delete ICD-9-CM code 999.3 from the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

#### **For Fecal Occult Blood Test:**

- Add ICD-9-CM codes 569.43, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Delete ICD-9-CM codes 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Modify the descriptor for ICD-9-CM code 005.1 in the Fecal Occult Blood Test (190.34) NCD to read “Botulism food poisoning.”
- Modify the descriptor for CPT code 82272 in the Fecal Occult Blood Test (190.34) NCD to read “Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening.”

#### **Additional Information**

The official instruction, CR 6084, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1531CP.pdf> on the CMS Web site.

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## July Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB)- 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:** MM6087-**Revised**      **Related Change Request (CR) #:** 6087  
**Related CR Release Date:** May 30, 2008      **Effective Date:** January 1, 2008, unless  
otherwise noted in CR 6087  
**Related CR Transmittal #:** R1528CP      **Implementation Date:** July 7, 2008

**Note: This article was revised on June 9, 2008, to correct the summary of CR6087 in the ‘Provider Action Needed’ section below. All other information remains the same.**

### Provider Types Affected

Physicians and providers who submit claims to Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for services rendered to Medicare beneficiaries that are paid based on the MPFSDB.

### Provider Action Needed

Payment files for the MPFS were issued based on the 2008 Medicare Physician Fee Schedule Final Rule. Change Request (CR) 6087 amends those files AND includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

### What You Need to Know

Physicians and providers may want to pay particular attention to the issue that effective July 1, 2008 payments are calculated using the conversion factor of \$34.0682, update factor of 0.899 and without the work geographic adjustment, which is the previous payment methodology that was outlined in the 2008 MPFS Final Rule but was delayed as a result of the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007. Make certain that your billing staffs are aware of these changes.

### Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physicians’ services. CR 6087 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, the CMS directs you to CR 6087, which contains lengthy lists of these items. CR 6087 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1528CP.pdf> on the CMS Web site. As mentioned above, the key portions of CR 6087 include the following information:

### New G-codes for the Home Sleep Study Test Portable Monitor

**New G-codes effective for services performed on or after March 13, 2008 are:**

Code	Long Descriptor	Short Descriptor
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7	Home sleep test/type 2 Porta

	channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.	
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	Home sleep test/type 3 Porta
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	Home sleep test/type 4 Porta

### **New G-codes for the Physician Quality Reporting Initiative (PQRI)**

**Effective for dates of service on or after July 1, 2008, the following HCPCS codes will be added to the MPFSDB:**

<b>Code</b>	<b>Long Descriptor</b>	<b>Short Descriptor</b>
G8485	Clinician intends to report the Diabetes measure group	Report, Diabetes Measures
G8486	Clinician intends to report the Preventive Care measure group	Report, Prev Care Measures
G8487	Clinician intends to report the Chronic Kidney Disease (CKD) measure group	Report CKD Measures
G8488	Clinician intends to report the End Stage Renal Disease (ESRD) measure group	Report ESRD Measures

### **New Category II Codes**

**Effective for dates of service on or after July 1, 2008, the following Category II Codes will be added to the MPFSDB. (These codes are not part of the Physician Quality Reporting Initiative for 2008.)**

<b>Code</b>	<b>Long Descriptor</b>	<b>Short Descriptor</b>
3351F	Negative screen for depressive symptoms as categorized by using a standardized depression screening/assessment tool	Neg scrn dep symp by deptool
3352F	No significant depressive symptoms as categorized by using a standardized depression assessment tool	No sig dep symp by dep tool
3353F	Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool	Mild-mod dep symp by deptool
3354F	Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool	Clin sig dep sym by dep tool

Please note that G-codes and CPT Category II codes are used to report quality measures under the PQRI program or for measure testing. The G-codes and CPT Category II codes applicable to the 2008 PQRI Measure Set are available in the “2008 PQRI Quality Measures Specification” document at [http://www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage) on the CMS Web site.

## New Category III Codes

**Effective for dates of service on or after July 1, 2008, the following Category III Codes (0188T through 0192T) will be added to the MPFSDB:**

<b>Code</b>	<b>Long Descriptor</b>	<b>Short Descriptor</b>
0188T	Videoconferenced Critical Care First 30-74 Min	Videoconf crit care 74 min
0189T	Videoconferenced Critical Care Ea Addl 30min	Videoconf crit care addl 30
0190T	Intraocular Radiation Src Applicator Placement	Place intraoc radiation src
0191T	Ant Segment Insertion Drainage W/O Reservoir Int	Insert ant segment drain int
0192T	Ant Segment Insertion Drainage W/O Reservoir Ext	Insert ant segment drain ext

Note that your carrier or MAC will not reprocess claims already paid prior to implementation of this update. However, if you bring such claims to your contractor's attention, they will adjust such claims.

### **Additional Information**

To see the official instruction (CR 6087) issued to your Medicare Carrier or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1528CP.pdf> on the CMS website.

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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## **Phase 2 Manual Revisions for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program**

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:** MM6119

**Related Change Request (CR) #:** 6119

**Related CR Release Date:** June 11, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1592CP

**Implementation Date:** July 7, 2008

### **Provider Types Affected**

All Medicare DMEPOS suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as any providers who refer or order DMEPOS for Medicare beneficiaries.

### **What You Need To Know**

Change Request (CR) 6119, from which this article is developed, is the second installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the *Medicare Claims Processing Manual*. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The companion MLN Matters article to CR 5978 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5978.pdf> on the CMS Web site.

Chapter 36 manualizes policies and instructions for Medicare Contractors on the DMEPOS Competitive Bidding Program. Subsequent installments may follow providing additional sections to the chapter.

This article complements MM5978, SE0805, SE0806, and SE0807, which already cover many of the sections of the new chapter being added to the *Medicare Claims Processing Manual*. These articles in combination with this one cover the key sections of Chapter 36.

### **Background**

The Medicare payment for most DMEPOS is currently based on fee schedules. However, in amending section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

In compliance with the statute's mandate that this competitive bidding program be phased in beginning in 2007, CMS issued the regulation for the competitive bidding program (published on April 10, 2007 (72 Federal Register 68 (10 April 2007) pp. 17991-18090)). This regulation is available at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid>.

### **Key Points of CR 6119**

Key Points of CR 6119 that address a number of areas detailed in Chapter 36 of the *Medicare Claims Processing Manual* are as follows:

## **Home Health Agencies**

Home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding Program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a Competitive Bidding Area (CBA). If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

## **Prescription for Particular Brand, Item, or Mode of Delivery**

Contract suppliers are required to furnish a specific brand name item or mode of delivery to a beneficiary if prescribed by a physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) to avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome. This documentation should include the following:

- The product's brand name or mode of delivery;
- The features that this product or mode of delivery has versus other brand name products or modes of delivery; and,
- An explanation of how these features are necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

- Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
- Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
- Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

## **Payment for Rental of Inexpensive or Routinely Purchased DME**

The monthly rental payment amounts for inexpensive or routinely purchased DME (identified using Healthcare Common Procedure Coding System (HCPCS) modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item.

## **Payment for Oxygen and Oxygen Equipment**

The monthly payment amounts for oxygen and oxygen equipment are equal to the single payment amounts established for the following classes of items:

- Stationary oxygen equipment (including stationary oxygen concentrators) and oxygen contents (stationary and portable);
- Portable equipment only (gaseous or liquid tanks);
- Oxygen generating portable equipment (OGPE) only (used in lieu of traditional portable oxygen equipment/tanks);
- Stationary oxygen contents (for beneficiary-owned stationary liquid or gaseous equipment); and,

- Portable oxygen contents (for beneficiary-owned portable liquid or gaseous equipment).

In cases where a supplier is furnishing both stationary oxygen contents and portable oxygen contents, the supplier is paid both the single payment amount for stationary oxygen contents and the single payment amount for portable oxygen contents. The payment amounts for purchase of supplies and accessories used with beneficiary-owned oxygen equipment are equal to the single payment amounts established for the supply or accessory.

### **Change in Suppliers for Oxygen and Oxygen Equipment**

The following rules apply when the beneficiary switches from one supplier of oxygen and oxygen equipment to another supplier after the beginning of each round of competitive bidding:

- **Noncontract supplier to contract supplier**

In general, monthly payment amounts may not exceed a period of continuous use of longer than 36 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 36-month period, at least 10 monthly payment amounts would be made to a contract supplier that begins furnishing oxygen and oxygen equipment in these situations provided that medical necessity for oxygen continues.

For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months 2 through 26, payment would be made for the remaining number of months in the 36-month period, because the number of payments to the contract supplier would be at least 10 payments. To provide a more specific example, a contract supplier that begins furnishing oxygen equipment beginning with the 20th month of continuous use would receive 17 payments (17 for the remaining number of months in the 36-month period). However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, no more than 10 monthly payments would be made assuming the oxygen equipment remains medically necessary.

- **Contract supplier to another contract supplier**

This rule does not apply when a beneficiary switches from a contract supplier to another contract supplier to receive his/her oxygen and oxygen equipment. In this scenario, the new contract supplier is paid based on the single payment amount for the remaining number of months in the 36-month period assuming the oxygen equipment remains medically necessary.

### **Payment for Capped Rental DME Items**

The monthly rental payment amounts for capped rental DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first 3 months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 13.

### **Change in Suppliers for Capped Rental DME Items**

The following rules apply when the beneficiary switches from one supplier of capped rental DME to another supplier after the beginning of each round of competitive bidding:

- **Noncontract supplier to contract supplier**

In general, rental payments may not exceed a period of continuous use of longer than 13 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 13-month rental period, a new 13-month period begins and payment is made on the basis of the single payment amounts described above under “Payment for Capped Rental DME Items”.

The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the new 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary. Once the beneficiary switches from a noncontract supplier to a contract supplier, he/she may not switch back to a noncontract supplier if he/she continues to maintain a permanent residence in a competitive bidding area (CBA). If, however, the beneficiary relocates out of the CBA to a non-CBA, then he/she may switch to a noncontract supplier and a new 13-month rental period does not begin.

- **Contract supplier to another contract supplier**

If the beneficiary switches from one contract supplier to another contract supplier before the end of the 13-month rental period, a new 13-month period does not begin. This rule applies in situations where the beneficiary changes suppliers within a CBA and in situations where the beneficiary relocates and switches from a contract supplier in one CBA to a contract supplier in another CBA. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary.

### **Payment for Purchased Equipment**

Payment for purchase of new equipment (identified using HCPCS modifier NU), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 100 percent of the single payment amounts established for these items. Payment for purchase of used equipment (identified using HCPCS modifier UE), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 75 percent of the single payment amounts established for new purchase equipment items.

### **Payment for Repair and Replacement of Beneficiary-Owned Equipment**

Beneficiaries who maintain a permanent residence in a CBA may go to any Medicare-enrolled supplier (contract or noncontract supplier) for the maintenance or repair of beneficiary-owned equipment, including parts that need to be replaced in order to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and, therefore, will be paid in accordance with Medicare's general payment rules. Payment for replacement parts that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount in that CBA for that replacement part. Payment is not made for parts and labor covered under a manufacturer's or supplier's warranty.

Beneficiaries must obtain replacements of all items that are part of the competitive bidding program for the areas in which the beneficiary resides from a contract supplier unless the item is a replacement part or accessory that is replaced as part of the service of repairing beneficiary-owned base equipment (e.g. wheelchair, walker, hospital bed, continuous positive pressure airway device, oxygen concentrator, etc.). All base equipment that is replaced in its entirety because of a change in the beneficiary's medical condition or because the base equipment the beneficiary was using was either lost, stolen, irreparably damaged, or used beyond the equipment's reasonable useful lifetime (see section 110.2.C of chapter 15 of the *Medicare Benefit Policy Manual* at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>) must be obtained from a contract supplier in order for Medicare to pay for the replacement. Payment for replacement of items that are part of the competitive bidding program for the CBA in which the beneficiary resides is based on the single payment amount for that item. The contract supplier is not required to replace an entire competitively bid item with the same make and model as the previous item unless a physician or treating practitioner prescribes that make and model.

If beneficiary-owned oxygen equipment or capped rental DME that is a competitively bid item for the CBA in which the beneficiary maintains a permanent residence has to be replaced prior to the end of its reasonable useful lifetime, then the replacement item must be furnished by the supplier (contract or noncontract supplier) that transferred ownership of the item to the beneficiary.

### **Payment for Enteral Nutrition Equipment**

The monthly rental payment amounts for enteral nutrition equipment (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first three months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 15.

### **Maintenance and Servicing of Enteral Nutrition Equipment**

The contract supplier that furnishes the equipment to the beneficiary in the 15th month of the rental period must continue to furnish, maintain, and service the equipment after the 15 month rental period is completed until a determination is made by the beneficiary’s physician or treating practitioner that the equipment is no longer medically necessary. The payment for maintenance and servicing enteral nutrition equipment is 5 percent of the single payment amount established for purchase of the item.

### **Traveling Beneficiaries**

Beneficiaries, who travel outside their CBA, for example, to visit family members or reside in a state with warmer climates during winter months, need to consider the following three factors when traveling:

- Where to go to obtain a DMEPOS item;
- Identify whether the item is a competitively bid item or not; and
- Determine the Medicare payment amount for that item.

Depending on where the beneficiary travels (whether to a CBA or a non-CBA), the beneficiary may need to obtain DMEPOS from a contract supplier in order for Medicare to cover the item. For example, a beneficiary who travels to a non-CBA may obtain DMEPOS, if medically necessary, from any Medicare-enrolled supplier. On the other hand, a beneficiary who travels to a CBA should obtain competitively bid items in that CBA from a contract supplier in that CBA in order for Medicare to cover the item. The chart below shows whether a beneficiary should go to a contract supplier or any Medicare-enrolled supplier when the beneficiary travels.

<b>Beneficiary Permanently Resides in</b>	<b>Travels to</b>	<b>Type of Supplier</b>
a CBA	a CBA	The beneficiary should obtain competitively bid items in that CBA from a contract supplier located in that CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare will cover DMEPOS, if medically necessary, from any Medicare-enrolled DMEPOS supplier.

Non-CBA	a CBA	The beneficiary should obtain the competitively bid item from a contract supplier in the CBA if the beneficiary wants Medicare to cover the item.
	a non-CBA	Medicare-enrolled DMEPOS supplier

Suppliers that furnish DMEPOS items to Medicare beneficiaries who maintain a permanent residence in a CBA and who travel to a non-CBA need to be aware of the public use files at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home> on the Competitive Bidding Implementation Contractor (CBIC) Web site. These files contain the ZIP codes for the CBAs, the HCPCS codes for competitively bid items, and related single payment amounts for competitively bid items. The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. For example:

1. If a beneficiary maintains a permanent residence in a CBA and travels outside of the CBA, payment for a competitively bid item for the CBA in which the beneficiary maintains a permanent residence is the single payment amount for that item in the beneficiary's CBA.
2. When a beneficiary maintains a permanent residence in an area that is not in a CBA and travels to CBA or non-CBA, the supplier that furnishes the item will be paid the fee schedule amount for the area where the beneficiary maintains a permanent residence.

### **Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items**

If a beneficiary who has two residences in different areas and uses a local supplier in each area or if a beneficiary changes suppliers during or after the rental period, this does not result in a new rental episode. The supplier that provides the item in the 36th month of rental for oxygen equipment or the 13th month of rental for capped rental DME is responsible for transferring title to the equipment to the beneficiary. This applies to "snow bird" or extended travel patients and coordinated services for patients who travel after they have purchased the item.

### **Advance Beneficiary Notice (ABN)**

#### **Billing Procedures Related to Advance Beneficiary Notice (ABN) Upgrades under the Competitive Bidding Program**

In general, an item included in a competitive bidding program must be furnished by a contract supplier for Medicare to make payment. This requirement applies to situations where the item is furnished directly or indirectly as an upgrade. An upgrade is an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive than, the item that is reasonable and necessary under Medicare coverage requirements. An item is indirectly furnished if Medicare makes payment for it because it is medically necessary and is furnished as part of an upgraded item. The billing instructions for upgraded equipment found in section 120 of chapter 20 of the *Medicare Claims Processing Manual* (available at <http://www.cms.hhs.gov/manuals/Downloads/clm104c20.pdf>) continue to apply under the DMEPOS Competitive Bidding Program. Consider the following:

**1. Where a beneficiary, residing in a competitive bidding area, elects to upgrade to an item with features or upgrades that are not medically necessary:**

• **Upgrades from a bid item to a non-bid item**

In this situation, Medicare payment will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

• **Upgrades from a non-bid item to a bid item**

When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

• **Upgrades from a bid item in one product category (category “S”) to a bid item in another product category (category “U”)**

In this case, Medicare payment is only made to a contract supplier for the product category “U” on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category “S”.

**2. Where a beneficiary, who does not reside in a competitive bidding area, but travels to a competitive bidding area, elects to upgrade to an item with features that are not medically necessary:**

• **Upgrades from a bid item to a non-bid item**

In this situation, Medicare payment is only made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

• **Upgrades from a non-bid item to a bid item**

When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

• **Upgrades from a bid item in one product category (category “S”) to a bid item in another product category (category “U”)**

In this case, Medicare payment is only made to a contract supplier for the product category “U” on an assignment-related basis. Medicare payment would be equal to 80 percent of lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category “S”.

Note: In the *Medicare Claims Processing Manual* chapter 36 section 40.11 attached to CR 6119 at <http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf> on the CMS website, a detailed chart describe situations where a beneficiary, residing in a CBA, elects to upgrade to an item with features or upgrades that are not medically necessary.

### **Beneficiary Liability**

Under the competitive bidding program, a beneficiary has no financial liability to a noncontract supplier that furnishes an item included in the competitive bidding program for a competitive bidding area, unless the

beneficiary has signed an advance beneficiary notice (ABN). Similarly, beneficiaries who receive an upgraded item from a noncontract supplier in a competitive bidding area are not financially liable for the item unless the supplier has obtained a signed ABN from the beneficiary.

In the case of upgrades, for a beneficiary to be liable for the extra cost of an item that exceeds their medical needs, an appropriate ABN must be signed by the beneficiary. See chapter 20, section 120 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> for additional information on ABN upgrades.

### **Billing Procedures Related to Downcoding under the Competitive Bidding Program**

The following downcoding guidelines describe situations where Medicare reduces the level of payment for the prescribed item based on a medical necessity partial denial of coverage for the additional, not medically necessary, expenses associated with the prescribed item.

**1. For beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare’s coverage requirements.**

- **Downcodes from a non-bid item to a bid item**

In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

- **Downcodes from a bid item to a non-bid item**

Medicare payment in this downcoding scenario will be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Downcodes from a bid item in one product category (category “U”) to a bid item in another product category (category “S”)**

In this case, Medicare payment will be made to a contract supplier for the product category “U” on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category “S”.

**2. For a beneficiary who does not reside in a CBA, but travels to a CBA and for whom Medicare determines that the prescribed item is downcoded to an item that is reasonable and necessary under Medicare’s coverage requirements.**

- **Downcodes from a non-bid item to a bid item**

In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.

- **Downcodes from a bid item to a non-bid item**

Medicare payment in this downcoding scenario will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- **Downcodes from a bid item in one product category (category “U”) to a bid item in another product category (category “S”)**

In this case, Medicare payment will only be made to a contract supplier for the product category “U” on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category “S”.

A detailed chart of downcoding scenarios is in the new Chapter 36, section 40.12 (attached to CR6119) for beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare’s coverage requirements.

### **Additional Information**

You can find more information about the payment changes for DMEPOS items as a result of the DMEPOS competitive bidding program and the Deficit Reduction Act of 2005 by going to CR 6119, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1532CP.pdf> on the CMS Web site. You will find the updated *Medicare Claims Processing Manual* Chapter 36 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program) as an attachment to that CR.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/> on the CMS dedicated Web site. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

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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## Notification of New Quarterly Updates to the Ambulance Fee Schedule Public Use File (PUF)

**MLN Matters Number:** N/A

**Related CR Release Date:** June 13, 2008

**Related CR Transmittal #:** R352OTN

**Related Change Request (CR) #:** 6091

**Effective Date:** July 28, 2008

**Implementation Date:** July 28, 2008

### General Information

Section 4531 (b)(2) of the Balanced Budget Act (BBA) of 1997 added a new Section 1834 (1) to the Social Security Act which mandated the implementation of a national fee schedule for ambulance services furnished as a benefit under Medicare Part B . the fee schedule was effective for claims with dates of services on or after April 1, 2002, and it applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals (except when it is the only ambulance service within 35 miles), and skilled nursing facilities. On an annual basis, the Centers for Medicare & Medicaid Services (CMS) post a file detailing the amounts payable under the Ambulance Fee Schedule for the benefit of public consumption to the CMS Web site, [http://www.cms.hhs.gov/AmbulanceFeeSchedule/02\\_afspuf.asp#Topofpage](http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp#Topofpage).

### Policy

With continuing Medicare Claims Processing Contracting reform, some of the Contractor/Carrier numbers included in the 2008 annual Ambulance Fee Schedule Public Use File (PUF) posted to the CMS Web site may be outdated. To ensure that the Contractor/Carrier numbers contained in the file are as accurate as possible, a quarterly update to the PUF file be posted to the CMS Web site until all contracting reform is completed. The quarterly file will be posted whether or not there are Contractor/Carrier number changes to report. Any updated information will be highlighted with *italicized red text*. The quarterly updates to the Ambulance Fee Schedule PUF file will be made available for ambulance providers 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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## **Revisions to the Billing Requirements for ESRD-Related Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp) Administrations Provided During Unscheduled or Emergency Dialysis Treatments in the Outpatient Hospital Setting**

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:** MM6047

**Related Change Request (CR) #:** 6047

**Related CR Release Date:** May 16, 2008

**Effective Date:** October 1, 2008

**Related CR Transmittal #:** R1503CP

**Implementation Date:** October 6, 2008

### **Provider Types Affected**

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

### **Impact on Providers**

This article is based on Change Request (CR) 6047 which revises the billing of End Stage Renal Disease (ESRD) related Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp) administrations provided during unscheduled or emergency dialysis treatment in an outpatient hospital setting.

### **Background**

CR 3184 dated June 4, 2004 established Medicare system edits that require the presence of hospital emergency room visit revenue code 045X in order to allow payment for End Stage Renal Disease (ESRD) related Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp) provided in conjunction with an emergency dialysis treatment. Effective October 1, 2008, revenue code 045x will no longer be required in order to allow for EPO and Aranesp payment related to an unscheduled or emergency dialysis treatment.

CR 6047 revises current Medicare system edits associated with unscheduled and emergency dialysis treatments in the hospital outpatient setting to allow for the payment of EPO and Aranesp, Healthcare Common Procedure Coding System (HCPCS) Q4081 and J0882 only when HCPCS G0257 is present on the same claim.

The definition for HCPCS code G0257 is as follows: Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility.

CR 6047 instructs Medicare contractors to:

- Only make payment for ESRD-related EPO or Aranesp in the outpatient hospital setting (13x and 85x bill types) when HCPCS code G0257 appears on the same claim, and
- Return to the provider any outpatient hospital claims containing ESRD-related EPO or Aranesp when HCPCS code G0257 does not appear on the same claim.

**Additional Information**

The official instruction, CR 6047, issued to FIs and A/B MACs regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1503CP.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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## **Medical and Other Health Services Furnished to SNF Patients**

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:** MM5991

**Related Change Request (CR) #:** 5991

**Related CR Release Date:** May 16, 2008

**Effective Date:** June 16, 2008

**Related CR Transmittal #:** R89BP

**Implementation Date:** June 16, 2008

### **Provider Types Affected**

Skilled Nursing Facilities (SNFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Part B services, including outpatient therapy services provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 5991 which revises the *Medicare Benefit Policy Manual* (Chapter 8, Section 70) to clarify coverage of Part B services paid in SNFs, including outpatient physical therapy services, outpatient occupational therapy services, and outpatient speech pathology services..

### **Background**

The Social Security Act (Section 1861) provides for the coverage of medical and other health services that are paid through Medicare Part B, including the provision of outpatient physical therapy services and outpatient occupational therapy services. You can review Section 1861 of the Social Security Act at [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) on the internet.

With CR 5991, the Centers for Medicare & Medicaid Services (CMS) is making a slight modification to Section 70, Chapter 8 of the *Medicare Benefit Policy Manual*. Previously, that section of the manual began with the following paragraph:

“The medical and other health services listed below and described in the *Medicare Benefit Policy Manual*, Chapter 6, “Hospital Services Covered Under Part B,” section 10, are covered under Part B when furnished by a participating SNF either directly or under arrangements to: inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met); **or outpatients.**” (Emphasis added on “or outpatients.”)

To avoid confusion, CMS is deleting the words “or outpatients” from the end of that quoted paragraph. That is the key change that CR 5991 makes, as none of the other services listed in this section of the manual can be provided by an SNF on an outpatient basis other than physical and occupational therapy and speech pathology services.

Outpatient physical and occupational therapy and outpatient speech pathology services may be provided by a SNF to its “outpatients,” including:

- Those of its own patients in their homes,

- Patients who come to the SNF's outpatient department,
- Inpatients of other institutions, and
- The SNFs own inpatients who have exhausted their Part A benefits or who are not otherwise eligible for Part A benefits.

In addition, CR5991 reminds SNFs of the following existing policies:

- SNFs may furnish physical therapy, occupational therapy, or speech language pathology services to their inpatients without having to set up facilities and procedures for furnishing the same services to outpatients. However, if the SNF chooses to furnish the therapy services mentioned in this article, the SNF must bill the program under Part B and may only charge the patient for the applicable deductible and coinsurance.
- In the case of a distinct part SNF, the certified part must bill the program under Part B for any outpatient physical therapy, occupational therapy, or speech language pathology services that the certified distinct part itself furnishes to inpatients of the non-certified part.
- Alternatively, residents of the non-certified part can receive outpatient therapy services from a hospital that exceed the Part B therapy caps, in accordance with CR 2674 (Program Memorandum A-03-040, May 9, 2003) which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/A03040.pdf> on the CMS Web site.

#### **Additional Information**

The official instruction, CR 5991, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R89BP.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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## **Charges to Hold a Bed during Skilled Nursing Facility (SNF) Absence**

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:** MM6030

**Related Change Request (CR) #:** 6030

**Related CR Release Date:** May 30, 2008

**Effective Date:** June 30, 2008

**Related CR Transmittal #:** R1522CP

**Implementation Date:** June 30, 2008

### **Provider Types Affected**

Skilled Nursing Facilities (SNFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for SNF services provided to Medicare beneficiaries.

### **What You Need to Know**

This article is based on Change Request (CR) 6030 which describes the policies relating to bed-hold payments in a SNF by updating the *Medicare Claims Processing Manual* (Chapter 1 (General Billing Requirements), Section 30.1 (Charges to Hold a Bed during SNF Absence)).

### **Background**

Charges to a beneficiary for admission or readmission to a Skilled Nursing Facility (SNF) are not allowable. However, when temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF. Under the [Social Security Act \(Section 1819\(c\)\(1\)\(B\)\(iii\)\)](#); and the Code of Federal Regulations (42 CFR §483.10(b)(5)-(6)), a SNF must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge.

**Note that SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if Medicare requirements are met.**

Bed-hold payments are readily distinguishable from payments made prior to initial admission, in that the absent individual has already been admitted to the facility and has established residence in a particular living space within it. Similarly, bed-hold payments are distinguishable from payments for readmission, in that the latter compensate the facility merely for agreeing in advance to allow a departing resident to reenter the facility upon return, while bed-hold payments represent remuneration for the privilege of actually maintaining the resident's personal effects in the particular living space that the resident has temporarily vacated.

One indicator that post-admission payments do, in fact, represent permissible bed-hold charges related to maintaining personal effects in a particular living space (rather than a prohibited charge for the act of readmission itself) would be that the charges are calculated on the basis of a per diem bed-hold payment rate multiplied by however many days the resident is absent, as opposed to assessing the resident a fixed sum at the time of departure from the facility.

Under §1819(c)(1)(B)(iii) of the Act and 42 CFR 483.10(b)(5)-(6), the facility must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge. For these optional payments, the facility should make clear that the resident must affirmatively elect to make them

prior to being billed. A facility cannot simply deem a resident to have opted to make such payments and then automatically bill for them upon the resident's departure from the facility.” See Chapter 30 of the *Medicare Claims Processing Manual* for related notification requirements. That chapter is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf> on the CMS Web site.

### **Additional Information**

The official instruction, CR 6030, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1522CP.pdf> on the CMS Web site. The revised section of the *Medicare Claims Processing Manual* is attached to CR 6030.

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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### **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 Newslines*.

<b>CSR Training Date</b>	<b>Time</b>
Friday, July 11, 2008	9:00 a.m.-11:00 p.m. CT
Friday, July 25, 2008	9:00 a.m.-11:00 p.m. CT



## **Healthcare Integrated General Ledger Accounting System (HIGLAS) Frequently Asked Questions (FAQs)**

We first told you about HIGLAS in the article [“HIGLAS—Healthcare Integrated General Ledger Accounting System,”](#) which was published in the June 2008 *Medicare A Newsline* and on the “What’s New From Cahaba GBA” Web page on April 29, 2008. The following provides frequently asked questions and answers about HIGLAS.

### **Q. What is HIGLAS?**

**A.** Healthcare Integrated General Ledger Accounting System – It is an integrated, dual-entry accounting system that replaces our current accounting system. This is a single system that will be used by all Medicare Contractors.

### **Q. What impact will HIGLAS have on claims processing?**

**A.** HIGLAS only involves the financial accounting system. The Fiscal Intermediary Standard System (FISS) will continue to be used for all claims processing functions.

### **Q. What are the benefits of HIGLAS?**

**A.** HIGLAS will improve the accountability for Medicare payments to providers serving Medicare beneficiaries. This system will strengthen management of accounts receivable, produce automated financial statements, and reduce costs by eliminating redundant and manual processes.

### **Q. Will we see any changes in our claims payments?**

**A.** For Home Health providers, RAP payments will take one extra day as all payments go through the HIGLAS system. No other changes will occur.

### **Q. When will this transition occur?**

**A.** The HIGLAS transition for Cahaba GBA is scheduled for late summer of 2008.



## Cahaba GBA’s Web site Re-Design

Cahaba Government Benefit Administrators®,LLC’s Web site for Medicare Part A, Part B, and Home Health and Hospice (HH+H) providers will soon have a new look! The site is being re-designed to present information in a more comprehensive, logical, and easy to navigate manner.

Please note that the content of information is not changing, just the layout and design of the site. You will continue to access the Cahaba Web site at: <https://www.cahabagba.com/index.htm>

The following provides an overview on some of the design changes you can expect to see.

### Home Page

- The more open layout provides links to “**Hot Topics**”, “**Quick Links**”, and “**News**” for quick and easy access to important information. A top navigation bar allows you to select “**Part A**”, “**Part B**”, or “**HH+H**” to access specific resource information. Please see below for an example of the top navigation bar.

The top navigation bar also includes links for “**Beneficiaries**”, “**FAQ**” (Frequently Asked Questions), “**Links**” (other important links) and “**Contact Us**” (how to contact Cahaba).



### Resource Web Pages

- From the Home page, the **Part A**, **Part B** and **HH+H** links direct you to a “**Resource**” page where you will find links to more specific topics, such as Claims, Education, Enrollment, and Medical Review. “**Popular Links**,” which will be available near the top of all pages, allow you to find information quickly, resulting in a fewer number of clicks.

As always, Cahaba GBA is dedicated to providing quality service to our Providers. Our new layout and design will help you more efficiently navigate our Web site by reducing clicks and prominently presenting your most wanted topics. Please watch for e-mail messages and Web site updates for additional information about the launch of our new Web site design.



## Consolidation of Part A (Fiscal Intermediary) and Part B (Carrier) Local Coverage Determinations (LCDs)

Effective July 1, 2008, Cahaba GBA Part A and Part B have consolidated LCDs which are in common.

The following table lists new LCD Titles and ICD-9 codes which have been added to Part A LCDs. Coverage has been **liberalized** as a result of the consolidation.

Providers are encouraged to review these updates to ensure compliance effective July 1, 2008.

LCD#	Old LCD Title	New LCD Title	New ICD-9 Codes
2365	Colonoscopy	Surgery: Colonoscopy (Diagnostic)	Part A has no ICD-9 additions. The Indications, HCPCS codes and ICD-9 codes for Screening Colonoscopies have been replaced with a statement referring Providers to the Medicare Benefit Policy Manual. (Pub 100-02), Section 280.2 for coverage of colorectal cancer screening tests and procedures.
20891	Colony Stimulating Factors	Drugs and Biologicals: Colony Stimulating Factors	For J1440, J1441, J2820 – add ICD-9 238.79, expand range 288.00 – 288.04, 288.09, 288.59  For J2505 – expand range 288.00 – 288.04, add ICD-9 288.59
22653	Computed Tomographic Angiography of the Heart and Coronary Vessels	Radiology: Computed Tomographic Angiography of the Heart and Coronary Vessels	Add ICD-9 codes 414.2, 427.31, 427.32 and V72.81
1495	Computed Tomography of the Abdomen and Pelvis	Radiology: Computed Tomography of the Abdomen and Pelvis	Add ICD-9 codes 006.2, 095.2 – 095.4, expand range 233.1 – 233.9, 251.4, 251.5, 251.8, 277.30, 277.31, 277.39, 289.53, 405.01, 446.0, 447.3, 535.61, 536.1, expand range 536.40 – 536.49, expand range 566 – 568.9, expand range 585.1 – 585.6, 629.89, 710.1, 787.01, 793.99, 996.82, 996.86
13071	Computed Tomography of the Head or Brain	Radiology: Computed Tomography of the Head or Brain	Add ICD-9 codes 052.2, 053.14, 054.74, 200.31, 200.41, expand range 200.50 – 200.58, 200.61, 200.71, expand range 330.0 – 334.9, 388.45, 768.7, expand

			range 770.81 – 770.89, 780.32, 995.20
22686	Computed Tomography of the Thorax	Radiology: Computed Tomography of the Thorax	Add ICD-9 codes 277.39, 414.12, 415.12, 423.3, 518.7 and 519.19
1090	Infliximab (REMICADE <sup>®</sup> )	Drugs and Biologicals: Infliximab (Remicade)	Correction: Change current ICD-9 code range 556.0 – 557.0 to 556.0 – 556.9
13118	Magnetic Resonance Imaging of the Brain	Radiology: Magnetic Resonance Imaging of the Brain	Add ICD-9 codes as follows: expand range 015.60 – 015.66, 036.2, 053.14, 054.74, 064, 137.1, 139.0, 200.31, 200.38, 200.41, 200.48, expand range 200.50 – 200.58, 200.61, 200.68, 200.71, 200.78, expand range 323.01 – 323.9, expand range 333.0 – 333.91, 376.30, 376.35, expand range 377.32 – 377.34, 377.43, 377.61, 377.63, 377.73, 377.75, 446.5, 446.7
1261	Magnetic Resonance Imaging of the Spine	Radiology: Magnetic Resonance Imaging of the Spine	Add ICD-9 codes 003.21, expand range 018.01 – 018.06, expand range 018.81 – 018.86, 036.0, 036.2, 053.14, 054.74, 098.53, 237.72, 433.20, 443.24, 876.1, 905.1, 907.2, 907.3, 926.11, 996.63
855	Pamidronate Disodium (Aredia <sup>®</sup> )	Drugs and Biologicals: Pamidronate Disodium (Aredia)	Add ICD-9: 238.6
21027	Ultrasound of the Abdomen and Retroperitoneum	Radiology: Ultrasound of the Abdomen and Retroperitoneum	For CPT codes 76700 and 76705 - 006.3, 122.0, 150.2, range 150.5 – 154.0, 189.1, 189.2, 197.4, 197.5, 198.0, range 235.0 – 235.3, 443.22, 443.23, range 453.0 – 453.3, 530.0, range 531.00 – 531.91, range 532.00 – 532.91, range 533.00 – 533.91, range 534.00 – 534.91, 535.01, 535.11, 535.21, 535.31, 535.41, 535.51, range 535.60 – 535.61, range 536.0 – 536.9, range 537.0 – 537.6, range 537.81 – 537.9, range 541 – 543.9, 551.1, range 551.20 – 551.29, 551.3, 552.1, range 552.20 – 552.29, 552.3, 553.1, 553.20, 553.21, 553.9, range 560.1 – 560.9, range 562.00 – 562.13, 564.2, 564.3, 564.7, 564.81, 568.0,

			<p>range 568.81 – 568.9, 569.5, range 569.60 – 569.69, range 569.82 – 569.89, range 573.0 – 573.4, 573.9, range 579.1 – 579.9, 751.2, range 751.60 – 751.69, 759.0, 771.81, 783.0, 783.21, 787.01, 790.4, 793.4, 793.6, range 863.0 – 863.39, range 863.41 – 863.44, range 863.51 – 863.54, range 864.02 – 864.09, 864.10, range 864.12 – 864.19, range 868.02 – 868.09, 868.10, range 868.12 – 868.19, 869.0, 869.1, 922.2, 959.12, V42.7, V42.83, V42.84, V67.1, V67.2, V71.1</p> <p>For CPT codes 76770 and 76775 - 183.0, 198.0, 236.91, 567.29, 593.3, 593.5, range 753.10 – 753.29, 753.3, 753.4, 788.1, 788.30, 789.00, 793.5, range 866.00 – 866.13, 868.14, 959.12, V10.52, V10.53, V42.0, V42.7, V42.83, V42.84</p>
21031	X-ray of the Chest	Radiology: X-Ray of the Chest	Add ICD-9 codes as follows: expand range 238.0 – 238.9, 277.39, expand range 284.01 – 284.9, expand range 420.0 – 429.9, expand range 440.0 – 448.9, 449, 488, expand range 510.0 – 519.9, 585.9, 731.3, expand range 768.2 – 771.1, 775.81, 775.89, 787.29, expand range 995.0 – 996.2
25722	Zoledronic Acid	Drugs and Biologicals: Zoledronic Acid	Add ICD-9 range 140.0 – 208.91



## **Comprehensive Error Rate Testing (CERT) Findings based on May 2008 Improper Medicare Fee-for-Service Payments Report**

The Improper Medicare Fee-for-Service Payments Long Report for May 2008 indicates a continual reduction in Cahaba Government Benefit Administrators ®, LLC Alabama's fiscal intermediary specific error rate. The report indicates an error rate of 0.7 percent. An error rate of 0.7 percent falls significantly below the National Medicare FFS Paid Claims Error Rate Goal for November 2008 to reduce the percent of improper payments under Medicare FFS to 3.8%. This goal was established under the Government Performance and Results Act (GPRA).

You may view the CERT Report Data by accessing the following Web site: <http://www.cms.hhs.gov/CERT/> and by selecting the "CERT Reports" link.

You may also utilize the CERT link at [www.cahabagba.com](http://www.cahabagba.com) to view newsletters, frequently asked questions and reports related to CERT.

While we are pleased to see a continual reduction in our overall error rate, we remain committed to performing analysis of the CERT data so that we can continue to identify strategies for error reduction.

The data in the May 2008 error rate report is derived from claims submitted 10/1/06 – 9/30/07. These errors were reported to the contractor via feedback files. An analysis of these files has resulted in the following findings:

- Approximately 53% of the errors were due to providers failing to submit adequate documentation
- Approximately 31% of the errors were due to coding issues
- Approximately 12% of the errors were for category 90 indicating an error for other reasons
- Approximately 4% of the errors were due to providers billing for services that demonstrated a lack of medical necessity, billing for services that were not rendered and billing for duplicate payments

There was one error due to a provider failing to submit documentation; however, the error code was later changed to insufficient documentation.

Three bill type categories have been identified as contributors to the May 2008 error rate. For this Intermediary, the OPPS, Laboratory (Billing an FI), Ambulatory (Billing an FI) TOB category poses the most significant challenges and even more specifically, TOB 13X is where most of the error rate reduction efforts have been targeted. Data indicates that the OPPS, Laboratory (Billing an FI), Ambulatory (Billing an FI) TOB category contributed to approximately 97% of the errors received. Failure to provide adequate documentation to substantiate the billing of laboratory services and diagnostic tests and services incorrectly coded serve as the most significant sources of these errors.

Data indicates that there were no errors in the SNF TOB category.

Data indicates that the Other FI Service Types category contributed to approximately 3% of the errors received. These errors were due to inappropriately billing a therapy evaluation as therapeutic exercise and under billing the number of units billed for therapeutic exercise. Only one of these errors was received for 85X TOB (Critical Access Hospitals) and it was for failure to provide adequate documentation to substantiate the billing of laboratory services.

One error was received for the Rural Health Clinic (RHC) category. This error was for failure to provide adequate documentation to substantiate the billing of laboratory services.

Based on these findings, this intermediary will continue to provide on-going communication with providers to encourage the submission of adequate documentation in response to CERT's request for medical records. It is important that providers submit all documentation that substantiates all of the services billed. We continue to publish articles on CERT errors identified for coding issues. These articles are intended for use as educational tools and they should serve as a prompt for an internal analysis of billing within each facility.



## **Medicare Credit Balance Quarterly Reminder**

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

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

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

### **Medicare Part A Credit Balance Reporting**

Cahaba GBA  
P.O. Box 10808  
Birmingham, AL 35202-0808  
Fax: 205 733-7022

If you have any questions or need a paper copy of the CMS-838, please contact the Medicare Credit Balance telephone line at **205-220-1280**.



## Quarterly Provider Update

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

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

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

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

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

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## July 2008 Education Events

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

➤ **[Medicare 101: Completing the UB04 Claim Form- Webinar](#)**

**Date:** Tuesday, July 22, 2008

**Time:** 10:00 a.m. - 11:00 a.m. (Central Standard Time)

**Registration Deadline:** Tuesday, July 15, 2008

**Intended Audience:** This educational event is tailored for 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.

**Description:** Educational topics for this Medicare 101 "Understanding the UB04 Claim Form" This webinar is designed for the beginner and will be very broad in nature. Learning outcomes will be assessed before and after this event. Please note, this is not a specialty seminar.

## 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](#).