

# 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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### Provider Contact Center Hours

The Medicare Part A Provider Contact Center may be reached Monday through Friday between the hours of:

- Alabama: 8:00 a.m. – 5.00 p.m. CST

Except on Training Days and Federal Holidays. See our [Training Schedule](#) for specific information.

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

- Alabama: 866 539-5598

### 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				

**Disclaimer**

This educational material was prepared as a tool to assist Medicare providers and other interested parties and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within this module, the ultimate responsibility for the correct submission of claims lies with the provider of services. Cahaba GBA, LLC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of these materials. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

We encourage users to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. Although this material is not copyrighted, CMS prohibits reproduction for profit making purposes.

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**ICD-9 Notice**

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## **Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians**

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 Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf>. The guide is also available in a print version. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”



## **Sole Community Hospital Fact Sheet**

The April 2008 version of the *Sole Community Hospital Fact Sheet*, which provides information about Sole Community Hospital classification and payments, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/2007sch.pdf>. It is also available in print format. To place your order for a print copy, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”



## **Physician Quality Reporting Initiative (PQRI)**

The Centers for Medicare & Medicaid Services (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. As a reminder, all educational resources about the 2008 PQRI are available on the dedicated PQRI Web page on the CMS Web site. To access this Web page, visit <http://www.cms.hhs.gov/pqri>.



## 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 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.

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## Medicare Improvements for Patients and Providers Act (MIPPA)

The Office of the Inspector General in the Department of Health and Human Services has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to [http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA\\_Policy\\_Statement.PDF](http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF) on the Internet.

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## Psychiatric Facility Prospective Payment System Fact Sheet

The revised *Inpatient Psychiatric Facility Prospective Payment System Fact Sheet* (May 2008), which provides general information about the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), how payment rates are set, and the Rate Year 2009 update to the IPF PPS, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/InpatientPsychFac.pdf>.

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## **Physician Quality Reporting Initiative (PQRI)**

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the PQRI web page on the CMS Web site and is available for ordering through the Medicare Learning Network product ordering system. The 2008 PQRI Reporting Options Quick Reference Chart is a two-sided laminated reference chart, which gives eligible professionals and practice staff a quick reference to the new reporting options available for 2008 PQRI with their corresponding alternative reporting periods. To access this new educational resource, visit <http://www.cms.hhs.gov/PQRI> and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the “Downloads” section and click on the “2008 PQRI Quick Reference Chart” link. To order the laminated product, visit [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 and click on the 2008 Physician Quality Reporting Initiative (PQRI) Reporting Quick Option Reference Chart (ICN# 900843) (May 2008) link.





## **Clarification on the Correct Condition Code to Report on Provider Adjustment Requests to Indicate a Health Insurance Prospective Payment System (HIPPS) Code Change- 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:** MM6002 Revised      **Related Change Request (CR) #:** 6002  
**Related CR Release Date:** July 25, 2008      **Effective Date:** January 1, 2009  
**Related CR Transmittal #:** R1565CP      **Implementation Date:** January 6, 2009

**Note:** This article was revised on July 28, 2008, to reflect that CR 6002 was revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6002 have been changed in this article. All other information remains the same.

### **Provider Types Affected**

Skilled Nursing Facilities (SNF), Swing Bed (SB) providers, Inpatient Rehabilitation Facilities (IRF) and Home Health Agencies (HHA) who bill Medicare Fiscal Intermediaries (FI) and Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries.

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

CR 6002, from which this article is taken, announces that, as of January 1, 2009, you should no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests, but rather should begin to use Condition Code D2 – Change in Revenue Codes/HCPCS/HIPPS Rate Codes instead.

### **Background**

Medicare systems have historically required Skilled Nursing Facilities (SNF) and Swing Bed (SB) providers to append condition code D4 to inpatient adjustment requests when a change is made to the original Health Insurance Prospective Payment System (HIPPS) code billed on the claim.

However, because the National Uniform Billing Committee (NUBC) has recently revised the definition for condition code D4, to indicate a change in clinical codes (ICD) for diagnosis and/or procedure codes, CR 6002, from which this article is taken, clarifies the correct condition code to report on adjustment requests when changing a previously processed HIPPS code,

Effective January 1, 2009, you should no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests, but instead should begin to use Condition Code D2 – Change in Revenue Codes/HCPCS/HIPPS Rate Codes.

In addition, Medicare systems have been updated to require Inpatient IRFs and HH agencies to also report a condition code D2 on adjustment requests that alter the existing HIPPS code on a previous paid claim, effective January 1, 2009.

You should be aware that your FI or A/B MAC will return adjustment requests when a claim contains a HIPPS code change without a condition code D2.

### **Additional Information**

You can find more information about the correct condition code to report on provider adjustment requests to indicate a health insurance prospective payment system (HIPPS) code change by going to CR 6002, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1565CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site.

You will find updated *Medicare Claims Processing Manual* Chapter 6 (SNF Inpatient Part A Billing), Sections 30.5 (Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections) and 30.5.1 (Adjustment Requests) as an attachment to CR 6002. In addition you might want to refer to Chapter 25, (Completing and Processing the Form CMS-1450 Data Set), at <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf> on the CMS Web site, for further description of the code sets reported on the CMS-1450.

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 Hemophilia Clotting Factor and HCPCS Code- 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:** MM6006 Revised      **Related Change Request (CR) #:** 6006  
**Related CR Release Date:** July 25, 2008      **Effective Date:** April 1, 2008  
**Related CR Transmittal #:** R1564CP      **Implementation Date:** January 5, 2009

**Note:** This article was revised on July 28, 2008, to reflect changes made to CR 6006, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6006 were revised. All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6006 which announces that Healthcare Common Procedure Coding System (HCPCS) code Q4096 (INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO VWF complex, NOS) will be payable for Medicare effective for claims with dates of service on or after April 1, 2008. Appropriate systems changes for editing hemophilia clotting factors **on inpatient claims** will not be made by Medicare’s Fiscal Intermediary Shared System (FISS) until January 5, 2009 release. This CR does not impact outpatient hospital claims or on any SNF claims as payment is made under different methodologies. Q4096 is payable in those settings effective April 1, 2008.

**Providers need to be aware of the instructions in the rest of this article in order to properly submit inpatient claims with Q4096 for discharges on or after April 1, 2008 through January 5, 2009.**

### Background

Effective for claims with dates of service on or after April 1, 2008, the new HCPCS code Q4096 listed in the following table will be payable for Medicare.

HCPCS	Short Descriptor	Long Description
Q4096	VWF complex, not Humate-P (NOS)	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF:RCO VWF complex, NOS

This factor (HCPCS code Q4096) is payable on inpatient claims effective April 1, 2008, and appropriate systems changes for editing Q4096 on inpatient claims will be made in the FISS on January 5, 2009.

**During the period between April 1, 2008 and January 5, 2009**, the following procedures need to be followed for inpatient claims:

- Hospital providers should submit inpatient claims to Medicare contractors (FIs and A/B MACs) for inpatient hospital stays during which Alphanate® (for the purposes of treating Von Willebrand disease) was given, omitting the line item(s) for HCPCS Code Q4096 for dates of discharge on and after April 1, 2008 but prior to January 5, 2009. This includes hospitals paid:
- Under the inpatient prospective payment system (IPPS), including Indian Health Service (IHS) hospitals,
- Under the long term care prospective payment system (LTCH PPS),
- Under the inpatient rehabilitation facility prospective payment system (IRF PPS), and
- On the basis of reasonable cost (TEFRA hospitals, and critical access hospitals (CAHs)).

This does not apply to claims from Inpatient Psychiatric Facilities (IPFs) paid under IPF PPS; IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including Q4096 on their inpatient claims.

Note: Medicare contractors will return to provider (RTP) any inpatient claims (Type of Bill (TOB) 11x) containing HCPCS Code Q4096 with discharge dates on and after April 1, 2008 but prior to January 5, 2009.

- Once the provider has received payment for the inpatient claim, the provider **should immediately submit an adjustment request** (TOB = 117), this time **including a line for HCPCS Code Q4096**.
- **Medicare contractors will hold these provider initiated adjustment requests containing HCPCS Code Q4096 with discharge dates between April 1, 2008 and January 5, 2009.**
- **Once the FISS system changes for Q4096 are implemented on January 5, 2009, Medicare contractors will process all held adjustment requests.**

As a reminder, for FY2008, the add-on payment for blood clotting factor administered to hemophilia inpatients is based on average sales price (ASP) plus 6 percent and a furnishing fee. The furnishing fee is updated each calendar year.

### **Additional Information**

The official instruction, CR 6006, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1564CP.pdf> on the Centers for Medicare & Medicaid Services (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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## **Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)- 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:** MM6048 **Revised**      **Related Change Request (CR) #:** 6048  
**Related CR Release Date:** July 25, 2008      **Effective Date:** March 13, 2008  
**Related CR Transmittal #:** R91NCD      **Implementation Date:** August 4, 2008

**Note:** This article was revised on July 28, 2008, to reflect changes to CR 6048, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. All other information remains the same.

### **Provider Types Affected**

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for Obstructive Sleep Apnea (OSA)-related services provided to Medicare beneficiaries.

### **Impact on Providers**

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of Continuous Positive Airway Pressure (CPAP) Therapy based upon a positive diagnosis of OSA by Home Sleep Testing (HST), subject to the requirements of CR 6048.

### **Background**

CMS reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the 'Additional Information' section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR 6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> on the CMS Web site.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The Apnea Hypopnea Index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The Respiratory Disturbance Index (RDI) is equal to the average number of respiratory disturbances per hour.

## Key Points of CR 6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

**NOTE:** DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
  - Polysomnography (PSG) performed in a sleep laboratory; or Unattended home sleep monitoring device of Type II; or
  - Unattended home sleep monitoring device of Type III; or
  - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

**NOTE:** In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is met:
  - AHI or RDI greater than or equal to 15 events per hour, or
  - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

**NOTE:** The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual

revision attached to CR 6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS website.

**NOTE:** The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.

- **G0398:** Home Sleep Test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.  
**G0398** Short Descriptor: Home sleep test/type 2 Porta
- **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  
**G0399** Short Descriptor: Home sleep test/type 3 Porta
- **G0400:** Home Sleep Test (HST) with type IV portable monitor, unattended; minimum of 3 channels  
**G0400** Short Descriptor: Home sleep test/type 4 Porta

#### **Additional Information**

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.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- 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:** MM6080 Revised      **Related Change Request (CR) #:** 6080  
**Related CR Release Date:** July 18, 2008      **Effective Date:** July 1, 2008  
**Related CR Transmittal #:** R1560CP      **Implementation Date:** July 7, 2008

**Note:** This article was revised on July 21, 2008, to reflect changes made to CR 6080 on July 18, 2008. CR 6080 was revised to reflect a legislative change that continues the cost-to-charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This required some adjustments to the table in this article. Also, the CR release date, transmittal number, and the Web address for accessing CR 6080 were revised. All other information remains the same.

### 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 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 Web site.

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 I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.

Effective Date	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 <b>RTP (Return to Provider)</b> .  <b>Note: The IOCE change to RTP this claim will no longer trigger an initial determination. The provider should bill statutorily excluded services as non-covered 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.
<b>1/1/08</b>	68	Implement mid-quarter NCD activation date for specified G codes and apply to G0398, G0399, and G0400 if Date of Service is before 03/13/08.
		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/R1560CP.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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## Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

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:** MM6107

**Related Change Request (CR) #:** 6107

**Related CR Release Date:** July 29, 2008

**Effective Date:** October 1, 2008

**Related CR Transmittal #:** R1566CP

**Implementation Date:** October 6, 2008

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and Fiscal Intermediaries (FIs) including regional home health intermediaries (RHHIs)).

### Impact on Providers

This article is based on Change Request (CR) 6107 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS website at

[http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage), or at the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

### Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

### Additional Information

The official instruction (CR 6107) issued to your Medicare contractor is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf> on the CMS Web site.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS Web site or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm>, in June of each year. The annual ICD-9-CM code changes are also

included in a CD-ROM, which you can purchase for \$25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01\\_overview.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage) on the CMS Web site.

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## **Requirement to Educate Providers Regarding Centers for Medicare & Medicaid Services (CMS) Use of Medicare Cost Report Data**

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:** MM6132

**Related Change Request (CR) #:** 6132

**Related CR Release Date:** August 1, 2008

**Effective Date:** January 1, 2009

**Related CR Transmittal #:** R3620TN

**Implementation Date:** January 5, 2009

### **Provider Types Affected**

Providers are required to submit cost reports to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 6132 which requires Medicare contractors to educate Medicare providers regarding the specific way that the CMS uses Medicare Cost Report (MCR) data. Medicare providers are statutorily required to submit cost reports annually.

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

MCR data play a central role in the development of the input price indexes (market baskets) used to update PPS payments. Similarly, they are essential in evaluating Medicare payment adequacy. It is crucial that Medicare providers fill out these reports with complete and valid data.

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

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

### **Background**

Most Medicare providers are statutorily required to submit annual Medicare Cost Reports (MCRs). The rules governing the submission of MCRs are set forth in the Code of Federal Regulations (CFR) (42 CFR 413.20(b) and 413.24(f)), which require providers to submit cost reports annually, with the reporting period based on the provider's accounting year. Additionally, under 42 CFR 412.52, all hospitals participating in the Prospective Payment System (PPS) must meet cost reporting requirements set forth in 42 CFR 413.20 and 413.24. See [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr413\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html) on the Internet. In reviewing the MCR data submitted by providers, CMS has found that many are failing to completely fill out their MCR with valid data likely due to the misconception that the data submitted on the MCR do not impact their payments.

To correct that misconception and to educate Medicare providers, CR 6132 is intended to provide information regarding how CMS uses the MCR data to update future PPS payments. It is crucial that Medicare providers know how CMS uses the MCR data and understand the importance of filling out these reports with complete and valid data.

The MCRs play a central role in CMS' development of the input price indexes (or market baskets) used to update PPS payments. Similarly, MCR data are essential in evaluating Medicare payment adequacy in aggregate and for subclasses of providers. Following are key uses of the MCR data:

- MCR data are used to develop the major cost weights that are used in the market baskets. Market baskets are used by CMS to annually update payments for the various providers paid via a PPS. They are designed to measure the input price inflation that providers face in the provision of the medical care services they deliver.
- MCR data are also used to determine the labor-related share of a given market basket, that is, the proportion of costs that are related to, influenced by, or vary with the local labor markets. The labor-related share is used in conjunction with the area wage index to determine the geographic adjustment to Medicare payments. This adjustment can vary widely, thus individual hospitals' payment levels can be very sensitive to the changes, and errors, in measuring the labor-related share. For more information on Medicare's Market Baskets, visit [http://www.cms.hhs.gov/MedicareProgramRatesStats/04\\_MarketBasketData.asp](http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasketData.asp) on the CMS website.
- CMS, as well as the Medicare Payment Advisory Commission (MedPAC), rely heavily on complete, valid, and up-to-date MCR data to evaluate the adequacy of PPS payments, i.e., determining whether Medicare is paying its "fair share" to providers' in aggregate and in a variety of subclasses (urban/rural, hospital-based/freestanding, etc.). In addition, periodically, CMS is approached by Congress or other payment rate stakeholders and asked to evaluate revenues and costs for specific providers and compare and contrast those estimates to those of their peers in the immediate market area. Having complete and valid data is essential to address such inquiries.
- Policymakers and program administrators, as stewards of the public trust, require the ability to validly quantify whether Medicare is paying a fair amount for the health services it purchases for its beneficiaries. The information submitted on the MCRs represents the only nationally-available data on which these statutorily-required payment updates in aggregate and by subclass can be appropriately based.

To carry out the tasks described above, CMS typically uses cost data from Worksheets A, B, D, and G of the cost report, provider characteristics and salary data from the S worksheets, and payment data from Worksheet E and other cost report worksheets (the location of which varies by provider-type). Be sure to be thorough and accurate in completing these worksheets.

### **Additional Information**

The official instruction, CR 6132, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R362OTN.pdf> on the CMS Web site.

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## **Intracranial Percutaneous Transluminal Angioplasty (PTA) with Stenting**

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:** MM6137

**Related Change Request (CR) #:** 6137

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

**Effective Date:** May 12, 2008

**Related CR Transmittal #:** R87NCD

**Implementation Date:** August 11, 2008

### **Provider Types Affected**

Physicians and providers who may wish to submit claims to Medicare Carriers, Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for PTA with stenting.

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

Be aware that CMS has reviewed the evidence and on May 12, 2008 posted a final decision memorandum following reconsideration of its National Coverage Determination (NCD) on Percutaneous Transluminal Angioplasty (PTA) with intracranial stent placement at section 20.7.B.5 of the Medicare NCD Manual. With CR 6137, CMS reaffirms its existing NCD with no changes, and will continue to cover PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis > 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. CMS will continue its national non-coverage for all other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries.

### **Background**

This article is based on Change Request (CR) 6137, which responds to a request on August 24, 2007 by the manufacturer to reconsider and expand coverage to include Coverage with Evidence Development (CED) for intracranial stenting and angioplasty for patients in the IDE clinical trials.

### **Additional Information**

You may see the official instruction (CR 6137) issued to your Medicare Carrier, FI, or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R87NCD.pdf> on the CMS Web site. Section 20.7 of the Medicare NCD Manual is attached to CR6137.

You may also review MM5432 which preceded this article and provides the previous CMS response to PTA with stenting at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.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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## **Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management**

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:** MM6138

**Related Change Request (CR) #:** 6138

**Related CR Release Date:** July 25, 2008

**Effective Date:** March 19, 2008

**Related CR Transmittal #:** R1562CP and R90NCD

**Implementation Date:** August 25, 2008

### **Provider Types Affected**

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs)) for home PT and International Normalized Ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

### **Impact on Providers**

This article is based on Change Request (CR) 6138, and alerts providers that effective for claims with dates of service on and after March 19, 2008 the CMS revised its National Coverage Determination (NCD) limits and will expand the population eligible for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. See the 'Key Points' section of this article for details.

### **Background**

The Prothrombin Time (PT) test is an in-vitro test to assess coagulation. PT testing and its normalized correlate, the International Normalized Ratio (INR), are the standard measurements for therapeutic effectiveness of warfarin therapy. Warfarin, Coumadin®, and others, are self-administered, oral anticoagulant, or blood thinner, medications that affect a person's Vitamin K-dependent clotting factors.

Currently, Medicare's National Coverage Determination (NCD) at 190.11 of the NCD Manual limits coverage of home PT/INR monitoring to anticoagulation management for patients with mechanical heart valves who are on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See [http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410\\_32.pdf](http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf) on the CMS Web site.) and the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device;
2. The patient must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
3. Self-testing with the device should not occur more frequently than once a week.

CMS received a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. CR 6138 is a result of that request.

## Key Points of CR 6138

Effective for claims with dates of service on and after March 19, 2008, CMS revised its NCD to provide for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device; and,
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home; and,
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring; and,
4. Self-testing with the device should not occur more frequently than once a week.

**NOTE:** Applicable HCPCS Codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 Outpatient Code Editor (OCE) and Medicare Physician Fee Schedule updates, the descriptors of these codes will change to reflect the revised coverage policy.

The following revised descriptors reflect the expanded NCD criteria and are effective for services on or after March 19, 2008 as follows:

- **Long Descriptor G0248:** Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.

**Short Descriptor G0248:** Demonstrate use home INR mon

- **Long Descriptor G0249:** Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week

**Short Descriptor G0249:** Provide INR test mater/equipm

- **Long Descriptor G0250:** Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.

### **Short Descriptor G0250:** MD INR test revie inter mgmt

**NOTE:** Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same.

**NOTE:** Porcine valves are not included in this NCD, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves unless covered by local Medicare contractors.

**NOTE:** This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the NCD Manual.

The following are applicable diagnosis codes to be used when submitting claims to Medicare contractors:

- For services furnished on or after March 19, 2008, the applicable ICD-9-CM diagnosis codes for this benefit are:
  - V43.3 (organ or tissue replaced by other means; heart valve);
  - 289.81 (primary hypercoagulable state);
  - 451.0-451.9 (phlebitis & thrombophlebitis);
  - 453.0-453.3 (other venous embolism & thrombosis);
  - 415.11-415.19 (pulmonary embolism & infarction); or
  - 427.31 (atrial fibrillation (established) (paroxysmal))

Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with CR 6138. Denied claims are subject to appeal. When denying such claims, your Medicare carrier, FI or A/B MAC will use the following codes:

- **Remittance Advice Remark Code N386**, “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp> on the CMS Web site. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- **Claim Adjustment Reason Code 50** will be used: “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”

Providers should be aware that your Medicare Contractor will assign liability for the denied charges to you unless documentation of an Advance Beneficiary Notice (ABN) is present on the claim. Also, your contractor will not search for claims but will adjust inappropriately denied claims with dates of service March 19, 2008, through the implementation date of CR 6138, that are brought to their attention.

#### **Additional Information**

CR 6138 was issued in two transmittals, i.e., one for the NCD Manual and one for the *Medicare Claims Processing Manual*. These transmittals are available at <http://www.cms.hhs.gov/Transmittals/downloads/R90NCD.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1562CP.pdf> respectively, on the CMS Web site.

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## Screening DNA Stool Test for Colorectal Cancer- **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:** MM6145 **Revised**      **Related Change Request (CR) #:** 6145  
**Related CR Release Date:** July 25, 2008      **Effective Date:** April 28, 2008  
**Related CR Transmittal #:** R93BP and      **Implementation Date:** August 25, 2008  
R92NCD

**Note:** This article was revised on August 11, 2008, to reflect changes made to CR 6145. The transmittal number, release date, and Web address for accessing the NCD portion of CR 6145 were revised. All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 6145 which announces the CMS decision regarding a request for reconsideration of the current National Coverage Determination (NCD) for colorectal cancer screening.

### What You Need to Know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

### What You Need to Do

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

### Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the Code of Federal Regulations (42 CFR 410.37(a)(1)(v)) at [http://www.access.gpo.gov/nara/cfr/waisidx\\_02/42cfr410\\_02.html](http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html) and the Social Security Act (section 1861(pp)(1)(D)) [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the Medicare NCD Manual for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time.

### **Additional Information**

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the Medicare Benefit Policy Manual and one for the National Coverage Determinations Manual. These two transmittals are at <http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf>, respectively, on the CMS Web site.

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## **Update-Long Term Care Hospital (LTCH) Prospective Payment System (PPS) for Rate Year (RY) 2009**

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:** MM6114

**Related Change Request (CR) #:** 6114

**Related CR Release Date:** July 3, 2008

**Effective Date:** July 1, 2008

**Related CR Transmittal #:** R1547CP

**Implementation Date:** July 7, 2008

### **Provider Types Affected**

Long Term Care Hospitals (LTCHs) claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services paid under the LTCH PPS that are provided to Medicare beneficiaries.

### **Provider Action Needed**

This article is based on Change Request (CR) 6114 which announces changes to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) for Rate Year (RY) 2009. Be sure billing staff is ware of this update.

### **Background**

On October 1, 2002, CMS implemented the LTCH PPS under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. See the Federal Register, Vol. 67, No. 169, August 30, 2002 at [http://www.access.gpo.gov/su\\_docs/fedreg/a020830c.html](http://www.access.gpo.gov/su_docs/fedreg/a020830c.html) on the internet.

Payments under this LTCH PPS are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data.

CMS is required to update the payments made under the LTCH PPS annually, and since 2004 there have been two significant LTCH PPS updates each year:

1. The Federal payment rates update that occur in July of each year (the Rate Year (RY) cycle), and
2. The LTC-DRG update that occurs in October of each year.

### **RY2009 Payment Updates**

In the RY 2009 final rule, CMS established a policy to consolidate these two annual update cycles such that the annual updates to both the Federal payment rates and the medical severity LTC-DRGs (MS-LTC-DRGs) will occur on October 1 of each year, beginning with October 1, 2009.

To begin this change, RY 2009 will be a 15-month rate year (from July 1, 2008 through September 30, 2009), and all updates to the PRICER for RY 2009 will be made based on calculations reflecting this change.

For the LTCH PPS 2009 Rate Year (July 1, 2008 through September 30, 2009):

- The standard Federal rate is \$39,114.36;
- The fixed loss amount is \$22,960;
- The labor-related share is 75.662 percent; and
- The non-labor related share is 24.338 percent.

There is no longer a phase-in of the LTCH PPS wage index adjustment as of cost reporting periods beginning on or after October 1, 2006. Therefore, the wage index table within the PRICER includes only one column that contains the wage index value that will be effective for all LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009.

### **Short-Stay Outlier (SSO) Payment Adjustment Formula**

On December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted that mandated a modification to the SSO payment adjustment formula for a 3-year period beginning on the date of enactment of the SSO policy implemented in RY 2008 shall not apply for a 3-year period beginning with discharges occurring on or after December 29, 2007. Therefore, there will be no comparison of the covered Length Of Stay (LOS) of the SSO case to the “IPPS threshold” in determining the payment adjustment for SSO cases. For SSO discharges occurring on or after December 29, 2007, and before December 29, 2010, the adjusted payment for a SSO case is equal to the least of:

- 100 percent of estimated cost of the case;
- 120 percent of the LTC-DRG per diem amount;
- the full LTC-DRG payment, or
- a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount.

As noted above, during this 3-year period specified by the MMSEA, all SSO cases (including those where the covered LOS exceeds the “IPPS threshold”) are paid under the SSO payment formula that became effective beginning in RY 2007.

CR 6114 makes other clarifying language adjustments to Chapter 3, Section 150.9 (Payment Rate) of the *Medicare Claims Processing Manual*. That revised section is attached to CR 6114. The CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.pdf> on the CMS Web site.

### **Legislative Adjustments to Payment Policy for Co-Located Providers**

For Hospitals within Hospitals (HwH), satellite facilities, and onsite SNFs, the MMSEA legislation also made several changes for a 3-year period beginning on December 29, 2007. These changes impact the basic payment formula under the 25 percent threshold payment adjustment for Medicare discharges from referring hospitals. These changes are annotated in a revised Chapter 3, Section 150.9.1.4 (Payment Policy for Co-Located Providers), which is attached to CR 6114.

### **COLA Factors for Alaska and Hawaii**

Also note that in the LTCH Final Rule for RY 2009, the Cost of Living Adjustment (COLA) factors for LTCHs located in Alaska and Hawaii are not revised from their current values, and these current COLA

factors will continue to be effective for LTCH PPS discharges occurring on or after July 1, 2008 through September 30, 2009. The COLA factors for Alaska and Hawaii hospitals are shown in the following table.

<b>Alaska and Hawaii Hospitals Area Cost of Living Adjustment Factors Effective for Discharges on and after October 1, 2008</b>	
<b><u>Alaska</u></b>	
City of Anchorage and 80-kilometer (50 mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50 mile) radius by road	1.24
City of Juneau and 80-kilometer (50 mile) radius by road	1.24
Rest of Alaska	1.25
<b><u>Hawaii</u></b>	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

### **Additional Information**

The official instruction, CR 6114, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1547CP.pdf> on the CMS Web site.

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

### **Disclaimer**

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## **Revision of the Requirements for Denial of Payment for New Admissions (DPNA) for Skilled Nursing Facility (SNF) Billing**

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:** MM6116

**Related Change Request (CR) #:** 6116

**Related CR Release Date:** July 18, 2008

**Effective Date:** January 1, 2009

**Related CR Transmittal #:** R1555CP

**Implementation Date:** January 5, 2009

### **Provider Types Affected**

SNFs impacted by payment ban situations and submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in SNFs.

### **Impact on Providers**

This article is based on Change Request (CR) 6116 and addresses the consequences that occur when CMS impose sanctions that preclude Medicare payment for new admissions (or DPNA) to a SNF when a facility is not in substantial compliance with Medicare requirements of participation. Be sure billing staff are aware of these instructions, especially the use of occurrence span code 80 on appropriate claims.

### **Background**

Under the Social Security Act at sections 1819(h) and 1919(h) and CMS regulations at 42 CFR 488.417, CMS may impose a DPNA against a SNF when a facility is not in substantial compliance with requirements of participation.

Medicare policy indicates that beneficiaries admitted before the effective date of a DPNA situation and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and are not subject to the denial of payment upon return.

Medicare instructions previously indicated that SNFs should append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply.

However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations.

For example, a readmission could apply to patients that resided in the SNF prior to the imposition of the ban, whether on private pay or covered under another insurer, then went out to a hospital for a qualifying stay and returned directly back to the SNF upon discharge of the hospital. If the patient, in this scenario, did not receive Medicare SNF covered care within 30 days of the readmission then the condition code 57 would not be appropriate.

Therefore, CMS is updating DPNA instructions to require SNF providers to append occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. **As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable.**

In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a LOA, the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

### **Key Points of CR 6116**

Chapter 6, Section 50 of the *Medicare Claims Processing Manual* covers SNF payment bans and related DPNA actions. That section is revised by CR 6116 as follows:

#### ***Billing for Admissions Not Covered by the Payment Ban***

Effective January 1, 2009, when a SNF that is under a payment ban needs to submit a claim for a Medicare beneficiary readmission that is not subject to the payment ban, the SNF must use **occurrence span code 80 for reporting prior same-SNF stay dates**. The definition of “Prior Same-SNF Stay Dates for Payment Ban Purposes” is: **The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.** (Previously, SNFs used condition code 57 for this purpose, but that code does not apply to all payment ban situations.)

#### ***Effect on Utilization Days and Benefit Period***

In situations where the beneficiary’s SNF admission is subject to the payment ban, but the **provider fails to issue the proper beneficiary liability notice, the provider is liable** for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary’s benefit period. The SNF may collect any applicable copayment amounts from the beneficiary. **These days will be charged against the patient’s utilization** as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

#### **Effect of an Appeal to A DPNA on Billing during the Period the SNF Is Subject to a DPNA**

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the provider liability billing instructions in the revised Section 50, which is attached to CR 6116. In essence, the SNF needs to file a covered bill with the FI or A/B MAC using occurrence span code 77 that indicates the facility is liable for the services in situations where the SNF failed to issue the proper beneficiary liability notice and any applicable copayments will be charged to the beneficiary’s Part A benefit period. In addition, the SNF needs to file a non-payment bill for non-covered Part A services using **condition code 21 that indicates beneficiary liability**. Remember that services that would have been eligible for Part A benefits in the absence of sanctions may not be billed as Part B charges to Medicare.

#### **Conducting Resident Assessments**

If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, no payment is made and the SNF must submit a claim using the Health Insurance

Prospective Payment System (HIPPS) default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-Required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF may bill the Medicare 5-day and 14 day assessment using the HIPPS code generated by the 14-day Omnibus Budget Reconciliation Act (OBRA) required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required five day or 14 day assessment, the SNF must bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an Assessment Reference Date (ARD) that fell in the applicable Medicare-Required Assessment window for the 30, 60 and 90 day Medicare-Required Assessments it shall bill the default rate. If the SNF did perform an assessment, including a Significant Change in Status Assessment (SCSA), where the ARD fell in the window of a 30, 60 or 90-day Medicare-Required Assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in Chapter 28 of the Provider Reimbursement Manual. The date the sanction is lifted is Day ONE for purposes of the Medicare assessment schedule.

**Example 1:** The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the five-day Medicare-Required Assessment for up to 14 days. Day 15 is day 1 for purposes of starting the Medicare-required assessment schedule and a five-day Medicare required assessment shall be performed.

**Example 2:** The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA Assessment. The initial OBRA assessment shall be used to bill the five -day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment may be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a five-day Medicare required assessment shall be performed.

### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 6116) issued to your Medicare contractor. Current Medicare instructions for DPNA billing reside in sections 50-50.7 of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual*. These sections are revised by CR 6116 and you may review these revised sections in the attachment to this CR 6116 at <http://www.cms.hhs.gov/Transmittals/downloads/R1555CP.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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### **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, September 12, 2008	9:00 a.m.-11:00 p.m. CST
Friday, September 26, 2008	9:00 a.m.-11:00 p.m. CST



## **Provider Reminder: Type of Bill 13X – Correct Billing of CPT Code 82962**

Recent Comprehensive Error Rate Testing (CERT) analysis has shown an increase in inappropriate billing by type of bill 13X for *Current Procedural Terminology* (CPT) 82962 (Glucose, blood by glucose monitoring device(s), cleared by the FDA specifically for home use).

CERT identified provider documentation errors for claims billed with CPT code 82962. Providers submitted documentation that supported routine testing and sliding scale insulin, per protocol, with no changes made or problems reported.

In order for glucose monitoring to be considered reasonable and necessary, it must be ordered by the physician who must be promptly notified of the results. The physician must use the results and instruct continuation or modification of patient care. This includes the physician's order for another lab service. Appropriate documentation must be maintained to support the medical necessity of the service and the claim submitted.

Upon request by the CERT Documentation Contractor, it is important that providers submit adequate documentation for laboratory testing.

Educational articles providing the results of previous reviews and guidelines for the appropriate utilization of blood glucose monitoring were posted on [What's New from Cahaba GBA Web pages](#) on December 15, 2005, February 8, 2007, May 2, 2007, July 25, 2007, October 24, 2007, March 3, 2008 and May 21, 2008.

For additional information regarding requirements for diagnostic tests, refer to the following references:

- [Publication 100-02 Medicare Benefit Policy Manual - Change Request 5743; Transmittal 80 - Subject: Requirements for Ordering and Following Orders for Diagnostic Tests;](#)
- [Title 42 Code of Federal Registry - section 410.32\(a\);](#) and,
- CERT Report Data may be viewed by selecting the "CERT Reports" link on the [CMS CERT Web page](#).



## 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.

## **September 2008 Education Events**

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

➤ **[Navigating the Medicare Resource Sea for New and Small Providers- Webinar](#)**

**Date:** Tuesday, September 9, 2008

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

**Registration Deadline:** Tuesday, September 2, 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:** This webinar will explore critical Medicare resources for Part A providers found on the Cahaba GBA and the Centers for Medicare & Medicaid Services (CMS) Web sites. The resources to be referenced are important in developing an understanding of the Medicare program. Although any Part A provider will benefit from attending, the intended audience for this event is Part A providers who have 25 or fewer full-time employees and recently received Medicare certification or new staff members of existing Medicare providers.

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

**Date:** Tuesday, September 30, 2008

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

**Registration Deadline:** Tuesday, September 23, 2008

**Intended Audience:** All Medicare Part A Fiscal Intermediary Providers

**Description:** This webinar will discuss the various function keys used in the Fiscal Intermediary Standard System (FISS), as well as, define the status/location codes, which appear in FISS. It will also cover capabilities available using the FISS inquiry screens, including identification of claims selected for Medical Review Additional Development Request (ADR).

## 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](#).