

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



January 2009

Vol. 16, No. 4

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



The Inside Story

News From Cahaba GBA	
	Disclaimer..... 2
	Provider Contact Center Training Schedule..... 3
	Local Coverage Determination (LCD)- Medicine: Partial Hospitalization Programs (L857)..... 3
	Local Coverage Determination (LCD)- Drugs and Biologicals: Immune Globulin Intravenous (IVIg) (L13075). 4
	Local Coverage Determination (LCD)- Medicine: Physical Therapy- Outpatient (L13267)..... 4
	Local Coverage Determination (LCD)- Drugs and Biologicals: Bevacizumab (Avastin) (L23585)..... 5
	Local Coverage Determination (LCD)- Drugs and Biologicals: Rituximab (Rituxan®) (L1007)..... 6
	Local Coverage Determination (LCD)- Drugs and Biologicals: Oxaliplatin (Eloxatin™) (L25905)..... 6
	Local Coverage Determination (LCD)- Drugs and Biologicals: Gemcitabine Hydrochloride (Gemzar®) (L1008)..... 7
	Changes to Duplicate Remittance Request Policy..... 8
	Provider Outreach & Education Advisory Group Accepting Applications in Alabama..... 9
	Medicare A Newsline Quality Survey..... 37
Cahaba GBA Learning Corner	
	Education Events..... 10
	Online Courses..... 11

News From CMS	
	News Flash Messages from CMS..... 12
	Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified Beds... 14
	Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update..... 17
	Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement- Annual Update..... 23
	Telehealth Services- Adding Certain Entities as Originating Sites..... 25
	Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes..... 28
	Laboratory National Coverage Determination (NCD) Edit Software Changes for January 2009..... 30
	Thermal Intradiscal Procedures (TIPs)..... 33

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

Key for Icons:

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

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Disclaimer

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ICD-9 Notice

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Provider Contact Center – Training Schedule

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

CSR Training Date	Time
Friday, January 9, 2009	9:00 a.m.-11:00 a.m.. CST
Friday, January 30, 2009	9:00 a.m.-11:00 a.m.. CST



Local Coverage Determination (LCD)- Medicine: Partial Hospitalization Programs (L857)

Effective **January 1, 2009**, the Local Coverage Determination for Medicine: Partial Hospitalization Programs, L857, has been revised. Please review the following LCD update:

The following HCPCS codes have been added:

- **G0410 - Group Psychotherapy Other Than of a Multiple-Family Group, in a Partial Hospitalization Setting, Approximately 45 to 50 minutes**
- **G0411 – Interactive Group Psychotherapy in a Partial Hospitalization Setting, Approximately 45 to 50 Minutes**

This revision is based on the 2009 CPT / HCPCS Annual Update. These codes reflect services which are currently addressed in this LCD and do not establish any new indications within nor restrict the current coverage.

Providers are encouraged to review these revisions to ensure compliance, effective January 1, 2009.

This LCD can be viewed on our [Active LCD](#) page.



Local Coverage Determination– Drugs and Biologicals: Immune Globulin Intravenous (IVIg) L13075

Effective **January 1, 2009**, the Local Coverage Determination for Drugs and Biologicals: Immune Globulin Intravenous (IVIg), L13075, has been revised. Please review the following LCD update:

HCPCS code Q4097, Injection, Immune Globulin (Privigen), Intravenous, Non-Lyophilized (e.g., liquid), 500 mg is invalid and has been replaced with HCPCS code J1459.

This revision is based on the 2009 CPT / HCPCS Annual Update.

Providers are encouraged to review these revisions to ensure compliance, effective January 1, 2009.

This LCD can be viewed on our [Active LCD](#) page.



Local Coverage Determination (LCD)- Medicine: Physical Therapy - Outpatient (L13267)

Effective **January 1, 2009**, the Local Coverage Determination (LCD) for Medicine: Physical Therapy – Outpatient (L13267) has been revised. Please review the following LCD update:

Services utilizing ‘standard canolith repositioning procedures’ are covered under CPT 95992. This code is untimed. Therefore, time spent performing these procedures should not be considered a part of any other timed code. Other medically necessary and distinct vestibular rehabilitation services are covered as either CPT 97110 or 97112, depending upon the specific services rendered.

This revision is based on the 2009 Annual Update to the Therapy Code List.

Providers are encouraged to review this revision to ensure compliance, effective January 1, 2009.

This LCD can be viewed on our [Active LCD](#) page.





Local Coverage Determinations (LCD)– Drugs and Biologicals: Bevacizumab (Avastin) L23585

Effective **December 1, 2008**, the Local Coverage Determination (LCD) for Drugs and Biologicals: Bevacizumab (Avastin) has been revised. Please review the following LCD update:

In accordance with the NCCN Drugs and Biologicals Compendium, language contained in the ‘Indications’ section has been revised to reflect coverage for Ovarian Cancer, Kidney Cancer and Central Nervous System Cancers.

The following ICD-9 codes have been added:

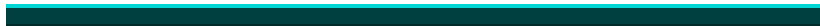
- 183.0
- 183.2 – 183.5
- 183.8
- 183.9
- 189.0
- 189.1
- 191.0 – 191.9

In addition, code ranges have been expanded to include the following ICD-9 codes:

- 153.9
- 154.2
- 154.3
- 162.9
- 174.9
- 175.9

Providers are encouraged to review these revisions to ensure compliance, effective December 1, 2008.

This LCD can be viewed on our [Active LCD](#) page.





Local Coverage Determination (LCD)- Drugs and Biologicals: Rituximab (Rituxan[®]) (L1007)

Effective **January 1, 2009** the Local Coverage Determination (LCD) for Drugs and Biologicals: Rituximab (Rituxan[®]) (L1007) has been revised. Please review the following LCD update:

- ICD-9 code ranges 202.00 – 202.08, 202.70 – 202.78 and 202.80 – 202.88 have been combined and expanded to range 202.00 – 202.98.
- ICD-9 code 446.6 has been added.

Providers are encouraged to review these revisions to ensure compliance, effective **January 1, 2009**.

This LCD can be viewed on our [Active LCD](#) page.



Local Coverage Determination (LCD)- Drugs and Biologicals: Oxaliplatin (Eloxatin[™]) (L25905)

Effective **January 1, 2009** the Local Coverage Determination (LCD) for Drugs and Biologicals: Oxaliplatin (Eloxatin[™]) (L25905) has been revised. Please review the following LCD update:

The following ICD-9 codes have been added:

- 151.9
- 152.1

Providers are encouraged to review these revisions to ensure compliance, effective **January 1, 2009**.

This LCD can be viewed on our [Active LCD](#) page.





Local Coverage Determination (LCD)- Drugs and Biologicals: Gemcitabine Hydrochloride (Gemzar[®]) (L1008)

Effective **January 1, 2009** the Local Coverage Determination (LCD) for Drugs and Biologicals: Gemcitabine Hydrochloride (Gemzar[®]) (L1008) has been revised. Please review the following LCD update:

The following ICD-9 codes have been added:

- 151.9
- 158.0 – 158.9
- 164.2
- 164.3
- 164.8
- 164.9
- 171.0 – 171.9
- 181
- 189.1
- 189.2
- 189.9
- 194.4

Providers are encouraged to review these revisions to ensure compliance, effective **January 1, 2009**.

This LCD can be viewed on our [Active LCD](#) page.





Changes to Duplicate Remittance Requests Policy

According to the *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 22, §10) the Centers for Medicare & Medicaid Services (CMS) allows contractors to charge for generating and mailing duplicate remittance advice (both electronic and paper) to recoup costs when generated at the request of a provider or any entity working on behalf of the provider.

Effective **February 1, 2009**, when a provider requests a copy of a remittance advice (electronic or paper), Cahaba will charge \$5.00 for each copy. Requests will be completed within 45 business days of receipt. Requests must be submitted using the “[Request for Duplicate Remittance Advice](#)” form. Return this form and your check payable to “Cahaba GBA” to the address provided on the form.

Note: Remember that an electronic remittance advice (ERA) file is available to download for 45 days. If necessary, you may request the ERA to be made available in your mailbox for another 45 days; however, after the second 45 days, the ERA file is no longer available.





Provider Outreach & Education Advisory Group Accepting Applications In Alabama

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

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

Contractor Responsibilities

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

POE Advisory Group Members' Responsibilities

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

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

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

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

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 Web site 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: Inpatient DRG Reviews

Date: January 22, 2009

Time: 10:00 a.m. – 11:00 a.m. Central

Open to the first 100 callers. Registration is required for this event.



Welcome to Medicare "New Provider Orientation" Workshop

Date: February 19, 2009

Time: To Be Decided

Place: Hyatt Place

4686 Highway 280 East

Birmingham, AL 35242

Registration is required for this event.



Advanced FISS Training (Webinar)

Topic: Claims/Attachments and Corrections

Date: March 5, 2009

Time: 10:00 a.m. – 11:30 a.m. Central

Registration is required for this event.



Skilled Nursing Facility Consolidated Billing (Webinar)

Date: March 17, 2009

Time: 10:00 a.m. – 11:00 a.m. 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](#).



Flu Season

Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. (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 personnel can spread the highly contagious flu virus to patients. Protect yourself. Don't Get the Flu. Don't Give the Flu. Get Your Flu Shot. 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 professionals, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site.



E-Prescribing Incentive Program

The Centers for Medicare & Medicaid Services (CMS) has posted "Medicare's Practical Guide to the E-Prescribing Incentive Program", which explains the e-prescribing incentive program, how eligible professionals can participate, and how to choose a qualified e-prescribing system. To read or print the guide, visit <http://www.cms.hhs.gov/partnerships/downloads/11399.pdf> on the CMS Web site. By adopting e-prescribing through Medicare's program, eligible professionals can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care while earning incentives from Medicare. For additional information about e-prescribing, you can also visit: <http://www.cms.hhs.gov/PQRI> and select "E-prescribing Incentive Program"; or visit <http://www.cms.hhs.gov/eprescribing> (for information on Part D e-prescribing standards that will be effective April 1, 2009); and <http://www.ehealthinitiative.org/> to download "A Clinician's Guide to Electronic Prescribing."



ICD-10-Clinical Modification/Procedure Coding System Fact Sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the CMS Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2008.pdf>.



Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)

A new MLN Matters provider education article is now available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0837.pdf> on the CMS Web site. This Special Edition article assists all providers who will be affected by Medicare Administrative Contractor (MAC) implementations. It provides information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. This article alerts providers as to what to expect and how to prepare for the MAC implementations and will help to minimize any disruption in your Medicare business.



Medicare Learning Network (MLN)

Would you like to stay informed of the educational products from the? If so, you can join the Medicare Learning Network (MLN) Education Products mailing list, which will deliver the latest information about new and revised MLN products, right to your inbox. To join, visit https://list.nih.gov/cgi-bin/wa?SUBED1=mln_education_products-l&A=1; then enter your email address and full name. Click “Join the List”. Follow the instructions in the confirmation email you will receive to confirm your subscription to the list. (Note, the sender of this email will appear as “NIH LISTSERV SERVER”.)



Competitive Acquisition Program (CAP) for Drugs and Biologicals

The Medicare Part B Competitive Acquisition Program (CAP) for Drugs and Biologicals has been postponed for 2009. Information about upcoming CAP deadlines is available at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp on the CMS Web site.



Medicare Payments Reductions

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.



Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

Background

Section 114 of the Medicare Medicaid State Children's Health Insurance Plan Extension Act (MMSEA) (Pub. L. 110-173), enacted December 29, 2007, establishes a number of provisions affecting Long-Term Care Hospitals (LTCH). Section 114(d)(1) establishes a 3-year moratorium on the designation of new LTCHs or LTCH satellites, and on an increase of beds in a LTCH. The moratorium began on December 29, 2007, and ends on December 28, 2010.

Policy: Section 114(d)(2) of the MMSE Act (Pub. L. 110-173)

For hospitals that are seeking to be excluded from the Inpatient Prospective Payment System for the first time as a LTCH, under the existing regulations at §412.23(e)(1) and (e)(2)(i), which implement Section 1886(d)(1)(B)(iv)(I) of the Social Security Act, such hospitals must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) greater than 25 days. The FI or MAC, as applicable, will verify whether the hospital meets the average LOS requirement.

Sections 114(d)(2) and (d)(3) of MMSEA provide for exceptions to the moratorium imposed by Section 114(d)(1) of MMSEA. It is important to note that the two categories of exceptions are mutually exclusive. The three exceptions specified in Section 114(d)(2) of MMSEA, discussed below, are only applicable to the establishment and classification of a LTCH or LTCH satellite facility; they do not apply to the moratorium on an increase in beds at Section 114(d)(1)(B) of MMSEA. Similarly, the exception at Section 114(d)(3)(A) of MMSEA only applies to the moratorium on increases in beds at existing LTCHs or LTCH satellites facilities, and not to the moratorium on the establishment of LTCHs and LTCH satellite facilities.

1. Establishment and Classification of a LTCH or LTCH Satellite

In accordance with Section 114(d)(2), the moratorium on the establishment and classification of a LTCH or LTCH satellite facility does not apply to a LTCH that, as of December 29, 2007, met one of the following three exceptions:

- a) The LTCH began "its qualifying period for payment as a long-term care hospital under Section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this Act Section 114(d)(2)(A)). This exception applies to an existing hospital that began its qualifying period for LTCH status on or before December 29, 2007. To qualify for this exception to the moratorium, the LOS data used to demonstrate that the hospital has met the average LOS requirement at 42 CFR 412.23 must be from its cost reporting period that began on or before December 29, 2007. Note that a LTCH satellite may not qualify for this exception, since there is no "qualifying period" for the establishment of a satellite facility for payment as a LTCH under 42 CFR 412.23(e).
- b) As of December 29, 2007, the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH and has expended, prior to December 29, 2007, at least 10 percent of the estimated cost of the project or, if less, \$2,500,000 (Section 114(d)(2)(B)). This exception applies in the following three circumstances:

(1) As of December 29, 2007, an existing hospital (that is, one that was certified as a hospital as of December 29, 2007) that will become a LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition for converting the hospital to a LTCH and has expended, before that date, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less;

(2) As of December 29, 2007, an entity that will develop a hospital that will ultimately become a LTCH has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease, or demolition of a hospital and that entity has expended, before that date, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less; or

(3) An existing LTCH, as of December 29, 2007, has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease or demolition of a new LTCH satellite facility and the LTCH has expended before December 29, 2007, at least 10 percent of the estimated cost of the project or \$2,500,000, whichever amount is less.

c) The LTCH has obtained an approved Certificate of Need (CON) in a State where one is required on or before December 29, 2007, (Section 114(d)(2)(C)). This exception applies to a hospital or entity that was actively engaged in developing a LTCH, as evidenced by the fact that either:

(1) An entity that wanted to create a LTCH, but did not exist as a hospital as of December 29, 2007, had obtained an approved CON for a hospital or LTCH, as applicable, on or before December 29, 2007. Depending on the State's CON law, there may or may not be a CON that is specifically for a long-term acute care hospital, as opposed to one for a general or short-term acute care hospital. If there is a CON that is specifically for a LTCH in the entity's State, then the entity must have been obtained an approved CON that is specifically for creation of a LTCH. If the State does not require a specific LTCH CON, then it is sufficient for the entity to have obtained an approved hospital CON on or before December 29, 2007, as long as it did not exist as a hospital by that date.

or

(2) A hospital that did exist as a hospital on December 29, 2007, had obtained an approved CON on or before December 29, 2007, to convert the hospital into a new LTCH, or an existing LTCH had obtained an approved CON by that date to create a satellite. This exception does not apply to an existing hospital that obtained an approved CON for a hospital type other than a LTCH on or before December 29, 2007. The fact that a hospital may have had a CON issued to it years before December 29, 2007, to operate a hospital would not be a reason to grant it an exception, unless that CON was specifically for a LTCH. In a State that does not require a specific CON for a LTCH type of hospital this exception is not available to any existing hospital.

2. Increase in the Number of LTCH Beds

In accordance with Section 114(d)(1)(B), an existing LTCH or LTCH satellite facility may not increase the number of beds in excess of the number of Medicare-certified beds at the hospital as of December 29, 2007. Section 114(d)(3) states that the moratorium on an increase in beds shall not apply if an existing LTCH or LTCH satellite facility is "located in a State where there is only one other long-term care hospital; and requests an increase in beds following the closure or the decrease

in the number of beds of another long-term care hospital in the State." There is further statutory language about the intersection of this exception with "grandfathered" LTCH Hospitals within Hospitals (HwHs) as specified at 42 CFR 412.22(f) and LTCH satellite facilities as specified at 42 CFR 412.22(h)(3).

It is likely that there are a very limited number of cases that might meet the exception criteria for an increase in the number of certified LTCH beds. The ROs that receive a request for a bed increase from a LTCH in a State with more than two certified LTCHs are to deny the request. (Note that LTCH satellites are not considered separate LTCHs.) The ROs that receive a request for a bed increase in a state that has only two certified LTCHs are to consult with David Eddinger at the CMS' Central Office on the evaluation of the request.

CMS Change Request 6172





Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

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

MLN Matters Number: MM6229

Related Change Request (CR) #:6229

Related CR Release Date: November 14, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1634CP

Implementation Date: January 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6229 which updates Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR 6229. Be sure billing staff are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

Note: The complete list of remark codes is available at <http://www.wpc-edi.com/codes> on the Internet.

Medicare contractors will use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the WPC Web site. The Web site address is <http://www.cmsremarkcodes.info/> on the Internet.

Note I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

Note II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are “Informational” will have “Alert” in the text to identify them as informational rather than explanatory codes. These “Informational” codes may be used without any CARC explaining a specific adjustment.

An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC -16, 17, 96, 125, and A1.

Remittance Advice Remark Code Changes

New Codes:

Code	Current Narrative	Medicare Initiated
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008	
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008	
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008	
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008	
N438	This jurisdiction only accepts paper claims. Start: 7/1/2008	
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008	
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008	
N441	This missed appointment is not covered. Start: 7/1/2008	
N442	Payment based on an alternate fee schedule. Start: 7/1/2008	
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008	
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.	

	Start: 7/1/2008	
N445	Missing document for actual cost or paid amount. Start: 7/1/2008	
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008	
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008	
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Start: 7/1/2008	
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008	
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008	
N451	Missing Admission Summary Report. Start: 7/1/2008	
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008	
N453	Missing Consultation Report. Start: 7/1/2008	
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008	
N455	Missing Physician Order. Start: 7/1/2008	
N456	Incomplete/invalid Physician Order. Start: 7/1/2008	
N457	Missing Diagnostic Report. Start: 7/1/2008	
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008	
N459	Missing Discharge Summary. Start: 7/1/2008	
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008	
N461	Missing Nursing Notes. Start: 7/1/2008	
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008	
N463	Missing support data for claim. Start: 7/1/2008	
N464	Incomplete/invalid support data for claim. Start: 7/1/2008	
N465	Missing Physical Therapy Notes/Report. Start: 7/1/2008	
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008	
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008	
N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008	
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008	Yes
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008	
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008	
N472	Payment for this service has been issued to another provider. Start: 7/1/2008	
N473	Missing certification. Start: 7/1/2008	
N474	Incomplete/invalid certification Start: 7/1/2008	
N475	Missing completed referral form. Start: 7/1/2008	
N476	Incomplete/invalid completed referral form Start: 7/1/2008	
N477	Missing Dental Models. Start: 7/1/2008	
N478	Incomplete/invalid Dental Models Start: 7/1/2008	

N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N481	Missing Models. Start: 7/1/2008	
N482	Incomplete/invalid Models Start: 7/1/2008	
N483	Missing Periodontal Charts. Start: 7/1/2008	
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008	
N485	Missing Physical Therapy Certification. Start: 7/1/2008	
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008	
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008	
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008	
N489	Missing referral form. Start: 7/1/2008	
N490	Incomplete/invalid referral form Start: 7/1/2008	
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008	
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008	
N493	Missing Doctor First Report of Injury. Start: 7/1/2008	
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008	
N495	Missing Supplemental Medical Report. Start: 7/1/2008	
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008	
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N499	Missing Medical Legal Report. Start: 7/1/2008	
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008	
N501	Missing Vocational Report. Start: 7/1/2008	
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008	
N503	Missing Work Status Report. Start: 7/1/2008	
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008	

Modified Codes

Code	Current Modified Narrative	Last Modified
M29	Missing operative note/report	7/1/08
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	7/1/08
N26	Missing itemized bill/statement.	7/1/08

N40	Missing radiology film(s)/image(s).	7/1/08
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/statement.	7/1/08
N233	Incomplete/invalid operative note/report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/report.	7/1/08

Deactivated Codes

There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site at <http://www.wpc-edi.com/codes> on the Internet.

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July. The list is available at <http://www.wpc-edi.com/codes> on the Internet.

New Codes:

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	01/05/2009
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	01/05/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	01/05/2009
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)Start Date: 6/1/2008	01/05/2009

Note: Codes 223 and 224 are Medicare initiated

Modified Code(s):

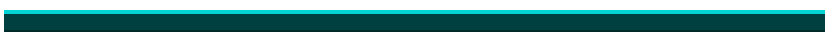
Code	Current Narrative	Implementation Date
60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	01/05/2009
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Worker's 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. Start: 01/27/2008- Stop 01/01/2009.	01/01/2009

Note: The Code Committee also reactivated CARC 2007

Additional Information

The official instruction, CR 6229, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1634CP.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.





Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement

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: MM6262

Related Change Request (CR) #:6262

Related CR Release Date: November 7, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1633CP

Implementation Date: January 5, 2009

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

What You Need to Know

This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

What You Need to Do

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

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm on the Internet and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20.1), available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

The **following HCPCS code is added** to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is deleted from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.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.





Adding Certain Entities as Originating Sites for Payment of Telehealth Services-- Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

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: MM6215

Related Change Request (CR) #:6215

Related CR Release Date: November 14, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R97BP & R1635CP

Implementation Date: January 5, 2009

Provider Types Affected

Hospital-based or critical access hospital-based renal dialysis centers (including satellites); Skilled Nursing Facilities (SNFs); and/or Community Mental Health Centers (CMHCs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for telehealth services provided to Medicare beneficiaries. Eligible distant site physicians and practitioners may now be paid for qualifying telehealth services provided to beneficiaries who are located at these new sites.

Provider Action Needed

This article is based on Change Request (CR) 6215 which announces that CMS is adding entities as originating sites for payment of telehealth services for dates of service on or after January 1, 2009. Those **added entities are:**

- Hospital-Based or critical access hospital-based renal dialysis centers (including satellites);
- Skilled Nursing Facilities; and
- Community Mental Health centers (CMHCs).

Please Note: MIPPA did not add independent renal dialysis facilities as originating sites for payment of telehealth services.

Consistent with existing requirements, in order to be eligible to serve as an originating site, entities must be located in either a non-Metropolitan Statistical Area (non-MSA) county or rural health professional shortage area (rural HPSA).

Be sure your billing staff is aware of these changes.

Background

Section 149 of the MIPPA amended §1834(m) of the Social Security Act (“the Act”) to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended §1888(e)(2)(A)(ii) of the Act

to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

This article provides you with updated instructions for billing the originating site facility fee. Providers are also subject to existing payment policy and claims processing instructions applicable to Medicare telehealth services that are not included in this change request, as set forth in the *CMS Medicare Benefit Policy Manual*, chapter 15, section 270 and the *CMS Medicare Claims Processing Manual*, chapter 12, section 190. These manuals are available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Web site.

Key Points of CR 6215

- The originating site facility fee is a separately billable Part B payment. Your Medicare contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.
- The originating site facility fee is updated annually by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is issued by November 1 prior to the start of the calendar year for which it is effective.
- An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Hospital-Based or CAH-based Renal Dialysis Centers

For dates of service on or after January 1, 2009, hospital-based and CAH-based renal dialysis centers (including satellites) are eligible for Medicare payment when they serve as originating sites for telehealth services.

- When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or monthly capitation payment (MCP) amount.
- With respect to the originating site facility fee, hospital-based and CAH-based renal dialysis centers should bill their regular FI or MAC for the originating site facility fee on type of bill (TOB) 72x using revenue code 078X and Healthcare Common Procedure Coding System (HCPCS) code Q3014 on a separate revenue line from any other services provided to the beneficiary. Note that the originating site facility fees (Q3014) are not ESRD services and do not count towards the number of services used to determine payment for ESRD services.

Skilled Nursing Facilities (SNFs)

For dates of service on or after January 1, 2009, SNFs as defined in 1819(a) of the Act are eligible for Medicare payment when they serve as originating sites for telehealth services.

- The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

- With respect to the originating site facility fee, SNFs will bill their regular FI or MAC for the originating site facility fee on **TOBs 22x or 23x**. For SNF inpatients in a covered Part A stay, SNFs will bill their regular FI or MAC for the originating site facility fee on **TOB 22X**. All SNFs will bill **using revenue code 078X and HCPCS code Q3014** on a separate revenue line from any other services provided to the beneficiary.

Community Mental Health Centers (CMHCs)

For dates of service on or after January 1, 2009, CMHCs as defined in 1861(ff)(3)(B) of the Act are eligible for Medicare payment when they provide telehealth originating site services.

- When a CMHC serves as an originating site, the originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.
- With respect to the originating site facility fee, CMHCs will bill their regular FI or MAC for the originating site facility fee on **TOB 76x using revenue code 078X and HCPCS code Q3014** on a separate revenue line from any other services provided to the beneficiary. Note that **Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services**.

Additional Information

The official instruction (CR 6215) issued to your Medicare FI or MAC consists of two transmittals. One transmittal revises the *Medicare Claims Processing Manual*, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1635CP.pdf>, and the other revises the *Medicare Benefit Policy Manual*, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R97BP.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.





Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes

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

MLN Matters Number: MM6106

Related CR Release Date: November 21, 2008

Related CR Transmittal #: R1639CP

Related Change Request (CR) #:6106

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Physicians and providers submitting claims to Medicare Carriers, Medicare Administrative Contractors (A/B MACs), and/or Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries in areas designated as geographic HPSAs.

Provider Action Needed

This article is based on Change Request (CR) 6106 and informs providers who are serving Medicare beneficiaries in areas that were eligible on December 31 of the prior year for the HPSA bonus but **not on the automated ZIP code list to use the AQ modifier to receive the HPSA bonus payment**. Make sure billing staff are aware of the clarified criteria for proper use of the AQ modifier.

Background

The Section 1833(m) of the Social Security Act provides for an additional 10 percent bonus payment for physicians' services furnished to a covered individual in an area that is designated as a geographic HPSA prior to the beginning of the year in which the services were provided. Such HPSA areas are identified by the Secretary of the Department of Health and Human Services prior to the beginning of such year. The Centers for Medicare & Medicaid Services (CMS) posts a file annually of ZIP codes within which the HPSA bonus payment should be made automatically. Physicians furnishing services in areas that were eligible for the HPSA bonus prior to the beginning of the year but not on the automated list have been instructed to use the AQ modifier to receive the HPSA bonus payment.


Key Points

- Effective for claims with dates of service on or after January 1, 2009, only services furnished in areas that are designated as geographic HPSAs as of December 31 of the prior year are eligible for the HPSA bonus payment.
- Services furnished in areas that are designated at any time during the current year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31.
- If you are providing services to Medicare beneficiaries in areas that are designated on December 31 of the prior year **but not included on the list of zip codes eligible** for automated HPSA bonus payments make certain you **use the AQ modifier to receive the HPSA bonus payment**.
- Remember, your Medicare Contractor will automatically make a HPSA bonus payment to physicians providing eligible services in a ZIP code included in the annual file.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6106) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1639CP.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.





Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 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: MM6304

Related CR Release Date: December 9, 2008

Related CR Transmittal #: R164CP

Related Change Request (CR) #:6304

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 6304 which announces the changes that will be included in the January 2009 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in October 2008.

Background

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

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the CMS Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6304 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for January 2009 as described below. These changes become effective for services furnished on or after January 1, 2009 and are as follows:

For HIV Testing:

- Add ICD-9-CM code 482.42 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM code range 249.40-249.41 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.

For Prothrombin Time (PT):

- Add ICD-9-CM code range 249.40-249.41 and the ICD-9-CM codes 197.7, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM code V15.2 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

For Serum Iron Studies:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91, 285.22, 285.29, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

For Blood Glucose Testing:

- Add ICD-9-CM code 482.42 and the code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.

For Glycated Hemoglobin/Glycated Protein:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

For Thyroid Testing:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

For Lipid Testing:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM code 275.2 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

For Fecal Occult Blood Test (FOBT):

- Add ICD-9-CM codes 530.86 and 530.87 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD.

For All 23 NCDs (190.12-190.34):

- Add ICD-9-CM codes V16.52 and V73.81 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

Additional Information

The official instruction, CR 6304, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1645CP.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.





Thermal Intradiscal Procedures (TIPs)

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: MM6291

Related CR Release Date: December 9, 2008

Related CR Transmittal #: R1646CP &
R97NCD

Related Change Request (CR) #:6291

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Physicians and other providers who bill Medicare carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (MAC) for providing thermal intradiscal procedures (TIP) to Medicare beneficiaries.

What You Need to Know

CR 6291, from which this article is taken, communicates the findings of a new national coverage determination (NCD) regarding thermal intradiscal procedures (TIPs), including billing requirements.

Effective for services performed on or after September 29, 2008, the Centers for Medicare & Medicaid Services (CMS) has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries.

Specifically, CR 6291:

- Announces the relevant Current Procedural Terminology (CPT) codes that (effective September 29, 2008) will be denied when submitted, and also the codes that will be denied when identified as a TIP;
- Instructs Medicare contractors to deny claims for radiologic or fluoroscopic guidance when performed in conjunction with a TIP; and
- Urges physicians, ambulatory surgical centers (ASC), and hospitals to provide appropriate liability notices to beneficiaries.

You should make sure that your billing staffs are aware of this NCD regarding TIPs, the details of which can be found in the Background section that follows.

Background

Percutaneous Thermal Intradiscal procedures (TIPs) involve the insertion a catheter(s)/probe(s) into the spinal disc under fluoroscopic guidance in order to produce, or apply, heat and/or disruption within the disc to relieve low back pain.

On January 15, 2008, the CMS initiated a national coverage analysis (NCA) on TIPs. CR 6291 communicates the findings of this NCA, and the resultant NCD. Please note that this is the first NCD to address thermal intradiscal procedures (TIPs).

The NCA addressed the use of TIPs to: 1) treat symptomatic patients with annular disruption of a contained herniated disc, 2) to seal annular tears or fissures, or 3) to destroy nociceptors for the purpose of relieving pain. It included the use of percutaneous intradiscal techniques that utilize devices employing a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material. Further, it included techniques that use single or multiple probes/catheters which: 1) utilize a resistance coil or other thermal intradiscal technology; 2) are flexible or rigid; and 3) are placed within the nucleus, the nuclear-annular junction, or the annulus.

Although not meant to be a complete list, TIPs are commonly identified as

- Intradiscal Electrothermal Therapy (IDET);
- Intradiscal Thermal Annuloplasty (IDTA);
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT);
- Radiofrequency Annuloplasty (RA);
- Intradiscal Biacuplasty (IDB);
- Percutaneous (or plasma) Disc Decompression (PDD) or ablation; or
- Targeted Disc Decompression (TDD).

At times, TIPs are identified, or labeled, based on the name of the catheter(s)/probe(s) that are used (e.g. SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes); and each technique or device has its own protocol for application of the therapy.

Note: Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within this NCD's scope.

TIPs NCD Requirements

CR 6291 announces that CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Therefore, effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries; and for services on and after that date, your carriers, FIs, and MACs will deny any claims that you submit for TIPs.

The following table displays the CPT/HCPCS codes that are identified for TIPs procedures performed within the annulus of the intervertebral disc. **On, or after, September 29, 2008, your Medicare contractors will deny claims that you submit for TIPs procedures with any of these non-covered codes.**

CPT/HCPCS Code	Description
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels

0062T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level
0063T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; one or more additional levels

CPT Codes Identified For TIPs Procedures Performed Within the Annulus of the Intervertebral Disc*

*The change to add the non-covered indicator for these codes will be part of the January 2009 Medicare Physician Fee Schedule Update and the change to the status indicator to non-covered for the above HCPCS is part of the integrated Outpatient Code Editor (IOCE) update for January 2009 .

Note that the following CPT codes, which can be used for TIPs procedures performed within the nucleus of the disc (e.g., PDD or TDD procedures), can also be used for procedures that are not within the scope of this NCD:

- 62287 (Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar);
- 22899 (Unlisted procedure, spine); and
- 64999 (Unlisted procedure, nervous system)

Please note that since codes 22899 or 64999 do suspend for review, when you submit them for TIPs procedures performed within the nucleus, **you should submit a clear description of the procedure in the narrative section of the claim. Contractors may also be advising providers to submit intervertebral disc nucleus procedures that are considered TIPs under codes 22899 or 64999 in order to avoid improper payment for a TIP under code 62287. Providers are also advised to submit the biacuplasty procedure under code 0062T (currently some providers are submitting this procedure under code 64999).**

In addition, as all TIPs procedures are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a noncovered service and would itself, therefore, also be noncovered. CR 6291 instructs your carrier, FI, or A/B MAC to deny claims for the radiologic or fluoroscopic guidance when performed in conjunction with a TIP.

When denying your TIPs claims, Medicare contractors will use:

- Medicare Summary Notice (MSN) 21.11 - “This service was not covered by Medicare at the time you received it;”
- Claim Adjustment Reason Code (CARC) 96 - “Non-covered charge(s)”, and
- Remittance Advise Remark Code N386, “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have access, you may contact the contractor to request a copy of the NCD.”

Note: Carriers, FIs, and A/B MACs do not need to search their files to recoup payment for claims already paid, however they will adjust claims that are brought to their attention.

CR 6291 further advises physicians and hospitals to give beneficiaries, who choose to have this procedure, an Advance Beneficiary Notice (ABN), consistent with the *Medicare Claims Processing Manual*, Chapter 30, (Financial Liability Protections). This ABN, which you must issue prior to the procedure, should indicate that, after an NCA, Medicare issued a national coverage determination (NCD) (*Medicare National Coverage Determinations (NCD) Manual*, section 150.11 (Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008)) which states that TIPs are not reasonable and necessary for Medicare beneficiaries. Therefore, Medicare never pays for this service and the beneficiary would be held financially responsible if they decide to have this procedure.

You should be aware that unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, you are liable for charges for TIPs.

You should also be aware that beginning March 1, 2009, the ABN-G will no longer be valid and you must issue the revised ABN (CMS-R-131).

Additional Information

You can find the official instruction, CR 6291, was issued to your carrier, FI or MAC in two transmittals. You will find revised *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2 (Sections 90 – 160.26) (Coverage Determinations), Section 150.11 (Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008) is a national coverage determination (NCD)) at <http://www.cms.hhs.gov/Transmittals/downloads/R97NCD.pdf> on the CMS Web site. The transmittal that revises the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 220 (Billing Requirements for Thermal Intradiscal Procedures (TIPs) Claims), 220.1 (General), 220.2 (Contractor A/B MAC), 220.3 (Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARA), and Remittance Advise Remark Code (RARC)), and 220.4 (Advanced Beneficiary Notice (ABN)) is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1646CP.pdf> on the CMS Web site.

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