

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



October/November 2008

Vol. 16, No. 1 & 2

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 149H <https://www.cahabagba.com>.



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	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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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 150H [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

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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Office of the Inspector General Statement

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 on the Internet.



Medicare Disproportionate Share Hospital Fact Sheet

The Medicare Disproportionate Share Hospital Fact Sheet (revised April 2008) is now available in print format. 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. To place your order, 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. 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> on the CMS Web site.



E-Prescribing

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the Administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value. Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a 2 percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a one half percent incentive payment in 2013. Beginning in 2012, eligible professionals who are not successful electronic prescribers will receive a reduction in payment. Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship. To read more, see the entire HHS Fact Sheet at <http://www.hhs.gov/news/facts/eprescribing.html> on the CMS website.



Flu Shot Reminder

Flu Season Is Coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care workers also need to protect themselves. Get Your Flu Shot. – Not the Flu. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, visit http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing, go to http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Web site.



Evaluation & Management Services Guide

The July 2008 version of the *Evaluation & Management Services Guide*, which provides evaluation and management services information about medical record documentation, International Classification of Diseases and Current Procedural Terminology codes, and key elements of service, is now available on the CMS Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf.



Critical Access Hospital Fact Sheet

The April 2008 version of the Critical Access Hospital Fact Sheet is now available in downloadable format from the CMS Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/CritAccessHospfctsht.pdf> on the CMS website. The fact sheet provides information about eligible Critical Access Hospital (CAH) providers; CAH designation; CAH payments; reasonable cost payment principles that do not apply to CAHs; election of Standard Method or Optional (Elective) Payment Method; Medicare Rural Pass-Through funding for certain anesthesia services; Health Professional Shortage Area Incentive payments; Physician Scarcity Area Bonus payments; Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and grants to states under the Medicare Rural Hospital Flexibility Program. The fact sheet is also now 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.”



Medicare Payments Reduced

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe. The Taxpayer Relief Act of 1997, Section 1024, authorizes the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of “WU” in the PLB03-1 data field. For more information, please see MLN Matters Article #MM6125 available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS Web site.



2009 Medicare Part B Competitive Acquisition Program (CAP)

The Centers for Medicare & Medicaid Services (CMS) recently announced the postponement of the 2009 Medicare Part B Competitive Acquisition Program (CAP). The program will continue through December 31, 2008. Earlier this year, CMS accepted bids for vendor contracts for the 2009-11 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the 2009 program. As a result, CAP physician election for participation in the CAP in 2009 will not be held, and CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008. Later this fall, CMS will provide additional guidance for participating CAP physicians on how to transition out of the program. This information will be posted on the CMS CAP physician’s page at: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp. CMS also plans to seek feedback on the CAP from participating physicians, potential vendors, and other interested parties. Information about how to submit comments will be available at <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>



Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

MLN Matters Number: MM6109

Related Change Request (CR) #: 6109

Related CR Release Date: July 25, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R1563CP

Implementation Date: October 6, 2008

Provider Types Affected

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

Impact on Providers

CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008. Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) website at <http://www.wpc-edi.com/Codes> on the Internet. The tables at the end of this article (right after the ‘Additional Information’ section) summarize the latest changes to these lists, as announced in CR 6109.

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

The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Medicare Initiated
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	02/29/08
N175	Missing review organization approval.	02/29/08
N241	Incomplete/invalid review organization approval.	02/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	02/29/08

Deactivated Codes

Code	Current Narrative	Last Modified
None		

Health Care Claim Adjustment Reason Codes

Code	Current Narrative	Effective Date (per WPC website)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	01/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	01/27/2008
215	Based on subrogation of a third party settlement	01/27/2008
216	Based on the findings of a review organization	01/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	01/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	01/27/2008
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	01/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	01/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	01/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	01/27/2008

Modified Codes

Code	Modified Narrative	Medicare Initiated
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	01/27/2008

Deactivated Codes

Code	Modified Narrative	Medicare Initiated
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	01/01/2009

Additional Information

To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf> on the CMS website.

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





Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries- 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: MM6139 **Revised** **Related Change Request (CR) #:** 6139
Related CR Release Date: August 8, 2008 **Effective Date:** March 1, 2009
Related CR Transmittal #: R22COM **Implementation Date:** January 5, 2009

Note: This article was revised on August 13, 2008, to change the title to more accurately reflect the Change Request requirements. Additionally, changes were made to further clarify the authentication requirements. In particular, the 'Note' was changed to show that you will only be allowed three attempts to correctly provide your NPI, PTAN, AND last 5-digits of your TIN.

Provider Types Affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN). Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

- **Authentication of Providers with No NPI**

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

- **Beneficiary Authentication**

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication: 1) last name, 2) first name or initial, Health Insurance Claim Number (HICN), 3) and either date of birth (eligibility, next eligible date), and 4) Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) or date of service (claim status, CMN/DIF (post-claim.)).

- **Written Inquiries**

In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)),

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at <http://www.cms.hhs.gov/Transmittals/downloads/R22COM.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.





Fiscal Year (FY) 2006 Supplemental Security Income (SSI) 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: MM6126

Related Change Request (CR) #: 6126

Related CR Release Date: August 8, 2008

Effective Date: May 5, 2008

Related CR Transmittal #: R363OTN

Implementation Date: September 8, 2008

Provider Types Affected

Hospitals submitting cost reports to a Medicare Administrative Contractor (A/B MAC) or fiscal intermediary (FI).

Impact on Providers

This article is based on Change Request (CR) 6126, which states that, as of May 5, 2008, hospitals (this includes Acute Care Hospitals paid under the Inpatient Prospective Payment System and Inpatient Rehabilitation Facilities (IRF)) may elect to use either its FY 2005 or FY 2006 Supplemental Security Income (SSI) ratio from the files published on the CMS Web site to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.

Key Points

- Until the FY 2007 SSI ratios are published, a hospital, as defined above, may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS website to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.
- Until the FY 2007 SSI ratios are published, if a hospital (as defined above) submitted its cost report using the FY 2006 ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit a written request, signed by an official of the hospital, to its FI or MAC. After receiving such a written request, the FI/MAC shall issue (or reissue to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Background

A hospital may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS Web site to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio. Once the FY 2007 SSI ratios are published on the CMS Web site, hospitals will no longer have the option of submitting cost reports using the published FY 2005 or FY 2006 SSI ratio.

If a hospital has already submitted its cost report using the FY 2006 SSI ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit its written request, signed by an official of the hospital, to its Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC). After receiving such a written request, the FI/MAC will issue (or re-issue, to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Additional Information

For complete details regarding this CR please see the official instruction (CR 6126) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R363OTN.pdf> on the CMS Web site.

CMS has published IRF SSI ratios in the “Downloads” section of

http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage on the CMS Web site. Other

SSI ratios are published in the “Downloads” section of

http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage on the CMS 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.





Transition of Responsibility for Medical Review from Quality Improvement Organizations (QIOs)- 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: MM5849Revised

Related Change Request (CR) #: 5849

Related CR Release Date: August 7, 2008

Effective Date: May 5, 2008

Related CR Transmittal #: R264PI and R1571CP

Implementation Date: No later than August 15, 2008

Note: This article was changed on August 19, 2008, to correct the effective date, which should have been stated as August 1, 2008, NOT April 1, 2008. All other information remains unchanged.

Provider Types Affected

Hospitals paid under the Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH).

What You Need to Know

CMS has shifted the majority of utilization review of inpatient hospital claims (including acute Inpatient Prospective Payment System (IPPS) hospital and Long-Term Care Hospital (LTCH) claims) from the Quality Improvement Organizations (QIOs) to Medicare Fiscal Intermediaries (FIs) and Part A and B Medicare Administrative Contractors (A/B MACs). FIs and MACs will begin performing reviews on IPPS hospital and LTCH claims for improper payment reduction purposes in August 2008. FIs and MACs will be allowed to review claims submitted January 1, 2008 forward.

Responsibility for IPPS hospital and LTCH error rate measurement has been shifted from the QIOs to the Comprehensive Error Rate Testing (CERT) contractor. The CERT contractor began reviewing acute care hospital claims for improper payment measurement beginning April 1, 2008.

Background

This article is based on Change Request (CR) 5849. CR 5849 makes modifications to the *Medicare Program Integrity Manual*. The key points are:

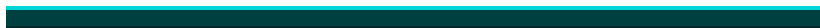
- FIs or MACs may still make referrals to the QIO for quality of care issues of claims when their review of outpatient claims or inpatient claims data reveal a problem provider.
- FIs and MACs will perform most utilization reviews, for improper payment reduction purposes, of acute care inpatient hospital claims, and the CERT contractor will measure the inpatient hospital paid claims error rate.
- QIOs will no longer conduct the HPMP program and will instead focus their efforts on quality improvement, continuing to perform quality reviews, expedited determinations, and certain utilization reviews, such as provider-requested higher-weighted Diagnosis Related Group (DRG) reviews and referrals.

Additional Information

The official instruction (CR 5849) was issued to your Medicare FI or A/B MAC in two transmittals, one related to the *Medicare Program Integrity Manual* and one for the *Medicare Claims Processing Manual*. These transmittals are available at <http://www.cms.hhs.gov/Transmittals/downloads/R264PI.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1571CP.pdf> respectively on the CMS Web site.

CMS has posted a Fact Sheet and Power Point Slides to the CMS website. These documents can be found at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/InpatientReviewFactSheet.pdf> and http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/Inpatient_Hospital_Review_Transition.zip 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.





2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations

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: MM6121

Related Change Request (CR) #: 6121

Related CR Release Date: August 15, 2008

Effective Date: September 15, 2008

Related CR Transmittal #: R366OTN

Implementation Date: September 15, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6121 which reminds the Medicare physician community of the requirements to correctly enroll in order to conduct Mass Immunization Roster Billing and Centralized Billing of Medicare for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for Mass Immunizer Roster Billers.

Background

CMS is issuing Change Request (CR) 6121 as a reminder for Mass Immunization Roster Billing and Centralized Billing for Influenza and Pneumococcal vaccinations.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals, and they must be properly licensed in the States in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

Providers who only offer influenza services:

- May enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a Centralized Biller, and
- Must meet the guidelines for being either a mass immunizer or centralized biller.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must:

- Accept assignment on both the vaccine and its administration,
- Bill only for influenza and/or pneumococcal vaccinations, and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS Central Office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS 855 provider enrollment form (See http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp on the CMS Web site). Applications are available from the local contractors. Refer to the *Medicare Claims Processing Manual*, Chapter 18, Sections 10-10.5 at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Web site for more information on billing requirements.

Note: Medicare Part B pays 100% for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year;
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration; and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease, and
- Have not received a pneumococcal vaccine within the last five years, or
- Are revaccinated because they are unsure of their vaccination status.

Additional Information

CMS offers a number of free educational products on its Medicare Learning Network (MLN). These products are available on the MLN Preventive Services Educational Products web page located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Web site.

The official instruction, CR 6121, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R366OTN.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.





Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice- 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: MM6125 **Revised** **Related Change Request (CR) #:** 6125
Related CR Release Date: August 15, 2008 **Effective Date:** October 1, 2008
Related CR Transmittal #: R367OTN **Implementation Date:** October 6, 2008

Note: This article was revised on August 21, 2008, to clarify the “Provider Types Affected”. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.

What You Need to Know

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of “WU” in the PLB03-1 data field.

What You Need to Do

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

Background

In July 2000, the Treasury Department’s Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of “WU”

in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.

Additional Information

To view the official instruction (CR 6125) issued to your Medicare contractor on this issue, visit <http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.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.





Implementation of a New Claim Adjustment Reason Code (CARC), #213

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: MM6131

Related Change Request (CR) #: 6131

Related CR Release Date: August 15, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1578CP

Implementation Date: January 5, 20089

Provider Types Affected

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

What You Need to Know

CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition. Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain Designated Health Services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A “financial relationship” includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC #213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition.

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

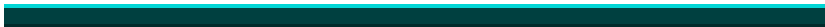
Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf on the CMS Web site; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information

You can find more information about CARC #213 by going to CR 6131, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf> on the CMS Web site. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR.

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





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

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

MLN Matters Number: MM6180

Related Change Request (CR) #: 6180

Related CR Release Date: August 22, 2008

Effective Date: January 1, 2008

Related CR Transmittal #: R1580CP

Implementation Date: October 6, 2008

Provider Types Affected

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

Key Points of CR 6180

- Changes in the October Update to the 2008 MPFSDB are as follows:

CPT/HCPCS Codes	Action
15878 and 15879	Bilateral Indicator= 1
92557 and 92567	PC/TC Indicator= 9
93660-26	Multiple Procedure Indicator =2
G0398, G0399, and G0400	PC/TC Indicator= 1

- Changes effective March 13, 2008 for G0398–TC, G0398–26, G0399-TC, G0399-26, G0400-TC, and G0400-26 are as described in Attachment 1 of CR 6180.
- An editorial change was made to the long descriptor of G0250 as noted in Attachment 1 of CR 6180.

Make certain your billing staffs are aware of these changes. Your Medicare contractor will retroactively adjust claims if you bring such claims to their attention.

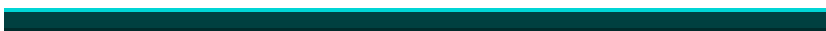
Background

This article is based on CR 6180, which states that payment files were issued to contractors based upon the 2008 MPFS Final Rule. CR 6180 amends those payment files.

Additional Information

You may see the official instruction (CR 6180) issued to your Medicare Carrier or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1580CP.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.





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: August 29, 2008 **Effective Date:** March 13, 2008
Related CR Transmittal #: R94NCD **Implementation Date:** August 4, 2008

Note: This article was revised on September 2, 2008, to reflect changes to CR 6048, which CMS revised on August 28, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. In addition, some language in item 3 of the 'Key Points' section was clarified. 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 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) are met:

- AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
- AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring 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 of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring.

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 Web site.

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 study 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/R94NCD.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.





Physician Signature Requirements for Diagnostic Tests

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: MM6100

Related Change Request (CR) #: 6100

Related CR Release Date: August 29, 2008

Effective Date: January 1, 2003

Related CR Transmittal #: R94BP

Implementation Date: September 30, 2008

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MAC)) for diagnostic laboratory services provided to Medicare beneficiaries.

What You Need to Know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests (including x-ray, laboratory, and other diagnostic tests) that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional Information

You can find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at <http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf> on the CMS Web site. You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR 6100.

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





2009 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

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: MM6150

Related Change Request (CR) #: 6150

Related CR Release Date: August 29, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R158CP

Implementation Date: January 5, 2009

Provider Types Affected

Physicians and other providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries in Health Professional Shortage Areas (HPSA).

What You Need to Know

CR 6150, from which this article is taken provides your carriers, FIs, and A/B MACs with the names of the test and final files for the Health Professional Shortage Area (HPSA) bonus payments for 2009 and alerts providers that the 2009 file will be posted to the CMS Web site when it is available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors in early December of each year. CR 6150, from which this article is taken, provides them the names of the test and final 2009 HPSA bonus payment files which contractors will use for the automated bonus payment for claims with dates of service on or after January 1, 2009, through December 31, 2009.

You will find the annual HPSA bonus payment file (as it becomes available) and other important HPSA information on the CMS Web site at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>. You should also review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf> on the CMS Web site and following the instructions on the page.

Additional Information

You can find the official instruction, CR 6150, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1582CP.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.



Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) Imaging for Infection and Inflammation

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: MM6099

Related Change Request (CR) #: 6099

Related CR Release Date: June 27, 2008

Effective Date: March 19, 2008

Related CR Transmittal #: R84NCD

Implementation Date: July 28, 2008

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6099 instructing that CMS is continuing its national non-coverage policy for the off-label indications of Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) imaging for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Background

CMS was asked to reconsider the current, de facto non-coverage for FDG PET imaging in the Medicare National Coverage Determinations (NCD) Manual (Section 220.6), for the following off-label uses (instead of bone, leukocyte, and/or gallium scintigraphy):

1. Suspected chronic osteomyelitis in patients with:
 - previously documented osteomyelitis with suspected recurrence, or
 - symptoms of osteomyelitis for more than 6 weeks (including diabetic foot ulcers);
2. Investigation of patients with suspected infection of hip prosthesis; and
3. Fever of unknown origin in patients with:
 - a febrile illness of >3 weeks duration,
 - a temperature of >38.3 degrees Centigrade on at least two occasions, and
 - uncertain diagnosis after a thorough history, physical examination, and 1 week of proper investigation.

Based upon its review, CMS determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore is not reasonable and necessary under the Social Security Act (section 1862(a)(1)(A) (See that provision at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet.)

Additionally, CMS determined that this request for coverage is not appropriate for the Coverage with Evidence Development (CED) paradigm.

Additional Information

The official instruction, CR 6099, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R84NCD.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.





Medicare Coverage of Artificial Hearts- 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: MM6185 Revised

Related Change Request (CR) #: 6185

Related CR Release Date: September 10, 2008

Effective Date: May 1, 2008

Related CR Transmittal #: R95NCD and R1592CP

Implementation Date: December 1, 2008

Note: This article was revised on September 11, 2008, to reflect changes made to CR 6185. The CR was changed to revise the implementation date to December 1, 2008. In addition, the transmittal numbers, CR release date, and the Web addresses for accessing CR 6185 were revised. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (A/B MACs)) for cardiac-related services and supplies to Fee-for-Service (FFS) Medicare beneficiaries and Managed Care Plan Medicare beneficiaries.

What You Need to Know

CR 6185, from which this article is taken, announces that Medicare has issued a National Coverage Determination (NCD) (effective on May 1, 2008), that establishes limited coverage for artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies meeting all of the Coverage with Evidence Development (CED) criteria.

Make sure that your billing staffs are aware of these artificial heart coverage and billing instructions in CR 6185. Details are presented in the 'Background' section below.

Background

As determined by the May 19, 1986 CMS NCD, the use of artificial hearts was not covered by Medicare prior to May 1, 2008. CR 6185 announces that Medicare has issued an NCD that establishes limited coverage for artificial hearts as a bridge-to-transplantation and as destination therapy, under CED.

This means that Medicare will cover artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies that meet all of the CED criteria listed below.

For your reference, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS has determined meet the standards, and address the research questions, that are listed below. Clinical studies that CMS has determined to have met these requirements will be listed at http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp on the CMS Web site, and coverage under CED will only apply to artificial hearts that are implanted in the context of one of these approved clinical studies.

To be approved, a clinical study must:

1. Address at least one of the following questions:

- Were there unique circumstances (such as expertise available in a particular facility or an unusual combination of conditions in particular patients) that affected their outcomes?
- What will be the average time to device failure when the device is made available to larger numbers of patients?
- Do results adequately give a reasonable indication of the full range of outcomes (both positive and negative) that might be expected from more widespread use?

And

2. The clinical study must meet all of the following criteria:

- It must be reviewed and approved by the Food and Drug Administration (FDA);
- Its principal purpose is to test whether a particular intervention potentially improves the participants' health outcomes;
- It is well supported by available scientific and medical information, or is intended to clarify or establish the health outcomes of interventions already in common clinical use;
- It does not unjustifiably duplicate existing studies;
- Its design is appropriate to answer the research question being asked in the study;
- It is sponsored by an organization, or individual, capable of executing the proposed study successfully;
- It is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46 (if a study is FDA-regulated it also must be in compliance with 21 CFR Parts 50 and 56.);
- All aspects are conducted according to appropriate standards of scientific integrity (see <http://www.icmje.org> on the Internet);
- It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with study participation (CSP) or CED coverage;
- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. (Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options);
- It is registered at <http://clinicaltrials.gov/> on the *ClinicalTrials.gov* Web site by the principal sponsor/investigator as demonstrated by having a National Clinical Trial control number;
- The research protocol must:

- Specify the method and timing of public release of all pre-specified outcomes to be measured, including release of outcomes if outcomes are negative or study is terminated early. (The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors, which can be found at <http://www.icmje.org> on the Internet. However a full report of the outcomes must be made public no later than three (3) years after the end of data collection.);
- Explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of these populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, it must discuss why these criteria are necessary;
- Explicitly discuss how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Billing Requirements

Claims related to the routine costs, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in the trial, and claims for managed care beneficiaries receiving services in an approved clinical study for artificial hearts, should be sent to the appropriate FFS contractor and include the appropriate codes to ensure proper payment.

Institutional and physician/supplier claims for routine services provided in approved artificial heart studies should be billed and processed according to previously issued instructions for clinical trials.

Your Medicare contractor will hold your claims until CR 6185 is implemented and the claims can be correctly processed. Upon successful implementation of CR 6185, Medicare contractors will process the claims and pay interest (as appropriate) on held claims.

CMS has also determined that since coverage is only available under clinical studies, the billing and coding requirements will be the same as those currently used for other Medicare covered clinical trials as included in the NCD effective September 2000. This means that Medicare Advantage (MA) organizations will not be responsible for payment for the artificial heart, or for routine services related to the study, until a plan's capitated rate has been appropriately adjusted to include them.

Coding Requirements

The following addresses the institutional and physician/supplier coding requirements for coverage of artificial hearts in clinical trials:

1. Institutional Claims

Effective for discharges on or after May 1, 2008, institutional claims for International Classification of Diseases, 9th edition (ICD-9) procedure code 37.52 are only payable when you include ICD-9 diagnosis code V70.7 (examination of participant in clinical research) and condition code 30 (qualifying clinical trial). In addition, Value Code D4, with an 8-digit National Clinical Trial Number that matches an approved clinical trial on the CMS website provided above, is also required.

If your FI or A/B MAC rejects your claim with ICD-9 procedure code 37.52, because it does not meet all of these necessary billing criteria, they will use:

- **Claim Adjustment Reason Code (CARC) 16** – *Claim/service lacks information which is needed for adjudication*, when ICD-9 procedure code 37.52 is present on a claim without all the required elements; and
-
- The following Remittance Advice Remark Codes (RARCs), when applicable
 - **MA97 – Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number**, for a missing/incomplete/invalid clinical trial number when ICD-9 procedure code 37.52 is billed;
 - **M64 – Missing/incomplete/invalid other diagnosis**, for a missing V70.7 diagnosis code when ICD-9 procedure code 37.52 is billed; or
 - **M44 – Missing/incomplete/invalid condition code**, for a missing Condition code 30 when ICD-9 procedure code 37.52 is billed.

2. Physician/Supplier claims

Effective for dates of service on or after May 1, 2008, physician/supplier claims for Common Procedural Terminology (CPT) code 0051T must include ICD-9 diagnosis code V70.7 and Healthcare Common Procedure Coding System (HCPCS) modifier Q0 on the same claim line as CPT Code 0051T, and must also include the 8-digit clinical trial number that matches an approved clinical trial on the CMS website provided above.

If your carrier or A/B MAC returns your claim with CPT code 0051T as unprocessable because it does not meet all of these necessary billing criteria, they will use:

- **CARC 16 – Claim/service lacks information which is needed for adjudication**, when CPT code 0051T is present on a claim without the required diagnosis code or 8-digit clinical trial number;
- **CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing**, when there is no HCPCS modifier Q0 appended to CPT code 0051T;
- **RARC MA 130 – (Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.)** when there is no HCPCS modifier Q0 appended to CPT code 0051T; and

The following RARCs when applicable:

- **MA97 – Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number**, for a missing/incomplete/invalid clinical trial number when CPT code 0051T is billed without the 8-digit clinical trial number; or
- **M64 – Missing/incomplete/invalid other diagnosis**, for a missing V70.7 diagnosis code when CPT code 0051T is billed without the V70.7 diagnosis code.

3. Additional Inpatient and Outpatient Claims Instructions Related to Clinical Trial Patients

Inpatient Claims

Institutional providers billing clinical trial service(s) must report a diagnosis code V70.7 and a condition code 30 regardless of whether all services are related to the clinical trial or not.

Note: HCPCS codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

Outpatient Claims

- Institutional providers billing clinical trial claims that contain only clinical trial line item services do not have to report the routine modifiers, QV or Q1. The presence of condition code 30, along with the absence of the QV or Q1 modifier, is the provider's attestation that all line item services on the claim are routine clinical trial services (with the exception of any investigational item on the claim that would be identified with a Q0 modifier on or after January 1, 2008, or a QA modifier before January 1, 2008)
- Institutional providers billing clinical trial claims that contain both clinical trial line item services and non-clinical trial line item services, must bill the following elements:

Claims with dates of service before January 1, 2008:

- HCPCS modifier 'QV' only on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the secondary diagnosis
- Condition Code 30

Claims with dates of service on or after January 1, 2008:

- HCPCS modifier 'Q1' only on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the secondary diagnosis
- Condition Code 30

Message to Principal Investigator (PI)

Finally, if you are the PI of an artificial heart clinical study seeking Medicare payment, you should submit the following documentation to CMS (who will notify you when the review is complete):

- The complete study protocol (must be dated or identified with a version number);
- The protocol summary;

- A statement that the submitted protocol version has been agreed upon by the FDA;
- A statement that the above study standards are met;
- A statement that the study addresses at least one of the above questions related to artificial hearts;
- Complete contact information (phone number, email address, and mailing address); and,
- The Clinicaltrials.gov registration number.

The PI should send this information to:

Director, Coverage and Analysis Group
Centers for Medicare & Medicaid Services
Re: Artificial Heart
Mailstop C1-09-06
7500 Security Boulevard
Baltimore, MD 21244-1850

Additional Information

CR 6185 was issued in two separate transmittals, one for conveying changes to the Medicare NCD Manual and one for changes to the *Medicare Claims Processing Manual*. These transmittals are available at <http://www.cms.hhs.gov/Transmittals/downloads/R93NCD.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1583CP.pdf>, respectively, on the CMS Web site. The revised portions of each manual are attached to the respective transmittals.

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





October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3

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: MM6186

Related CR Release Date: September 8, 2008

Related CR Transmittal #: R1590CP

Related Change Request (CR) #: 6186

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6186 which notifies FIs, RHHIs, and A/B MACs of changes, additions, and deletions of ambulatory Payment Classification (APC) codes, Health Care Common Procedure System Codes (HCPCS) and diagnosis codes to ensure correct billing and processing of claims that are routed through the I/OCE. See the 'Background' and 'Additional Information' sections of this article for further details regarding these changes.

Background

CR 6186 informs Medicare contractors and providers that the Integrated OCR (I/OCE) will be updated for October 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE which eliminates 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.

The integration did not change the logic that is applied to outpatient bill types that previously passed through the OPPS OCE software. It merely expanded the software usage to include non-OPPS hospitals.

CR 6186 provides the Integrated OCE instructions and specifications for the I/OCE 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 6186 and will also be posted to <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS Web site.

There are numerous changes/additions/deletions to diagnosis codes, APC codes, and HCPCS codes in October 2008. All of the changes will not be detailed in this article. Instead, please see CR 6186 for those details. CR 6186 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1590CP.pdf>. The key changes for the October 2008 I/OCE (V9.3) are summarized as follows:

Effective Date	Modification
08/01/00	<p>Modify the software to restore all (4) previously purged versions of programs & codes in each release. The earliest version date included in the October 2008 release will be 8/1/2000.</p> <p>[Removal of older versions will be restarted in '09].</p>
10/01/08	<p>New edit 79 – Incorrect billing of revenue code with HCPCS code (RTP).</p> <p>Criteria: Revenue code 381 with HCPCS other than packed red cells (P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9057, P9058). Or Revenue code 382 with HCPCS other than whole blood (P9010, P9051, P9054, P9056,)</p>
10/01/08	<p>Change the disposition for edit 21 to claim returned to provider (RTP)</p> <p>Note: The IOCE change to RTP means this claim will no longer trigger an initial determination. The provider should validate the medical documentation and correct the bill as appropriate.</p>
10/01/08	<p>Change the disposition for edits 67, 68 and 69 to Line item denial (LID)</p> <p>Note: The IOCE change to LID is for no medical necessity and the provider is held liable if billed as covered. If the notice of noncoverage was provided to the patient prior to the service being rendered, then the provider should bill the services as noncovered and affix liability with the GA or GZ modifier as appropriate.</p>
10/01/08	<p>Modify appendix D to apply bilateral procedure discounting with modifier 50 only to type “T” procedures that are on the conditional bilateral list.</p>
01/01/08	<p>New edit 80 – Mental health code not approved for partial hospitalization (RTP) Criteria: Mental health HCPCS codes that are not approved for partial hospital program submitted on TOB 13x and Condition Code 41 (list of codes).</p>
	<p>Make HCPCS/APC/SI changes as specified by CMS in CR 6186.</p>
	<p>Implement version 14.2 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).</p>
10/01/08	<p>Update the valid diagnosis code list with ICD-9-CM changes</p>
10/01/08	<p>Update diagnosis/age and diagnosis/sex conflict edits with MCE changes</p>
01/01/08	<p>Change bilateral indicator for CPT code 76645 to ‘3’ (Independent bilateral)</p>
01/01/08	<p>Update radiopharmaceutical edit requirements</p>
	<p>Create a 508 compliant version of the document-for publication on CMS website.</p>

Affected providers should also read through the specifications attached to CR 6186 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.

Additional Information

The official instruction, CR 6186, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1590CP.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.





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: MM6195

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1584CP

Related Change Request (CR) #: 6195

Effective Date: July 1, 2008

Implementation Date: October 6, 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) 6195, which **revises and clarifies payment** of travel allowances that are based on either a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2008. The new rates are \$1.035 per mile (P9603) and \$9.55 per flat-rate trip (P9604).

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act and payment is made based on the clinical laboratory fee schedule. (See Section 1833(h)(3) of the Social Security Act at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet.) 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 \$1.035 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.

As of August 1, 2008, the per mile allowance rate of \$1.035 cents per mile was computed using the Federal mileage rate of \$0.585 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 \$1.035 cents per mile if local conditions warrant it.

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.

The following are examples to further clarify the new allowances:

Example 1: On August 2, 2008, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be \$62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

Example 2: On August 2, 2008, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$41.40 (40 x 1.035), plus the specimen collection fee.

Note: Some Medicare contractors have established local policy to pay based on a flat rate basis only.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$9.55 for a total trip reimbursement of \$19.10, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x \$9.55 = \$57.30). Each of the claims submitted would be for \$11.46 (\$57.30 / 5 = \$11.46). Since one of the patients is non-Medicare, four claims would be submitted for \$11.46 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The \$9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2 x \$9.55 = \$19.10) and then divided by five (1/5 of \$19.10 = \$3.82). Since one of the patients is non-Medicare, four claims would be submitted for \$3.82 each, plus the specimen collection fee.

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

To see the official instruction (CR 6195) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1584CP.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.



Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 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: MM6166

Related Change Request (CR) #: 6166

Related CR Release Date: September 5, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R1585CP

Implementation Date: October 6, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6166 which provides updated rates used to correctly pay IRF PPS claims for FY 2009. Be sure billing staff are aware of these changes.

Background

The FY 2009 IRF PPS Final Rule published on August 1, 2008, sets forth the prospective payment rates applicable for IRFs for FY 2009. A new IRF PRICER software package will be released prior to October 1, 2008, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2008 through September 30, 2009. Medicare systems will install the new revised Pricer program in a timely manner to ensure accurate payments for the IRF PPS claims with discharges occurring on or after October 1, 2008 through September 30, 2009.

PRICER Updates - For IRF PPS FY 2009, (October 1, 2008 – September 30, 2009):

- The standard Federal rate is: \$12,958
- The fixed loss amount is: \$10,250
- The labor-related share is: 75.464%
- The non-labor related share is: 24.536%
- Urban national average CCR is: 0.490
- Rural national average CCR is: 0.619

Additional Information

The official instruction, CR 6166, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1585CP.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.



Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

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: MM6079

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1586CP

Related Change Request (CR) #: 6079

Effective Date: October 6, 2008

Implementation Date: October 6, 2008

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6079 and notifies providers that CMS revised Form CMS-1500 to accommodate the reporting of the National Provider Identifier (NPI). The current Form CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills. Therefore your Medicare contractor should NOT return claims as unprocessable to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of Form CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.

Key Point of CR 6079

The requirement of an NPI for the rendering provider **does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills.**

Additional Information

To see the official instruction (CR 6079) issued to your Medicare FI, carrier, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1586CP.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.





Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage

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: MM6136

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1587CP

Related Change Request (CR) #: 6136

Effective Date: March 3, 2008

Implementation Date: March 1, 2009

Provider Types Affected

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

What You Need to Know

CR 6136, from which this article is taken announces that, effective March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN); which combines the general Advance Beneficiary Notice (ABN-G) and laboratory Advance Beneficiary Notice (ABN-L) into a single form, with form number (CMS R-131).

You should be aware that beginning March 3, 2008 and prior to March 1, 2009, your contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification. However, beginning **March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.** Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions paid under Part A; were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR 6136 is the updated Chapter 30 and the Web address for viewing CR 6136 is contained in the 'Additional Information' section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-

medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised SNFABN is implemented, Skilled Nursing Facilities must use the revised SNFABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:

- Care is not reasonable and necessary;
- There was a violation of the prohibition on unsolicited telephone contacts;
- Medical equipment and supplies supplier number requirements not met;
- Medical equipment and/or supplies denied in advance;
- Custodial care; and
- A hospice patient who is not terminally ill.

4. In the following situations ABN use is voluntary

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

Additionally, the ABN can also be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
 - Services for which there is no legal obligation to pay;
 - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
 - Services required as a result of war;
 - Personal comfort items;
 - Routine physicals (except the initial preventive physical or “Welcome to Medicare” physical examination) and most screening tests;
 - Routine eye care;
 - Dental care; and
 - Routine foot care.

5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as “notifiers”. Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three “triggering events” during a course of treatment (initiation, reduction, and termination).

Notifiers must give an ABN to “recipients” (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers’ inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient’s record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN Preparation Requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF).

Additional Information

You can find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf> on the CMS Web site. There you will find the updated *Medicare Claims Processing Manual* Chapter 30(Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives website at <http://www.cms.hhs.gov/bni>. Questions regarding the revised ABN can be emailed to RevisedABN_ODF@cms.hhs.gov.

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





Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments

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: MM6183

Related Change Request (CR) #: 6183

Related CR Release Date: September 12, 2008

Effective Date: September 29, 2008

Related CR Transmittal #: R141FM

Implementation Date: September 29, 2008

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, Medicare Administrative Contractors (A/B/MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided or supplied to Medicare Beneficiaries.

What You Need to Know

CR 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a Qualified Independent Contractor (QIC).
- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.
- If the at the ALJ level process reverses the Medicare overpayment determination, Medicare will refund with interest any overpayments already collected on that debt.
- Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.
- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

This article provides more detail on these general points and clarifies which overpayments are subject to this limitation on recoupment and which types of overpayments are not subject to this limitation. Make sure that your billing staffs are aware of these changes as described below.

Background

Before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted, a provider's electing to appeal an overpayment determination did not affect Medicare's prerogative to

recover the debt. However, through an amendment of Title XVIII of the Social Security Act (the Act); MMA Section 935 changed this process, by adding a new paragraph (f) to section 1893 of the Act.

This amendment requires CMS to change: 1) the way it recoups certain overpayments to providers, physicians and suppliers; and 2) how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent administrative (Administrative Law Judge (ALJ)) or judicial levels of appeal. Further, CR 6183 defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in CMS' obligation to pay interest to a provider or supplier whose appeal is successful at levels above the Qualified Independent Contractor (QIC). These changes relate to the Medicare fee-for-service claims process.

CR 6183 describes these changes to the providers, physicians and suppliers overpayment recoupment process. Specifically, Section 1893 (f)(2)(a) of the Social Security Act protects providers physicians, and suppliers during the initial stages of the appeal process (both first level appeal – contractor redetermination, and second level appeal -- Qualified Independent Contractor (QIC) reconsideration) by limiting the recoupment process for Medicare overpayments while the appeals process is underway.

It requires that when a valid first or second level appeal is received from a provider on an overpayment, subject to certain limitations (see below), CMS and its Medicare contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Overpayments that ARE subject to Limitation on Recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision);
- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued;
- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision); or
- Medicare Secondary Payer (MSP) recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).
- The final Claims associated with a Home Health Agency (HHA) Request for Anticipated Payment (RAP) under Home Health Prospective Payment System (HH PPS), but not the RAP itself (see Table 2, below).

Overpayments that ARE NOT Subject to Limitation on Recoupment

- All other Medicare Secondary Payer recoveries except those identified in the preceding section of this article;
- Beneficiary overpayments;
- Overpayments that arise from a cost report determination;
- Overpayments that are appealed under the Provider Reimbursement Payment (PRB) process of 42 CFR parts 405 subpart R-Provider /Reimbursement Determinations and appeals;

- HHA Requests for Anticipated Payment (RAP) under HH PPS;
- Note: While a RAP is not considered a claim for purposes of Medicare appeals regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the Medicare Claims Processing Manual, Chapter 10 (Home Health Agency Billing), Sections 10.1.10 (Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment (RAP)), and 50 (Beneficiary-Driven Demand Billing Under HH PPS).
- Hospice Caps calculations. This manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS website.)
- Hospice Caps calculations;
- Provider initiated adjustments;
- Accelerated/Advanced Payments; and
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The Rebuttal Process

Here is how the rebuttal process with the limitation on recoupment works.

You are given an opportunity to rebut any proposed recoupment action submitting a statement within 15 days of the notice of an impending recoupment action. These rebuttal procedures occur prior to the appeals process and are separate from the requirements of the limitation on recoupment.

The rebuttal process gives you a vehicle to indicate why the proposed recoupment should not take place; but you should remember that, as opposed to the limitations that CR 6183 describes, your Medicare contractor may (based on the rebuttal statement) determine to either stop, or proceed with, recoupment.

Step One -- Adjustment

Part A

As a result of post-pay reviews or MSP recoveries and during the Part A claim adjustment process (including Part B of A claims), Medicare FIs, RHHIs, and/or MACs, will determine if the limitations apply to the claim and annotate the system of the MMA Section 935 adjustment. If the adjustment results in a refund to the provider, they will follow existing underpayment policies; however, if the adjustment is deemed an overpayment and the 935 rules apply, they will mark the claim as being available for the limitation on recoupment protections.

Part B

As a result of post-pay reviews or MSP recoveries and during the Part B claim adjustment process, Medicare carriers and MACs, including DME MACs, will adjust claims in the normal manner.

Step Two -- Demand Letter

These adjustments will trigger the creation of the first demand letter (unless previously issued) which (in addition to the requirements listed in the Medicare Financial Management Manual, Chapter 3 (Overpayments), and Chapter 4 (Debt Collection)) will:

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment);
- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter;
- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct;
- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, or (when appropriate) why the provider was not found to be without fault in causing the overpayment.
- Explains that recoupment will begin on the 41st day from the date of the first demand letter if: 1) payment is not received in full, or 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter. However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received but Medicare may not refund any recoupment already taken.

Step Three -- How to Stop Recoupment:

As mentioned above, CR 6183 provides that when your Medicare contractor receives your valid first level (redetermination) or second level (reconsideration) appeal on an overpayment subject to the limitations outlined in CR6183, Medicare will cease recoupment, or not begin recoupment at the normally scheduled time (which would be no sooner than 41 days after the initial demand letter is issued, 60 days after the 1st level decision, and no earlier than 30 days after the 2nd level decision).

If you disagree with the overpayment decision, you may file an appeal (performed by people independent of those who have reviewed your claim so far). Please keep in mind that you must file this request for first level of appeal (redetermination) with your Medicare contractor within 120 days from the date of demand letter, but if you want to stop recoupment of this overpayment you must file your request for redetermination within 30 days from the date of the letter.

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.
2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities, may resume within the designated timeframes.
3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process.

You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

First Level Appeal (Redetermination)

Recoupment can proceed on day 41 from the first demand letter unless you submit a request for a redetermination by the 30th day following the date of the first demand letter.

Table 1, below displays the time frame for the recoupment process after the first demand letter.

Table 1
Timeframe for Medicare Recoupment Process After the First Demand Letter

Timeframe	Medicare Contractor	Provider
Day 1	Date of Demand Letter (Date demand letter mailed)	Provider receives notification by first class mail of overpayment determination
Day 1-15	Day 15 deadline for Rebuttal request. No recoupment occurs	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs	Provider can appeal and potentially limit recoupment from occurring
Day 41	Recoupment begins	Provider can appeal and potentially stop recoupment

Redetermination or Reconsideration (Appeals) Requests

Upon receiving your valid request for a redetermination of an overpayment, your Medicare contractor will take the following actions:

- Cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started;
- Retain any amounts recouped, if they had already recouped funds before receiving the request for redetermination, and apply them first to interest and then to principal; and
- Will continue to collect any other debts that you might owe, but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A Redetermination can have three possible outcomes:

1. Full reversal of the overpayment decision.

In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (they may apply these funds to any other debt that you might owe and then release any excess to you).

2. Partial reversal (Partially Favorable) of the overpayment decision

In this instance (in which the debt is reduced below the initial stated amount) Medicare contractors will recalculate the correct amounts of both the underpayment and the overpayment, make appropriate payments to you if due; or, if necessary, issue a revised demand letter for the newly calculated overpayment amount. This letter will state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination if they have not been notified by the QIC that you have requested a reconsideration. It will also state that in order to stop recoupment under the provisions of Section 935 of the MMA, you must request a valid appeal (reconsideration) of the overpayment within 60 days from the date of the notice. It will also remind you that you have an opportunity to rebut the proposed recoupment action (but keep in mind that a rebuttal does not mandate that recoupment will stop).

3. Full Affirmation of the overpayment decision–

With this “unfavorable” decision that upholds the overpayment determination, the Medicare contractor will issue the 2nd or 3rd demand letter (as appropriate), which will state that they can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice, if they have not been notified by the QIC that you have requested a reconsideration.

Table 2, below displays the time frame for the recoupment process after redetermination.

Table 2
Timeframe for Medicare Recoupment Process After Redetermination

Timeframe	Medicare Contractor	Provider
Day 60 following revised notice of overpayment following redetermination	Date Reconsideration request is Stamped in Mailroom, or Payment Received from the revised overpayment notice	Provider Must Pay Overpayment or Must have submitted request for 2nd level appeal
Day 61- 75	Recoupment could begin on the 61st day	Provider appeals or pays
Day 76	Recoupment Begins or Resumes	Provider Can Still Appeal. Recoupment stops on date receipt of appeal

Second Level Appeal (Reconsideration)

You can also stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the appropriate notice/letter.

When your Medicare contractor receives notification from the QIC of your valid and timely request for a reconsideration, they will:

- Cease recoupment of the overpayment, or not initiate recoupment if it has not yet begun;
- Retain the amount recouped, and apply it first to interest and then to principal (if the recoupment process had begun before the reconsideration request was received);
- Will continue to collect other debts that you might owe, if an overpayment is appealed and recoupment stopped; but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A QIC Reconsideration can have three possible outcomes:

1. Full Reversal

In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (the amount held may be applied to any other debt that you might owe and any excess refunded to you);

2. Partial Reversal

In this instance, this reduces the overpayment. Medicare contractors effectuate the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Medicare contractors

may apply the excess to any other debt (including interest) that you might owe before releasing payment to you.

They will issue you a notice of the revised overpayment amount, which will also state that they can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give you an opportunity to make payment arrangements or to rebut the recoupment as described above.

3. Affirmation

If the QIC reconsideration results in an “unfavorable” overpayment decision, recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives you time to make payment or to request a repayment plan.

Note: Medicare Contractors can initiate (or resume) recoupment immediately upon receipt the QIC’s decision or dismissal notice of a physician’s, provider’s, or supplier’s request for reconsideration, regardless of a subsequent appeal to the ALJ (third appeal level) and all further levels of appeal (see below).

Third Level of Appeal (Administrative Law Judge (ALJ))

Whether or not the provider, physician or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or Federal court, the Medicare contractor will continue to recoup until the debt is satisfied in full.

Additional Details of CR 6183

CR 6183 also provides some additional specific payment details, i.e.:

- 1) If you have been granted an extended repayment schedule (ERS) and have submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, you will not be considered in default if your payments were not made. The appeal would supersede the ERS agreement.

Further, Payments that you make under an ERS are not recoupment for the limitation provision and are not subject to Section 935 interest, if reversed at the ALJ appeal or above. However, if you default on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupment are subject to payment of interest under the Section 935 interest requirements.

- 2) Suspended funds involving providers who have been put on payment suspension are not a “recoupment” for purposes of the limitation on recoupment. Medicare is not restricted from applying suspended funds to reduce or dispose of an overpayment. However, if the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR, Section 405.379 "Limitation on Recoupment," provision under section 1893(f)(2) of the Social Security Act, Section 935 of the MMA Act will be applicable to any remaining balance still owed to CMS.
- 3) Payments made by a provider in response to a demand are not recoupments. Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are not subject to Section 935 interest.

- 4) Lastly, CR 6183 amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called Section 935 interest, which is payable on an underpayment when the reversal occurs at the ALJ level or subsequent levels of administrative appeal, when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds (based on the period that Medicare recouped the provider's or supplier's funds). Payment of 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions, and is only payable on the principal amount recouped. In these instances, Medicare will pay simple interest rather than compound interest, and **will not pay interest on interest; (mirroring the manner in which interest against providers is assessed)**. Monies recouped and applied to interest would be refunded and not included in the "amount recouped" for purposes of calculating any interest due the provider.

The periods of recoupment will be calculated in full 30-day periods; and interest **will not** be payable for any periods of less than 30 days in which Medicare had possession of the recouped funds; and will be calculated for each 30-day period using the interest Rate in Effect on the ALJ decision Date or the (revised written Final Determination Date). Your Medicare contractor will have 30 days from the ALJ Decision date or the final determination Date to calculate and refund interest to you.

Note: Medicare has the obligation to pay providers, physicians and suppliers interest if the overpayment determination is reversed at the first (redetermination) and second (reconsideration) level of the administrative appeal process and the decisions are not effectuated timely. At these levels of appeal, interest would continue to be payable by Medicare if the underpayment is not paid within 30 days of the final determination decision

Finally, please be aware that CR 6183 does not change the rebuttal process for this recovery, nor the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, or the decision making time frames.

Additional Information

You can find the official instruction, CR 6183, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf> on the CMS Web site. You will find the updated Medicare Financial Management Manual, Chapter 3 (Overpayments), as an attachment to CR 6183.

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





October 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: MM6175

Related Change Request (CR) #: 6175

Related CR Release Date: September 12, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R1595CP

Implementation Date: October 6, 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 6175, from which this article is taken, instructs Medicare contractors to download and implement the October 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised July 2008, April 2008, January 2008, and October 2007 files.

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.

The ASP methodology is based on quarterly data that drug manufacturers submit to 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. Please note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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 Food and Drug Administration (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 Healthcare Common Procedure Coding System (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

In general, 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:

- End Stage Renal Disease (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 OPSS.

Beginning January 1, 2008, under the OPSS, 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 OPSS 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 determined in the same manner that 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 are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPSS at the amount specified for the Ambulatory Payment Classification (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 when the vaccine is furnished in a hospital outpatient department. When furnished in a 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, Medicare 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.**

Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- 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. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. 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 September 16, 2008, the October 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 September 16, 2008, the October 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 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:

Payment Allowance Limit Revision Date	Applicable Dates of Service
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and 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

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 (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) 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, except that pricing for compounded drugs is done by your local Medicare contractor.

Please be aware that your contractors will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

You can find the official instruction, CR 6175, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1595CP.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.





National Provider Identifier (NPI) for Secondary Providers

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: MM6093

Related Change Request (CR) #: 6093

Related CR Release Date: September 12, 2008

Effective Date: May 23, 2008

Related CR Transmittal #: R267PI

Implementation Date: September 26, 2008

Provider Types Affected

All Medicare providers who submit claims to Medicare carriers, Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and/or Fiscal Intermediaries (FIs) in which a secondary provider must be identified.

Provider Action Needed

This article is based on CR 6093 and outlines the need to use NPIs to identify secondary providers in Medicare claims beginning May 23, 2008.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers and entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS- 0045-F).

Effective May 23, 2008, paper and electronic Medicare claims must contain NPIs to identify health care providers in their role as health care providers. (NPIs do not replace Taxpayer Identification Numbers, which identify health care providers in their role as taxpayers.)

Medicare claims always identify primary providers. Primary providers are the Billing and Pay-to Providers and, for non-institutional and non-pharmacy claims, the Rendering Provider.

Some Medicare claims also need to identify one or more secondary providers. A secondary provider could be a health care provider who ordered services for a Medicare patient or who referred a Medicare patient to another health care provider (ordering/referring providers); an attending, operating, supervising, purchased service, other, or service facility provider; or a prescriber (the latter only in retail pharmacy drug claims). Prior to May 23, 2008, health care providers who ordered/referred were identified by Unique Physician Identification Numbers (UPINs). UPINs were assigned to physicians as defined in section 1861(r) of the Social Security Act, and to nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical social workers, clinical psychologists, and certified nurse midwives—the only practitioners who are permitted by law to order/refer in the Medicare program. Medicare ceased assigning UPINs in June 2007 as part of the implementation of the NPI.

Note: CR6093 does not alter existing requirements for capturing the name and address, when required, of secondary providers or instructions that address the specific practitioner types that must be reported in certain referral and “incident to” situations. CR6093 instruction addresses only the reporting of the identifier for secondary providers, when required.

Key Points of CR 6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that **identifier must be an NPI**.
- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) **does not furnish** its NPI at the time of the order/, referral, purchase, prescription, or time of service, **YOU as the billing provider need to know that NPI in order to use it in your claim**.
- You may use the NPI Registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the Implementation Guides for the X12N claims transactions permit the reporting of the Social Security Number (SSN) for some secondary providers if there is no NPI, the Centers for Medicare & Medicaid Services (CMS) does not believe you will be successful in having secondary providers disclose their SSNs.
- If you are **unable to obtain the NPI of the entity** to be identified as the **service facility provider, or if that entity has not obtained an NPI, NO identifier is to be reported in that loop**.
- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, **you (the Billing Provider) must use YOUR NPI as the identifier for that secondary provider**.
- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6093) issued to your Medicare carrier, DME/MAC, MAC or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R267PI.pdf>.

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



Payment for Implanted Prosthetic Devices for Medicare Part B Inpatients- 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: MM6050 **Revised** **Related Change Request (CR) #:** 6093
Related CR Release Date: September 12, 2008 **Effective Date:** May 23, 2008
Related CR Transmittal #: R267PI **Implementation Date:** September 26, 2008

Note: This article was revised on November 4, 2008, to reflect revisions made to CR 6050, which was revised to reflect that the new C-Code discussed in CR 6050 is HCPCS code C9899. This article was revised accordingly. In addition, the CR release date, transmittal number, and Web address for accessing CR 6050 were revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6050 which clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.

What You Need To Know

Change Request (CR) 6050 revises the *Medicare Claims Processing Manual* (Chapter 4, Section 240) to provide instructions regarding how contractors are to establish the payment to be made under the Outpatient Prospective Payment System (OPPS) for implanted prosthetic devices that are furnished to Medicare beneficiaries who, on the date that the device is implanted, are hospital inpatients without Part A coverage of services, but with Part B coverage.

What You Need To Do

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

Background

CMS can designate medical and other health services (that are payable under the Medicare Outpatient Prospective Payment System (OPPS)) for beneficiaries who are hospital inpatients with Medicare Part B benefits, but who do not have Part A benefits. See the Social Security Act (Section 1833(t)(2)(A)) at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet.

The Medicare Benefits Policy Manual (Chapter 2, Section 10) includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but who do have Part B coverage, on the day that they receive an implanted prosthetic device. The processing of claims for these services is discussed in the *Medicare Claims Processing Manual* (Chapter 4, Section 240). Under Medicare PPSes, payment for these items is packaged into payment for the procedure in which they are implanted.

Change Request (CR) 6050 revises the *Medicare Claims Processing Manual*, (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 240 (Inpatient Part B Hospital Services)) to provide instructions regarding how Medicare contractors are to establish payment for providers subject to the OPSS for implanted prosthetic devices that are furnished to Medicare beneficiaries who are hospital inpatients not having Part A coverage of services on the date that the device is implanted.

Specifically, the manual is revised to specify that **providers must submit these services on a 12X type of bill, reporting a new HCPCS code (C9899)** that will be effective for services furnished on and after January 1, 2009, **when they furnish an implanted prosthetic device** to a Medicare beneficiary

- Who is a hospital inpatient, but
- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

By reporting the new C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

The manual is also revised to specify that Medicare contractors will:

- Determine if the device meets the definition for an implanted prosthetic device, and if so,
- Establish the payment to be made for the device.

Medicare contractors will first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in Chapter 6, Section 10, of the *Medicare Benefits Policy Manual*. If the item does not meet the criteria for coverage as an implantable prosthetic device, the Medicare contractor will deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

Once the Medicare contractor determines that the device is covered, it will then determine the appropriate payment amount for the device.

The contractor shall begin this process by determining if the device has pass through status under the OPSS. If so, the contractor will establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio.

Where the device does not have pass through status under the OPSS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the DMEPOS fee schedule, where there is such an amount or the actual charge for the device. Where there is no amount for the device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. Payment would be made at the lesser of the contractor established payment rate for the specific device or the actual charge for the device.

In setting a Medicare contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC

payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

See <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> for the amount of reduction to the APC payment that would apply in these cases. From this OPSS web page, select “Device, Radiopharmaceutical and Procedure Edits” from the list on the left side of the page. Open the file “Procedure to Device edits” to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPSS webpage and open the file “APC Adjustments in Cases of Full Credit/No Cost or Partial Credit for Replaced Devices.” Select the “Full offset reduction amount” that pertains to the APC that is most applicable to the device described by the new C code. It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient.

For example, if the new C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in “remarks”) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4,881.77. It would therefore be reasonable for the FI or MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to \$4,881.77. In this case the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount or the contractor established amount, or the actual charge where applicable), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Note that Medicare contractors will deny payment for an item reported with the new C9899 if they determine that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily. On such denials, the remittance advice remark code will show N180 (This item or service does not meet the criteria for the category under which it was billed.) with a group code or PR (Patient Responsibility) and a claim adjustment reason code of 96 (Non-covered charges).

Medicare contractors will also deny payment if they or Medicare systems determine that the beneficiary was in a covered Part A stay on the date of service of the item reported with the new C9899. Such denials will contain a remittance advice remark code of M2 (Not paid separately when the patient is an inpatient), a group code of CO (Contract Obligation) and a claim adjustment reason code of 96 (Non-covered charges). Note: The revised *Medicare Claims Processing Manual*, (Chapter 4 Part B Hospital (Including Inpatient Hospital Part B and OPSS), Section 240 (Inpatient Part B Hospital Services)) is included as an attachment to CR 6050.

Additional Information

The official instruction, CR 6050, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1628CP.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.



Incorporation of Recent Regulatory Revisions into Chapter 10 of the Program Integrity Manual (PIM)

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: MM6178

Related Change Request (CR) #: 6178

Related CR Release Date: September 19, 2008

Effective Date: October 20, 2008

Related CR Transmittal #: R269PI

Implementation Date: October 20, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6178 which incorporates recent regulatory changes into the *Medicare Program Integrity Manual* (Chapter 10 (Healthcare Provider/Supplier Enrollment)).

Background

The *Medicare Program Integrity Manual* (Chapter 10) specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program.

Change Request (CR) 6178 revises Chapter 10 (Healthcare Provider/Supplier Enrollment) of the *Medicare Program Integrity Manual* and incorporates non-appeals related provisions contained in “Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)” which was published in the Federal Register on June 27, 2008. This CR instructs contractors to —

- Establish an enrollment bar for those providers and suppliers whose billing privileges are revoked. The enrollment bar will require that providers and suppliers whose billing privileges are revoked to wait from one to three years before reapplying to participate in the Medicare program.
- Require providers and supplier to receive payments by electronic funds transfer (EFT) when enrolling, making a change to their enrollment information, or during a revalidation process. In addition, providers or suppliers must continue to receive payment via EFT when Medicare contractor transition occurs and the provider or supplier was previously receiving payment via EFT.
- Allow Medicare contractors to reject an enrollment application when a provider or supplier fails to provide missing information/documentation within 30 days of a contractor’s request for additional information. (The previous standard was 60 days.)
- Establish a new revocation reason for services that could not be provided (e.g., physician billing for services within in the United States when the physician was living outside of the country.)

Additional Information

The official instruction, CR 6178, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R269PI.pdf> on the CMS Web site. The revised Chapter 10 of the *Program Integrity Manual* is attached to CR 6178.

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





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

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

MLN Matters Number: MM6178

Related Change Request (CR) #: 6178

Related CR Release Date: September 19, 2008

Effective Date: October 20, 2008

Related CR Transmittal #: R269PI

Implementation Date: October 20, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6196 which describes changes to, and billing instructions for various payment policies implemented in the October 2008 OPSS update.

What You Need to Know

The October 2008 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification. October 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6186, October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3.

What You Need to Do

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

Background

This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the October 2008 OPSS update. The October 2008 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 6196.

October 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6186, "October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3" which has a related MLN Matters article at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6186.pdf> on the CMS Web site.

Key Points of CR 6196

1. Revenue Code Reporting

Hospitals must continue to report HCPCS codes and charges with an appropriate UB revenue code consistent with NUBC requirements. When reporting the appropriate revenue code for services, hospitals should choose the most precise revenue code, or subcode, if appropriate. As NUBC guidelines dictate, “It is recommended that providers use the more detailed subcategory when applicable/available rather than revenue codes that end in “0” (General) or “9” (Other).”

Hospitals are required to follow the Medicare cost apportionment regulations at 42 CFR 413.53(a)(1) which convey that, under the departmental method of separately rather than being combined with another department. In order to comply with the requirements of this regulation, hospitals must follow the Medicare reimbursement policies in The Provider Reimbursement Manual I (PRM-I), Section 2302.8 and PRM-II in order to ensure that their ancillary costs and charges are reported in the appropriate cost centers on the cost report. The PRM manuals are available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp> on the CMS web site.

CMS relies on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies because the CMS uses a revenue code to cost center crosswalk to estimate the service costs that underpin OPSS payment rates. The current revenue code to cost center crosswalk that CMS uses for setting annual hospital outpatient payments may be found on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage. CMS always invites reviews of this crosswalk and welcomes comments. The accuracy of hospital outpatient payments for future years depends on hospitals appropriately implementing NUBC instructions and reporting appropriate revenue codes, and following all cost report instructions.

2. Payment for Radiology Services Reported with Modifier-52

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.6 to remove language incorrectly stating that payment is not reduced for radiology services reported with modifier -52 (Reduced Services). As indicated in Section 20.6.4 of the same manual, modifier -52 should be appended to procedures for which anesthesia is not planned that are discontinued after the patient is prepared and taken to the room where the procedure is to be performed. These procedures are paid at 50 percent of the full OPSS payment amount. The revised Section 20.6.6 of the *Medicare Claims Processing Manual* is attached to CR 6196.

3. Changes to Procedure and Device Edits for October 2008

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under “2008 Device and Procedure Edits” at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

4. Billing for Devices

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 61.1 to clarify correct HCPCS coding and charge reporting for all devices that are used to perform procedures that require the use of devices where such codes exist and are designated with a status indicator of “N” (for packaged payment) or “H” (for pass-through device payment) in the OPSS Addendum B that applies to the date of service. If there are device HCPCS codes with status indicators other than “N” or “H” that describe devices that are used to perform the procedure or that are furnished because they are necessary for the function of an implanted device, hospitals should report the charges for those other devices on an uncoded revenue code line, but should not report the HCPCS codes for those items. Typically, payment

for the costs of all internal and external components required for the function of a nonpass-through device is packaged into the APC payment for the associated procedure in which the device is used. Accurate reporting of HCPCS codes and charges for these internal and external device components is necessary so that the OPSS payment for the associated procedures will be correct in future years in which the claims are used to set the APC payment rates. The revised Section 61.1 of the *Medicare Claims Processing Manual* is attached to CR 6196.

5. Billing for Medical and Surgical Supplies

When medical and surgical supplies described by HCPCS codes with status indicators other than “H” or “N” are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPSS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPSS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPSS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPSS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

CMS reminds hospitals that under the OPSS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

a) Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2008

In the CY 2008 OPSS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2008 release of the OPSS PRICER. The updated payment rates, effective October 1, 2008, will be included in the October 2008 update of the OPSS Addendum A and Addendum B, which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS Web site shortly.

b) Drugs and Biologicals with OPSS Pass-Through Status Effective October 1, 2008

Three drugs have been granted OPSS pass-through status effective October 1, 2008, as noted in the following table.

Table 1-Drugs Granted Pass-Through Status Effective October 1, 2008

HCPCS Code	Long Descriptor	SI	APC
J9225	Histrelin implant (Vantas), 50 mg	G	1711
C9243*	Injection, bendamustine hcl, 1 mg	G	9243
C9359*	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc	G	9359

NOTE: Those HCPCS codes identified with a “*” indicate that they are new codes effective October 1, 2008.

c) New HCPCS Codes for Drugs and Biologicals

There is one new drug HCPCS code for October 2008. HCPCS code C9244 (Injection, regadenoson, 0.4 mg) is assigned status indicator “K” and is assigned to APC 9244 effective October 1, 2008.

d) Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

The payment rates for several HCPCS codes were incorrect in the January 2008 OPSS Pricer. The corrected payment rates are listed in Table 2 below and have been installed in the October 2008 OPSS Pricer, effective for services furnished on January 1, 2008 through implementation of the April 2008 update. If you have claims that were already processed for these HCPCS codes for services provided on or after January 1, 2008, and prior to April 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

Table 2- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted
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				Copayment
J7324	0877	Orthovisc inj per dose	\$169.10	\$33.82
J9015	0807	Aldesleukin/single use vial	\$757.34	\$151.47
J9303	9235	Panitumumab injection	\$82.86	\$16.42

e) Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 OPSS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the October 2008 OPSS Pricer, effective for services furnished on April 1, 2008 through implementation of the July 2008 update. If you have claims that were already processed for these HCPCS codes for services provided on or after April 1, 2008, and prior to July 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

Table 3- Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7324	0877	Orthovisc inj per dose	\$174.63	\$34.93
J9303	9235	Panitumumab injection	\$82.83	\$16.29
Q4096	1213	VWF complex, not Humate-P	\$0.65	\$0.13

f) Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

The payment rate for one HCPCS code was incorrect in the July 2008 OPSS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the October 2008 OPSS Pricer, effective for services furnished on July 1, 2008 through implementation of the October 2008 update. If you have claims that were already processed for this HCPCS code for services provided on or after July 1, 2008, and prior to October 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

Table 4- Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7324	0877	Orthovisc inj per dose	\$175.85	\$35.17

g) Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPSS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the

procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h) Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

i) Correct Reporting of Outpatient Diagnostic Nuclear Medicine Procedures When a Radiolabeled Product is Provided in the Inpatient Setting

Effective January 1, 2008, under the OPPS, payment for diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures. In order to ensure that CMS captures appropriate diagnostic radiopharmaceutical costs for future rate setting purposes, CMS implemented nuclear medicine procedure-to-radiopharmaceutical edits in the I/OCE effective January 2008 that required a diagnostic radiopharmaceutical to be present on the same claim as a nuclear medicine procedure for payment under the OPPS to be made.

As is the standard process for edit lists under the OPPS, CMS reviews the appropriateness of the edits and considers modifying the edits quarterly as issues are brought to their attention. In April 2008, in response to several descriptions of specific clinical scenarios provided to CMS by members of the public, CMS added HCPCS code A9517 (Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie) to the list of radiopharmaceuticals that would be accepted for a nuclear medicine procedure claim to process. In addition, in July 2008, in response to additional comments and clinical scenarios provided to CMS by members of the public, CMS expanded the list of radiolabeled products that are accepted for nuclear medicine procedure claims to process to include all therapeutic radiopharmaceuticals and brachytherapy sources, in addition to all diagnostic radiopharmaceuticals.

Since these changes to the edit list were adopted for the July update, CMS has received additional reports of a clinical scenario where a radiolabeled product is provided to a patient by a hospital during an inpatient stay, and a nuclear medicine procedure follows after the patient has been discharged from the inpatient setting (typically days or weeks after the provision of the radiolabeled product). No additional radiolabeled product is administered to the patient for purposes of the nuclear medicine procedure. Payment for the radiolabeled product is bundled into payment for the inpatient admission, so the hospital is unable to report a HCPCS code for a radiolabeled product on the OPPS claim for the nuclear medicine procedure in order to meet the edit requirements.

Similar to other clinical scenarios CMS previously addressed through changes to the edit list, members of the public bringing this situation to CMS' attention has indicated that situations where

these radiolabeled products would be provided to a hospital inpatient, with follow-up diagnostic imaging performed in the hospital outpatient setting days or weeks later, would be rare, but are sufficiently common that hospitals require a methodology to appropriately bill and be paid for the associated nuclear medicine procedures. As a result of these requests, for the October 2008 update CMS has created HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay. This HCPCS code is assigned status indicator “N” because no separate payment is made for the code under the OPSP. The effective date of the code is January 1, 2008, the date the procedure-to-radiopharmaceutical edits were initially implemented. Because the Medicare claims processing system requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than \$1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898.

With the specific exception described above for HCPCS code C9898, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

CMS expects that the majority of hospital outpatient claims for diagnostic nuclear medicine procedures will include reporting of a diagnostic radiopharmaceutical because both the radiopharmaceutical and the nuclear medicine procedure are provided in the hospital outpatient department, and that it will be only in uncommon circumstances that hospitals will provide a radiolabeled product during a hospital inpatient stay, followed by a diagnostic nuclear medicine procedure after the patient has been discharged. CMS will be monitoring claims to ensure that this is the case.

Therefore, beginning in October 2008, claims for diagnostic nuclear medicine procedures in which the radiolabeled product that provides the radioactivity for the study was furnished during a hospital inpatient stay will not be returned to the provider as long as the nuclear medicine procedure and HCPCS code C9898 are included on the same claim, with a token charge for HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits. Hospitals may submit claims reporting HCPCS code C9898 for dates of service beginning January 1, 2008.

The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp on the CMS Web site.

j) Payment for Therapeutic Radiopharmaceuticals

The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to the costs. Therefore, the prospective payment rates for the HCPCS codes listed in Table 5 below, which were listed in Addendum B to the CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as CMS indicated in Transmittal 1536 (CR 6094 dated June 19, 2008; see <http://www.cms.hhs.gov/Transmittals/Downloads/R1536CP.pdf> on the CMS Web site). Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at

charges adjusted to cost will remain “H” effective July 1, 2008 through December 31, 2009, to indicate payment will be made for therapeutic radiopharmaceuticals at hospitals’ charges adjusted to their costs.

Table 5 – Therapeutic Radiopharmaceuticals Paid At Charges Adjusted to Cost From July 1, 2008 through December 31, 2009

HCPCS Code	Long Descriptor	SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H
A9605	Samarium Sm-153 lexitronamm, therapeutic, per 50 millicuries	H

7. Payment for Brachytherapy Sources

The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospitals’ charges adjusted to the costs (with the exception of C2637, which is non-payable, as noted in the table below). Therefore, the prospective payment rates for each source, which are listed in Addendum B to the CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as CMS indicated in Transmittal 1536 (dated June 19, 2008; see <http://www.cms.hhs.gov/Transmittals/Downloads/R1536CP.pdf> on the CMS website.) Instead, the status indicators of brachytherapy source HCPCS codes (except C2637) which were previously paid at charges adjusted to cost will remain “H” effective July 1, 2008 through December 31, 2008, for payment of brachytherapy sources at hospitals’ charges adjusted to their costs. In addition, because of their cost-based payment methodology through CY 2009, brachytherapy sources will not be eligible for outlier payments or for the rural sole community hospital (SCH) adjustment during that time period. CMS will provide new instructions at a later date for brachytherapy source payment effective January 1, 2010. The codes for separately paid brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 6, the comprehensive brachytherapy source table below.

NOTE: When billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007 at <http://www.cms.hhs.gov/Transmittals/Downloads/R1259CP.pdf> on the CMS Web site, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007.

Table 6- Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008

HCPCS Code	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716

C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

8. Mental Health codes on Partial Hospitalization (PH/PHP) Claims

If a hospital-based PHP bills with Condition Code 41 for mental health codes that are not on the PHP code list (List B) housed in the I/OCE, the I/OCE will return the claim to the provider (edit 80) with the claim message, "Mental Health (MH) code not approved for partial hospitalization program". Examples of current mental health codes that are not used in PHP processing are 90804, 90805, 90810, 90811, 96110, and 96111. These codes may be billed by the hospital but cannot be counted toward the 3 minimum services required to qualify for partial hospitalization.

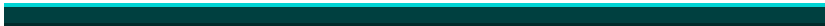
9. Coverage Determinations

Remember that the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FI/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 6196, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1599CP.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.





Update of the Intern-to-Bed Ratio for Method II Teaching Critical Access Hospitals (CAHs)

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: MM6176

Related Change Request (CR) #: 6176

Related CR Release Date: August 29, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R372OTN

Implementation Date: January 5, 2009

Provider Types Affected

Method II teaching Critical Access Hospitals (CAHs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 6176 which notifies Medicare contractors that they should update the intern-to-bed ratio on the Provider Specific File for Method II teaching CAHs when the field contains zeroes. Your Medicare contractor will contact you to obtain your intern to bed ratio. An intern-to-bed ratio greater than zero is used to determine if the Method II CAH is a teaching hospital, and CMS identifies teaching hospitals by an intern-to-bed ratio greater than 0.

Background

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the Critical Access Hospital (CAH). When the billing rights are reassigned to the Method II CAH, payment is then made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

Medicare makes payment for an assistant-at-surgery when:

- The procedure is authorized for an assistant; and
- The person performing the service is a:
 - Physician;
 - Physician assistant (PA);
 - Nurse practitioner (NP); or
 - Clinical nurse specialist (CNS).

The Social Security Act (Section 1842(b)(7)(D); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the internet) stipulates that no payment shall be made for the services of assistant-at-surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified individual on the staff of the hospital is available to provide such services. Payment may be made for assistant-at-surgery services that are required due to exceptional medical circumstances.

Payment may be made for the services of assistants-at-surgery in teaching hospitals notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries, etc.) which require immediate treatment, or there may be situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant-at-surgery even though a qualified resident is available.

Payment may also be made for the services of assistants-at-surgery in teaching hospitals if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

An intern-to-bed ratio greater than zero is used to determine if the Method II CAH is a teaching hospital, and CMS identifies teaching hospitals by an intern-to-bed ratio greater than 0. It has been brought to the attention of the CMS that the intern-to-bed ratio located on the Provider Specific File is not being updated for Method II teaching CAHs. Therefore, CR 6176 advises Medicare contractors to contact Method II teaching CAHs to obtain their intern to bed ratio and update the intern-to-bed ratio on their Provider Specific File for Method II teaching CAHs when it contains zeroes so that teaching CAHs are properly identified for claims processing purposes.

Additional Information

The official instruction, CR 6176, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R372OTN.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.





Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 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: MM6193

Related Change Request (CR) #: 6193

Related CR Release Date: September 19, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R1600CP

Implementation Date: October 6, 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 services paid under the SNF PPS.

Impact on Providers

This article is a reminder that the SNF PPS rates are updated annually.

Background

Annual updates to the PPS rates are required by §1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

CMS will publish the SNF payment rates for FY 2009 and those rates will be effective as of October 1, 2008. The rates will be published in the Federal Register before that date.

Key Points of CR 6193

- The Fiscal Year (FY) 2009 SNF payment rates will be effective October 1, 2008, through September 30, 2009.
- The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS.
- The statute mandates an update to the Federal rates using the latest SNF full market basket.

Additional Information

To see the official instruction (CR 6193) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1600CP.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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Smoking and Tobacco Use Cessation Counseling Billing Update for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Physical Therapy Providers (OPTs)

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: MM6163

Related Change Request (CR) #: 6163

Related CR Release Date: September 12, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1593CP

Implementation Date: December 12, 2008

Provider Types Affected

Comprehensive Outpatient Rehabilitation facilities (CORFs) and Outpatient Physical Therapy Providers (OPTs) who bill Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6163, from which this article is taken, updates CR 5878 (Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare), released February 1, 2008, to remove outpatient physical therapy provider (OPT) bill type 74X and Comprehensive Outpatient Rehabilitation Facility (CORF) bill type 75X from the list of applicable bill types for smoking and tobacco cessation counseling (effective July 1, 2008).

In addition, CR 6163 also announces that the applicable revenue codes for CORF billing are being updated to remove 029X (Durable Medical Equipment) because CORFs do not bill DME; and lists the revenue codes for which CORFs can bill on 75X bill types.

Make sure that your billing staffs are aware (effective July 1, 2008) that smoking and tobacco use cessation counseling is not billable by OPT or CORF providers, and are also aware of the current, applicable CORF revenue codes for 75X bill types.

Background

OPT and CORF providers cannot bill for smoking and tobacco use cessation counseling. CR 6163, from which this article is taken, updates: 1) CR 5878 (Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare), released February 1, 2008; and 2) The *Medicare Claims Processing Manual* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 100.1.1 (Allowable Revenue Codes on CORF 75X Bill Types) and 100.8 (Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings), and Chapter 32 (Billing Requirements for Special Services), Section 12.3 (FI Billing Requirements) to reflect that these bill types are not applicable for smoking and tobacco cessation counseling.

In addition, CR 6163 also announces that the applicable revenue codes for CORF billing are being updated to remove 029X (Durable Medical Equipment) because CORFs do not bill DME.

You should note that Effective July 1, 2008, only those revenue codes displayed in table 1, below, are allowable for reporting CORF services on 75X bill types.

Table 1
Revenue Codes Billable by CORFS on 75X Bill Types*

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

*Effective July 1, 2008

Additional Information

You can find more information about the billing of OPT and CORF smoking and tobacco use cessation counseling services, and about revenue codes billable by CORFs on 75X bill types by going to CR 6163, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1593CP.pdf> on the CMS website.

You will find the revised *Medicare Claims Processing Manual* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 100.1.1 (Allowable Revenue Codes on CORF 75X Bill Types) and 100.8 (Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings), and Chapter 32 (Billing Requirements for Special Services), Section 12.3 (FI Billing Requirements) as an attachment to CR 6163.

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

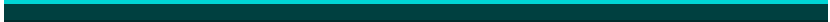




Provider Contact Center – Training Schedule

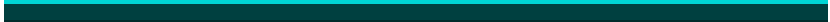
Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the Provider Contact Centers the opportunity to offer training to our Customer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

CSR Training Date	Time
Friday, November 21, 2008	9:00 a.m.-11:00 p.m. CST



Investigation Device Submission Requirements

Providers billing Cahaba GBA who are seeking [Investigational Device](#) approval should visit the new section of the web site that outlines this process and the submission requirements.





Submitting Accurate National Provider Identifiers (NPIs)

This article serves as a reminder for providers to review the NPI for accuracy before submitting their claim. Effective May 23, 2008, all Medicare claims were required to include only the NPI number. The Fiscal Intermediary Standard System (FISS) edits claims to verify that the NPI submitted, matches information on the NPI crosswalk. When the NPI is invalid, and a match is not found, FISS is unable to continue processing the claim until research is done to identify the provider who submitted the claim. The following reason codes apply:

32102—The NPI number is submitted for the billing provider, or attending, operating, or other physician is invalid, as the first digit is not equal to 1, 2, 3, or 4.

32103—The NPI number submitted for the billing provider is not present in the NPI crosswalk file.

Research has identified that some claims receive reason code 32102 or 32103 for the following reasons.

- NPI submitted matches the beneficiary's health insurance claim number (HICN);
- NPI submitted matches the medical record number;
- NPI submitted matches one of the physician NPI numbers;
- NPI submitted on the claim was 9 or less digits (NPI number must have 10 digits);
- NPI submitted included transposed digits; or
- NPI submitted as though typing was to the right or left of the number that should have been entered (e.g., 1234567890 entered as 234567890-).

Reason code **32104** is assigned when there is an inconsistency between the OSCAR number that corresponds with the NPI submitted on claims and the OSCAR number corresponding with the NPI in the crosswalk file. Typically, this occurs when a provider has multiple NPIs for different lines of business (i.e. home health and hospice). Example: provider submits the NPI assigned to their hospice on their home health claims.

Reason code **32105** applies to claims when the submitted NPI is present on the crosswalk file, but it corresponds to multiple OSCAR numbers. In this situation, FISS is unable to determine which OSCAR number is appropriate to apply to the claim. To expedite processing of such claims, report the appropriate OSCAR number in the "Remarks" field located on the Claim Page 04.

To avoid payment delays for claims due to NPI issues, providers should also be aware that FISS also checks that the following information matches between the NPI crosswalk, and the FISS provider file.

- Tax identification number (TIN);
- Employer identification number (EIN);
- Provider name;
- Provider address; and
- Zip code (5-digit or 9-digit)

The NPI crosswalk includes information provided to the National Plan and Provider Enumeration System (NPPES). If the information on NPPES is incorrect, providers need to update their information with [NPPES](#). If the information on NPPES is correct, contact our [Provider Contact Center](#) to verify your information with the information on the FISS provider file.

Please remember that in addition to ensuring that a correct billing provider's NPI is submitted, the attending, ordering, or referring physician's NPI must also be reported accurately.

To access a comprehensive listing of resources on the NPI, please access the "[National Provider Identifier \(NPI\)](#)" page of the Cahaba Web site.





Appropriate Documentation to Support KX Modifier

Medical Review's recent review of Outpatient Therapy services billed with the KX modifier has shown an increase in documentation errors. Medical Review identified the following errors:

- The medical necessity of continued services was not supported in the records.
- Documentation did not support that services required the skills and expertise of a therapist.
- Required daily treatment notes were not submitted for review.
- Documentation did not support the increased frequency of services provided 5 times per week.

Providers should remember:

- When using the KX modifier, the therapist is attesting that therapy services exceeding the financial limitation are medically necessary.
- Documentation must be sufficiently detailed to support the use of the KX modifier.
- Use of the KX Modifier does not exempt services from the Medical Review process; medical records can be requested for review.
- Routine use of the KX modifier is considered atypical use.

For physical therapy and speech language pathology services combined, the limit on covered charges is \$1,810.00 for calendar year 2008. For occupational therapy services, the limit is \$1,810.00. The exceptions process to the financial limitations has been extended to December 31, 2009. The KX modifier does not apply for hospital outpatient therapy services.

Cahaba GBA's goal is to reduce claim payment errors and address billing errors concerning coverage and coding through provider education. Providers can assist in lowering claim payment errors by documenting thoroughly and appropriately in the medical record and then submitting correctly coded claims to support all billed services.

Remember, if outpatient therapy services billed with the KX modifier are reviewed and determined not to be medically necessary, the patient is liable.

Outpatient Therapy documentation and billing guidelines are located on the Cahaba GBA, LLC website at www.cahabagba.com and the CMS website at www.cms.hhs.gov:

- Search Part A Local Coverage Determinations (LCDs) for Outpatient Therapy Services
Documentation: www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm
- Pub 100-2 Medicare Benefit Policy Manual, Chapter 15, Section 220 – 230
 - Documentation of Therapy Services - Section 220.3
- Medicare Benefit Policy Manual; chapter 8, Section 30.2. - SNF / Skilled Rehabilitation
www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf
- Pub 100-4 Medicare Claims Processing Manual, Chapter 5



Local Coverage Determinations: 2009 ICD-9-CM Updates

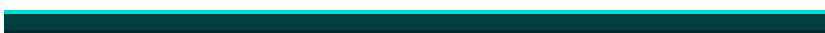
The Local Coverage Determinations (LCDs) revisions listed below are based on the 2009 ICD-9-CM coding changes. Effective **October 1, 2008**, these revised LCDs may be accessed at https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm

Notification of these updates was posted in an article on the '[News From Cahaba](#)' section of Cahaba GBA's website on August 20, 2008.

2009 ICD-9 CM Codes			
LCDs	Old Code	Replaced with	ADD
Drugs and Biologicals: Colony Stimulating Factors (L20891)			For J1440, J1441 and J2820: 203.02, 205.02, 238.77
Drugs and Biologicals: Immune Globulin Intravenous (IVIg) (L13075)	695.1	For J1561, J1566, J1568, J1569, J1572 and Q4097: 695.10 – 695.19	For J1561, J1566, J1568, J1569, J1572 and Q4097: 204.12
Drugs and Biologicals: Pamidronate Disodium (Aredia) (L855)			For J2430: 203.02; For Hypercalcemia of Malignancy: 199.2, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00 – 209.30
Drugs and Biologicals: Rituximab (Rituxan) (L1007)			204.12
Drugs and Biologicals: Zoledronic Acid (L25722)			For J3487: 199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02,

			208.12, 208.22, 208.82, 208.92, 209.00 – 209.30
Medicine: Debridement Services (L1505)			707.21, 707.22, 707.23, 707.24, 998.30, 998.33
Medicine: Occupational Therapy – Outpatient (L13314)	729.9	For Rehab CPT Codes : 729.90 – 729.99	
Medicine: Physical Therapy – Outpatient (L13267)	729.9	For Rehab CPT Codes: 729.90 – 729.99	For Rehab CPT Codes: 707.21, 707.22, 707.23, 707.24
Medicine: Wireless Capsule Imaging (L15152)			For CPT 91110: 558.41, 558.42
Radiology: Computed Tomographic Angiography of the Heart and Coronary Vessels (L22653)			414.3
Radiology: Computed Tomography of the Abdomen and Pelvis (L1495)	599.7; 780.6	599.70 – 599.72; 780.60 – 780.62	038.12, 199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00 – 209.69, 558.41, 558.42, 571.42, 625.70, 625.71, 625.79
Radiology: Computed Tomography of the Head or Brain (L13071)	046.1; 136.2 780.6	046.11; 136.21, 136.29; 780.60 – 780.62	046.19, 046.71, 046.72, 046.79, 199.2, 203.02, 208.92, 346.02 – 346.93, 349.31, 349.39
Radiology: Computed Tomography of the Thorax (L22686)	511.8; 997.3	511.81, 511.89; 997.31, 997.39	199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00 – 209.69, 482.42, 530.13, 535.70, 535.71

Radiology: Magnetic Resonance Imaging of the Brain (L13118)	046.1; 136.2; 337.0	046.11; 136.21, 136.29; 337.00 – 337.09	046.19, 046.71, 046.72, 046.79, 199.2, 205.02, 205.12, 205.22, 205.32, 205.82, 205.90, 205.91, 205.92, 346.02 – 346.93, 349.31, 349.39
Radiology: Magnetic Resonance Imaging of the Spine (L1261)	046.1	046.11	046.19, 046.71, 046.72, 046.79, 199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00 – 209.69, 349.31, 349.39
Radiology: Ultrasound of the Abdomen and Retroperitoneum (L21027)	599.7	For CPT Codes 76770 and 76775: 599.70 – 599.72	For CPT Codes 76700 and 76705: 199.2, range 209.00 – 209.20, 209.23, range 209.25 – 209.60, 209.63, range 209.65 – 209.69, 535.70, 535.71, 571.42; For CPT Codes 76770 and 76775: 199.2, 209.20, 209.24, 209.29, 209.60, 209.64, 209.69
Surgery: Colonoscopy (Diagnostic) (L2365)			199.2, 558.41, 558.42, 569.44
Surgery: Upper Gastrointestinal Endoscopy (L1200)			199.2, 209.00 – 209.20, 209.22, 209.23, 209.25 – 209.60, 209.62, 209.63, 209.65 – 209.69, 530.13, 535.70, 535.71, 558.41, 558.42



Education Events

To register go to the “[Calendar of Educational Events](#)” page on our Web site. Select the event title for registration instructions. You should watch for future listserv notifications and continue to visit our website for additional details and/or registration for these events. Please join us!

Medicare Part A, Provider Outreach and Education are planning the following educational events:



Ask Cahaba A (Teleconference)

Topic: Medicare Updates and Top Claim Submission Errors

Date: December 4, 2008

Time: 10:00 a.m. – 11:00 Central

Open to the first 100 callers. Registration is required.



Understanding the Basics of Medicare (Webinar)

Date: December 18, 2008

Time: 10:00 a.m. – 11:00 Central

Registration is required for this event.

Open to the first 100 callers. Registration is required.



Ask Cahaba A (Teleconference)

Topic: Comprehensive Error Rate Testing – “November 2007 Report”

Date: January 22, 2009

Time: 10:00 a.m. – 11:00 Central

Open to the first 100 callers. Registration is required.



New and Small Provider Workshop (Face to Face/Webinar)

Date: February 19, 2009

Time: To Be Decided

Place: Cahaba Government Benefit Administrators®, LLC

300 Corporate Parkway

Birmingham, AL 35242

Building 500 Auditorium

Registration is required.



Advanced FISS Training (Webinar)

Claims/Attachments and Claims Correction

Date: March 5, 2009

Time: 10:00 a.m. – 11:30 Central

Registration is required for this event.



Skilled Nursing Facility Consolidated Billing (Webinar)

Date: March 17, 2009

Time: 10:00 a.m. – 11:00 Central

Registration is required for this event.

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](#).