

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



CAHABA
GOVERNMENT
BENEFIT
ADMINISTRATORS, LLC

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



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Provider Contact Center Hours

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

- Alabama: 8:00 a.m. – 5:00 p.m. CST

Key for Icons:

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

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, March 13, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, March 27, 2009	9:00 a.m.- 11:00 a.m. CST



Local Coverage Determination (LCD)– Erythropoietin Analogues (L20432)- Revision

The Local Coverage Determination (LCD) for **Erythropoietin Analogues (L20432)** has been updated.

Language in the “Documentation Requirements” section has been further clarified.

For ESRD and CKD patients, requirements for the physician’s “comprehensive assessment” includes:

Patient’s most recent serum creatinine or GFR within the last month, prior to initiation of EA therapy.

Providers are encouraged to review this clarification to ensure compliance, effective **February 1, 2009**.

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



Bone Mass Measurement (A47207)

Effective **March 1, 2009**, the Educational Article for [Bone Mass Measurement \(A47207\)](#) has been updated. Please review the following changes:

The following ICD-9 codes have been added:

- 256.31
- 627.2
- 627.4
- 805.00 – 805.8
- 806.00 – 806.79

Providers are encouraged to review these revisions to ensure compliance.

This original [Article A47207](#) was effective February 1, 2008.



Local Coverage Determination (LCD)– Pathology and Laboratory: B-Type Natriuretic Peptide (BNP) Testing (L20418)

Effective **March 1, 2009**, the Local Coverage Determination (LCD) for **Pathology and Laboratory: B-Type Natriuretic Peptide (BNP) Testing (L20418)** has been revised. Please review the following LCD update:

The “*Indications*” section has been revised to include the following:

- Serum BNP, for the purpose of coverage, is considered a ‘point-of-service’ test (performed and immediately used in the disposition of patient care).
- Predicting the long term risk of cardiac events or death across the spectrum of acute coronary syndromes when measured in the first few days after an acute coronary event. Since this situation is an inpatient service, it is not addressed in this LCD.

The “*Limitations*” section has been revised to include the following:

- Since BNP is a ‘point-of-service’ test, the primary outpatient site of service expected to perform a serum BNP is the emergency room or a physician’s office.

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

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



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 and after**, when a provider requests a copy of a remittance advice (electronic or paper), Cahaba GBA 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 Enrollment Applications-Address Change

Beginning **February 1, 2009**, Cahaba GBA began processing enrollment applications and storing the data electronically. As of this date, all Part A enrollment applications should be mailed to the address listed below:

Cahaba GBA
Provider Enrollment Part A
PO Box 1537
Birmingham, AL 35201





Top Electronic Data Interchange (EDI) Claim Rejections for January 2009

The top five reasons for claim rejections in **January 2009** are:

Note: This information is applicable to Medicare Part A Providers who send their electronic claims submission to the Cahaba GBA, LLC office in Birmingham, Alabama.

Claim Rejection	Description	Number of Claims
205	INVALID PATIENTS LAST NAME The last name submitted for the beneficiary does not match the last name we have on record for the HIC number submitted.	842
777	APASS MODULE REJECTION An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	629
888	INSTREAM REJECTION There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred.	260
207	INVALID PATIENTS SEX CODE Patient's gender code on the submitted claim was blank or not equal to M, F, or U.	197
206	INVALID PATIENTS 1ST NAME/INITIAL The first name/initial of the patient on the submitted claim does not match the first name/initial of the beneficiary as we have it in our records.	188





Reminder of New Provider Authentication Requirements—Effective April 6, 2009

Effective **April 6, 2009**, the Provider Contact Centers (PCCs) customer service staff are required to properly authenticate callers and writers before disclosing protected health information.

Phone Inquiries

When you call either the Interactive Voice Response (IVR) system, or select to speak to a customer service representative (CSR), you will be required to provide three data elements for authentication.

- National Provider Identifier (NPI);
- Provider Transaction Access Number (PTAN) (often referred to as OSCAR); and
- Last 5-digits of your Tax Identification Number (TIN)

Please have this information available before you call the Provider Contact Center (PCC). The PCC numbers are: Alabama 1-866-539-5598; Georgia 1-877-567-7271 or Mississippi 1-866-419-9454.

Written Inquiries

The above elements are also required when submitting written inquiries; however, an exception applies when the written inquiry is received on your official letterhead. The name and address on the letterhead must clearly establish your identity, and must match the information on the provider file within the Fiscal Intermediary Standard System (FISS) for Part A inquiries or the Multi Carrier System (MCS) for Part B inquiries. In addition, the letterhead must include and match, either, the NPI, PTAN, or the last 5-digits of the TIN.

For additional information, refer to the Medicare Learning Network (MLN) Matters article, “Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries” (MM6139) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6139.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site.





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:



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

It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage of flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. 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. Health care professionals and their staff can learn more about Medicare's coverage of the influenza vaccine and other Medicare Part B covered vaccines and related provider education resources created by CMS, by reviewing Special Edition MLN Matters article SE0838, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf> on the CMS Web site.



ICD-10-CM/PCS National Provider Conference Call Transcript

The transcript of the Centers for Medicare & Medicaid Services (CMS) ICD-10-CM/PCS National Provider Conference Call for Physicians that was held on November 17, 2008 is now available at <http://www.cms.hhs.gov/ICD10/Downloads/November17calltranscript.pdf> on the CMS Web site.



Medicare Billing Information for Rural Providers, Suppliers, and Physicians

The revised publication titled Medicare Billing Information for Rural Providers, Suppliers, and Physicians (October 2008), which consists of charts that provide Medicare billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf> on the CMS Web site.



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”.)



Adult Immunizations Brochure

The Adult Immunizations (October 2008) brochure for health care providers has been updated and is now available in downloadable PDF format from the CMS Learning Network. This brochure provides an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. To view, download, and print, please go to http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf on the CMS Web site.



Subscribe to Cahaba GBA’s E-mail Notification Service

Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to Cahaba GBA’s website and sign up for their [listserv or e-mailing list](#).



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.





Summary of Policies in the 2009 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount

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: MM6349	Related Change Request (CR) #: 6349
Related CR Release Date: December 19, 2008	Effective Date: January 1, 2009
Related CR Transmittal #: R419OTN	Implementation Date: January 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6349 which provides a summary of the policies in the 2009 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2009.

The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in §1842(i)(3) of the Act. The MEI increase for CY 2009 is 1.6 percent. The telehealth originating site facility fee for 2009 is 80 percent of the lesser of the actual charge or \$23.72.

Summary of Key Changes Discussed by CR 6349

A complete summary of significant issues discussed in CMS-1403-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is attached to CR6349, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R419OTN.pdf> on the CMS website. The following further summarizes the key points of that attachment to CR6349.

MPFS Issues

Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin (IVIG)

Payment is no longer made under the physician fee schedule for G0332, for preadministration related services for IVIG infusion, effective January 1, 2009. This code has been deleted from the MPFS database and is no longer recognized for services furnished after December 31, 2008.

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging

CMS added several additional procedures to the MPPR list. Six procedures represent codes newly created since the MPPR list was established. Four additional procedures were identified as similar to procedures currently subject to the MPPR. CMS also removed CPT code 76778, a deleted code, from the list.

Proposed HCPCS code for Prostate Saturation Biopsies

Prostate Saturation Biopsy is a technique that was previously described by Category III CPT code 0137T, Biopsy, prostate, needle, saturation sampling for prostate mapping. Typically, this service entails 40-80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a gross and microscopic examination, which is separately billed by the physician for each core sample taken. CPT Code 88305 has a physician work value of 0.75 and a total nonfacility payment rate of \$102.83. CMS added four G codes to more accurately represent the pathologic evaluation, interpretation, and report for this service. In the final rule with comment period, CMS finalized its proposal, but provided assigned values to the four new G codes based upon assumption of the number of cancerous cells.

New and Revised Codes

CMS received work relative value unit (RVU) recommendations for 128 new and revised CPT codes from the American Medical Association (AMA) Relative Update Committee (RUC) this year. Of the recommendations received, CMS accepted 114 and disagreed with 14.

The CPT Editorial Panel created 20 CPT codes to replace the G codes for monthly and per diem end-stage renal disease (ESRD) services. CMS accepted the AMA RUC recommendations for these services. The new CPT codes are listed in the following table:

Deleted G Code	New CPT Code	Short Descriptor
G0308	90951	Esrd serv, 4 visits p mo, <2
G0309	90952	Esrd serv, 2-3 vsts p mo, <2
G0310	90953	Esrd serv, 1 visit p mo, <2
G0311	90954	Esrd serv, 4 vsts p mo, 2-11
G0312	90955	Esrd srv 2-3 vsts p mo, 2-11
G0313	90956	Esrd srv, 1 visit p mo, 2-11
G0314	90957	Esrd srv, 4 vsts p mo, 12-19
G0315	90958	Esrd srv 2-3 vsts p mo 12-19
G0316	90959	Esrd serv, 1 vst p mo, 12-19
G0317	90960	Esrd srv, 4 visits p mo, 20+
G0318	90961	Esrd srv, 2-3 vsts p mo, 20+
G0319	90962	Esrd serv, 1 visit p mo, 20+
G0320	90963	Esrd home pt, serv p mo, <2
G0321	90964	Esrd home pt serv p mo, 2-11
G0322	90965	Esrd home pt serv p mo 12-19
G0323	90966	Esrd home pt, serv p mo, 20+
G0324	90967	Esrd home pt serv p day, <2

G0325	90968	Esrd home pt srv p day, 2-11
G0326	90969	Esrd home pt srv p day 12-19
G0327	90970	Esrd home pt serv p day, 20+

Renumbered CPT Codes

Effective for CY 2009, the following CPT codes have been renumbered:

Deleted CPT Code	New CPT Code	Short Descriptor
90760	96360	Hydration iv infusion, init
90761	96361	Hydrate iv infusion, add-on
90765	96365	Ther/proph/diag iv inf, init
90766	96366	Ther/proph/diag iv inf addon
90767	96367	Tx/proph/dg addl seq iv inf
90768	96368	Ther/diag concurrent inf
90769	96369	Sc ther infusion, up to 1 hr
90770	96370	Sc ther infusion, addl hr
90771	96371	Sc ther infusion, reset pump
90772	96372	Ther/proph/diag inj, sc/im
90773	96373	Ther/proph/diag inj, ia
90774	96374	Ther/proph/diag inj, iv push
90775	96375	Tx/pro/dx inj new drug addon
90776	96376	Tx/pro/dx inj new drug adon
90779	96379	Ther/prop/diag inj/inf proc
99289	99466	Ped crit care transport
99290	99467	Ped crit care transport addl
99293	99471	Ped critical care, initial
99294	99472	Ped critical care, subsq
99295	99468	Neonate crit care, initial
99296	99469	Neonate crit care, subsq
99298	99478	Ic, lbw inf < 1500 gm subsq
99299	99479	Ic lbw inf 1500-2500 g subsq
99300	99480	Ic inf pbw 2501-5000 g subsq
99431	99460	Init nb em per day, hosp
99432	99461	Init nb em per day, non-fac
99433	99462	Sbsq nb em per day, hosp
99435	99463	Same day nb discharge
99436	99464	Attendance at delivery
99440	99465	Nb resuscitation

Medicare Telehealth Services

CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services.

For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014 at 80 percent of the lesser of the actual charge or \$23.72. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Part B Drug Issues

In the 2009 MPFS final rule, CMS announces it will adopt three regulatory changes affecting payment of Part B Drugs under the Average Sales Price (ASP) methodology, i.e.:

- CMS will update its regulations to comport with the new volume-weighting ASP calculation methodology established in section 112(a) of the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2008.
- CMS will make conforming changes to its regulations to address the special payment rule for certain single source drugs or biologicals that are treated as multiple source drugs because of the application of the grandfathering provisions of section 1847A of the Act.
- Section 1847A(d)(1) of the Act allows the Secretary to disregard the ASP for a Part B drug or biological that exceeds the WAMP or the AMP for such drug by an applicable threshold percentage. For CY 2009, CMS will maintain the threshold at 5 percent, absent of data that suggests a change is appropriate.

Application of Health Professional Shortage Area (HPSA) Bonus Payment

CMS makes minor policy revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

Independent Diagnostic Testing Facilities (IDTF)

CMS is requiring all mobile units providing diagnostic testing services to Medicare beneficiaries to enroll in the Medicare program. In addition, all mobile units furnishing diagnostic testing services will be required to bill for services unless the service is furnished under arrangement with a hospital. When services are furnished under arrangement, the hospital will continue to bill for the diagnostic testing services.

Physician and Nonphysician Enrollment Safeguards

The following is a summary of the enrollment provisions in the MPFS final rule for 2009:

1. Limit retrospective payments to physicians and nonphysician practitioners and physician and nonphysician practitioner organizations.

CMS has established that the effective date of billing for physicians and nonphysician practitioners and physician or nonphysician practitioner organizations as the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or nonphysician practitioner first started rendering services at a new practice location. This provision permits physicians and nonphysician practitioners to retrospectively bill for services furnished up to 30 days prior to the effective date of enrollment if the physician or nonphysician practitioner meets all program requirements, even if the initial enrollment application is rejected or denied as long as the application is ultimately approved. In addition, physicians and non-physician practitioners will be permitted to the physician or non-physician practitioner meets all program requirements and there is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act).

2. Prohibit physicians and nonphysician practitioners, as well as owners, authorized officials, and delegated officials of a physician or nonphysician practitioner organization from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.
3. Require all providers and suppliers, including individual practitioners, to maintain ordering and referring documentation for 7 years from the date of service.
4. Require physician and nonphysician organizations, physicians and nonphysician practitioners, and IDTFs to submit all outstanding claims within 60 days of the revocation date.
5. Require physicians and nonphysician practitioners and physician and nonphysician practitioner organizations to notify their Medicare contractor of a change of ownership, final adverse action, or change of location that impacts a payment amount within 30 days. Failure to notify the designated contractor of these changes may result in an overpayment from the date of the reportable change.

Educational Requirements for Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

In the 2009 MPFS final rule, CMS finalizes its proposal to recognize the Doctor of Nursing Practice (DNP) degree and also states that it will continue to study the evolution of the DNP degree to ensure that it continues to be consistent with our program requirements. In addition, CMS finalized a proposed technical correction to the NP regulatory qualifications that will clarify that the requirement for a master's degree in nursing is the minimum educational level for newly enrolled NPs and CNSs independently treating Medicare beneficiaries.

PROVISIONS FROM THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

Section 101: Improvements to Coverage of Preventive Services

Payment for the IPPE

The MMA provided for one IPPE per beneficiary per lifetime. A beneficiary is eligible when first enrolling in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate existing HCPCS G code(s). MIPPA made several changes to the IPPE including expanding the IPPE benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. (Other changes to this benefit were included in segment 1 of the rule.) The following is a summary of the payment changes resulting from section 101 of the MIPPA:

The Deductible Change with MIPPA

The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009 within the beneficiary's 12-month initial enrollment period of Medicare Part B. The waived deductible is applicable to the IPPE service only. Medicare will pay for one IPPE per beneficiary per lifetime. The Medicare deductible for the IPPE performed before January 1, 2009 (G0344) applies. Co-insurance applies irrespective of codes or date of the IPPE. The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG.

New G Codes Needed with MIPPA Implementation

CMS revised the G codes for the IPPE and EKG to reflect the changes in the legislation. The EKG codes will reflect a once-in-a lifetime screening with a referral from an IPPE.

Section 132: Incentives for Electronic Prescribing

Eligible professionals who are successful electronic prescribers shall be paid 2 percent incentive of estimated allowable charges submitted not later than 2 months after the end of the reporting period for 2009 successful electronic prescribing.

A “successful electronic prescriber” is defined under section 1848(m)(3)(B)(ii) of the Social Security Act as an eligible professional who reports the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the professional. Although the Secretary is given authority to assess successful electronic prescribing using either data reported by eligible professionals using electronic prescribing quality measures or using Part D prescription data, CMS will use the former for 2009. CMS will set forth the statutory criteria for successful electronic prescriber as reporting the measure in 50 percent of applicable cases.

There is also a limitation of the applicability of the e-prescribing incentive. For CY 2009, in order to be considered an eligible professional for purposes of the e-prescribing incentive, the e-prescribing measure denominator codes must apply to at least 10 percent of the total of allowed charges for all such covered services furnished by the eligible professional.

Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth

Currently, telehealth may substitute for a face-to-face, “hands on” encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth. Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician. The originating site must be located in a non-metropolitan statistical area (non-MSA) county or rural HPSA. To date, originating sites have been limited to: the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic (RHC); and a federally qualified health center (FQHC).

The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009: a hospital-based or CAH-based renal dialysis center (including satellites); a skilled nursing facility (SNF); and a community mental health center (CMHC).

Additional Information

The official instruction, CR6349, issued to your Medicare A/B MAC, carrier or FI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R419OTN.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.





Adjustment for Medicare Mental Health Services

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: MM6208	Related Change Request (CR) #: 6208
Related CR Release Date: December 31, 2008	Effective Date: July 1, 2008
Related CR Transmittal #: R426OTN	Implementation Date: February 2, 2009

Provider Types Affected

Physicians, Clinical Psychologists (CPs), Clinical Social Workers (CSWs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs) who submit claims to Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), or carriers, for mental health services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6208 that identifies the CPT “Psychiatry” procedure codes that represent mental health services that have already been increased in payment by 5% effective for these “specified services” provided on or after July 1, 2008 through December 31, 2009. Be sure your billing staff is aware of this list of CPT codes that represent “specified services”.

Key Points of CR6208

(MIPPA) of 2008 defines “specified services” as CPT procedure codes consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings under the subcategories of services that are insight oriented, behavior modifying, or supportive psychotherapy or, interactive psychotherapy. This list of CPT codes for specified services provides contractors with a way to link the already increased payment amounts for specified services to a particular CPT code. Accordingly, the specific “Psychiatry” CPT codes affected by the 5 percent increase are as follows:

- **Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy**
CPT codes 90804, 90805, 90806, 90807, 90808, and 90809
- **Interactive Psychotherapy**
CPT codes 90810, 90811, 90812, 90813, 90814, and 90815
- **Inpatient Hospital, Partial Hospital or Residential Care Facility (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy)**
CPT codes 90816, 90817, 90818, 90819, 90821, 90822
- **Interactive Psychotherapy**
CPT codes 90823, 90824, 90826, 90827, 90828, and 90829

Background

Medicare contractors were previously sent the payment rates that include the 5% increase for certain mental health services under the RV3D file for the 2008 Medicare Physician Fee Schedule. Accordingly, Medicare contractors should have loaded the already increased payment rates that are effective from July 1, 2008 through December 31, 2009. While contractors do not have to increase payment for these codes, they will now be able to link a CPT code with the appropriate payment amount for the code. The notification under CR #6208 provides contractors with the list of CPT codes that represent the specified services under the MIPPA provision that corresponds with the increased payment amounts already in place.

Additional Information

To see the official instruction (CR6208) issued to your Medicare Carrier, FI or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R426OTN.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.





End Stage Renal Dialysis (ESRD) Medicare Claims Processing Manual Clarification

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: MM6245	Related Change Request (CR) #: 6245
Related CR Release Date: December 31, 2008	Effective Date: January 1, 2009
Related CR Transmittal #: R1655CP	Implementation Date: February 2, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 6245 which clarifies existing policies related to laboratory billing procedures for laboratory services furnished to hospital-based and independent dialysis facility patients. Be sure billing staff is aware of these clarifications.

Key Points

CR 6245 clarifies existing policy located in the *Medicare Claims Processing Manual*, Chapters 8 and 16 regarding billing for ESRD related laboratory services. The clarified policy chapters are attached to CR 6245 at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.pdf> on the CMS Web site. The revisions are summarized as follows:

- Hospital-based laboratories providing separately billable laboratory services to dialysis patients of the hospital's dialysis facility or another dialysis facility bill and are paid in accordance with the hospital outpatient laboratory provisions in Chapter 16, section 40.3. This may be reviewed at <http://www.cms.hhs.gov/manuals/Downloads/clm104c16.pdf> on the CMS Web site.
- If the ESRD patient also receives other hospital outpatient services on the same day as a specimen collection and/or laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. When the patient does not also receive hospital outpatient services on the same day as the specimen collection and/or laboratory test, then the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.
- Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with the Clinical Laboratory Improvement Act (CLIA) may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. (See Chapter 16, Section 40.3 (as referenced above) for details on Part B hospital billing rules for laboratory services.)

- When a hospital laboratory is billing for laboratory services ordered by an ESRD facility and the patient (beneficiary) is a Skilled Nursing Facility (SNF) resident under a Part A stay, the hospital laboratory must use the “CB” modifier for those services excluded from consolidated billing.
- Beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic tests that are not directly related to the beneficiary’s ESRD are subject to the SNF consolidated billing requirements. Physicians may bill the contractor for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate and is not separately billable to the contractor.
- If you have claims that may not have been paid correctly based on the above clarifications, note that your Medicare contractor will not search its files to adjust the claims. However, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR6245, issued to your Medicare MAC, carrier or FI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.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.





Correction to Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management

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

MLN Matters Number: MM6313	Related Change Request (CR) #: 6313
Related CR Release Date: January 8, 2009	Effective Date: March 19, 2008
Related CR Transmittal #: R1663CP	Implementation Date: February 9, 2009

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6313, which corrects CR 6138 (Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management, released on July 25, 2008) by adding particular ICD-9-CM codes (451.11, 451.19, 451.2, 451.80-451.84, 451.89, 453.40-453.49 and 415.12) that CR 6138 omitted. **It contains no other changes; however its content is repeated in this article for your convenience as a reference document.**

CR 6313 alerts providers that effective for claims with dates of service on and after March 19, 2008, CMS revised its National Coverage Determination (NCD) on Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. Effective March 19, 2008, Medicare now covers the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with 1) mechanical heart valves, 2) chronic atrial fibrillation and 3) venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

Background

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

In response to a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin, CMS revised its NCD on Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management.

Effective for claims with dates of service on and after March 19, 2008, Medicare will cover the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

This coverage includes the following ICD-9-CM codes.

ICD-9-CM Code	Descriptor
V43.3	Organ or tissue replaced by other means; heart valve
289.81	Primary hypercoagulable state
451.0	Phlebitis and thrombophlebitis: of superficial vessels of lower extremities: saphenous vein (greater) (lesser)
451.11	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: femoral vein (deep) (superficial)
451.19	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein popliteal vein tibial vein)
451.2	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein, popliteal vein, tibial vein)
451.80	Phlebitis and thrombophlebitis: of other sites
451.81	Phlebitis and thrombophlebitis: of other sites: iliac vein
451.82	Phlebitis and thrombophlebitis: of other sites: of superficial veins of upper extremities (antecubital vein, basilic vein, cephalic vein)
451.83	Phlebitis and thrombophlebitis: of other sites: of deep veins of upper extremities (brachial vein, radial vein, ulnar vein)
451.84	Phlebitis and thrombophlebitis: of other sites: of upper extremities, unspecified
451.89	Phlebitis and thrombophlebitis: of other sites: other
451.9	Phlebitis and thrombophlebitis: of other sites: of unspecified site
453.0	Other venous embolism and thrombosis: Budd-Chiari Syndrome (hepatic vein thrombosis)
453.1	Other venous embolism and thrombosis: thrombophlebitis migrans
453.2	Other venous embolism and thrombosis: of vena cava
453.3	Other venous embolism and thrombosis: of renal vein
453.40	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of unspecified vessels of lower extremity (deep vein thrombosis NOS, DVT NOS)
453.41	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of proximal lower extremity (femoral, iliac, popliteal; thigh, upper leg NOS)
453.42	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of distal lower extremity (calf, lower leg NOS; peroneal, tibial)
453.8	Venous embolism and thrombosis of deep vessels of lower extremity: of other specified veins
453.9	Venous embolism and thrombosis of deep vessels of lower extremity: of unspecified site
415.11	Pulmonary embolism and infarction: iatrogenic pulmonary embolism and infarction
415.12	Pulmonary embolism and infarction: septic pulmonary embolism

415.19	Pulmonary embolism and infarction: other
427.31	Atrial fibrillation (established) (paroxysmal)

You should keep in mind that the monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf on the CMS Web site) and all of the following requirements must be met:

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

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

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

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

Short Descriptor G0248: Demonstrate use home INR mon

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

Short Descriptor G0249: Provide INR test mater/equipm

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

Short Descriptor G0250: MD INR test revie inter mgmt

NOTES:

1. Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same.
2. Porcine valves are not included in this NCD, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves unless covered by local Medicare contractors.
3. This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the NCD Manual.

Your Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with this CR; however denied claims are subject to appeal, and medical review override of denials for appeal purposes will be allowed. When denying such claims, your Medicare carrier, FI or MAC will use the following codes:

- **Medicare Summary Notice 15.20**, “The following policies (NCD 190.11) were used when we made this decision.”
- **Remittance Advice Remark Code N386**, “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp> on the CMS Web site. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- **Claim Adjustment Reason Code 50**, “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”

Your Medicare contractor will adjust claims already processed and inappropriately denied prior to the implementation of CR6313, but only if you bring such claims to the attention of the contractor.

Additional Information

You can find more information about Prothrombin Time (PT/INR) monitoring for home anticoagulation management by going to CR 6313, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1663CP.pdf> on the CMS Web site. The revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 60 (Coverage and Billing for Home Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management), Subsections 4.1 (Allowable Covered Diagnosis Codes) and 5.2 (Applicable Diagnosis Codes for Carriers) can be found 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.



January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0

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: MM6315	Related Change Request (CR) #: 6315
Related CR Release Date: January 9, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R1664CP	Implementation Date: January 5, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) that are subject to the edits of the I/OCE.

Provider Action Needed

This article is based on Change Request (CR) 6315, which describes changes to the January 2009 update of the Integrated Outpatient Code Editor (I/OCE). CR6315 provides the I/OCE instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, and for all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Be sure billing staffs are aware of these changes.

Background

CR 6315 describes changes to billing instructions for various payment policies implemented the January 2009 update of the Integrated Outpatient Code Editor (I/OCE). Attached to CR 6315 are lengthy specifications for the I/OCE. The full CR6315 can be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1664CP.pdf>, but a summary of the changes for January 2009 is within Appendix M of Attachment A of CR 6315 and that summary is captured in the following key points.

Key Points of CR 6315 Based on Appendix M of the I/OCE Specifications

Part 1 of Appendix M

1. Item 1 of Appendix M has no impact on providers. This is an I/OCE logic change that supports the policy covered in #6 below.
2. For CY 2009, Medicare replaced current status indicator “Q” with three new separate status indicators: “Q1,” “Q2,” and “Q3.” Status indicator “Q1” is assigned to all “STVX-packaged codes;” status indicator “Q2” is assigned to all “T-packaged codes;” and status indicator “Q3” is assigned to all codes that may be paid through a composite Ambulatory Payment Classification (APC) based on composite-specific criteria or separately through single code APCs when the criteria are not met. The change to establish new status indicators “Q1,” “Q2,” and “Q3 facilitates the use of status indicator-driven logic in Medicare ratesetting calculations, and in hospital billing and accounting systems. For CY 2009, Medicare is using new payment status indicator “R” for all blood and blood

product APCs. This new status indicator was created in order to facilitate implementation of the reduced market basket conversion factor that applies to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. This reduced conversion factor applies to CY 2009 payment for blood and blood products. For CY 2009, Medicare created a new status indicator “U” to designate brachytherapy source APCs for which separate payment is made in CY 2009.

3. For CY 2009, Medicare is implementing a new edit for mental health HCPCS codes that are not payable outside the partial hospital program submitted on Hospital Outpatient TOBs without Condition Code 41. Claims that meet these criteria will be returned to the provider.
4. For CY 2009, Medicare is implementing a new OPPS edit for claims when code C9898 is billed with charges greater than \$1.01. Claims that meet these criteria will be returned to the provider.
5. For CY 2009, Medicare is implementing a new edit that results in a line item denial for services provided on or after the effective date of NCD non-coverage.
6. For CY2009, Medicare will pay for multiple imaging procedures performed during a single session using the same imaging modality by applying a composite APC payment methodology. The services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and results in the creation of five new composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the “with contrast” composite APC (either APC 8006 or 8008) will be assigned.
7. For CY 2009, Medicare is creating two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which is being deleted for CY 2009. When a Community Mental Health Center (CMHC) or hospital provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital will be paid through APC 0172. When the CMHC or hospital provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital will be paid through APC 0173.
8. For CY 2009, Medicare will reduce payment only for procedure codes that map to the APCs on the list of APCs subject to the adjustment for devices furnished without cost or with a full or partial credit from the manufacturer that are reported with modifier –FB or –FC, and that are present on claims with specified device HCPCS codes.
9. For CY 2009, Medicare will include HCPCS code G0384 (Level 5 Hospital Type B ED Visit) in the criteria that determine eligibility for payment of composite APC 8003 (Level II Extended Assessment and Management). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. There is no

limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8.

10. For CY 2009, Medicare has updated the list of codes approved for the partial hospitalization program.
11. No impact on providers.
12. With the APC split for PHP, the payment rate for the Daily Mental Health cap (APC 34) will be set to equal the payment rate for the Level II PHP APC (APC 173).
13. To solve the issue of processing differences between date of discharge (inpatient) and "from" date of service (outpatient), TOB 12x was added to the bypass for diagnosis edits (1-5) if claim From date is <10/1/xx and Through date is >= 10/1/xx.
14. NCCI edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. In the past, the Outpatient Code Editor (OCE) had not applied the NCCI edits for the following categories of services: anesthesiology, evaluation and management, and mental health services. For CY 2009, Medicare has determined that these categorical exclusions will no longer apply. As a result, a large number of new institutional NCCI edits will be applied to claims effective January 1, 2009 to take into account the edits that were previously excluded. Providers are encouraged to begin to educate their staff about the application of the additional categories of NCCI edits to their claims.
15. For CY 2009, Medicare has determined that deductible is not applicable to HCPCS codes G0402 and Q0091.
16. No impact on providers.
17. For CY 2009, Medicare has determined that current procedural terminology (CPT) code 0183T, Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day, is newly designated as a "sometimes therapy" wound care service. In CY 2009, hospitals will receive separate payment under the OPSS when they bill for wound care services described by CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, "GP" for physical therapy, "GO" for occupational therapy, and "GN" for speech language pathology) or report their charges under a therapy revenue code (that is, revenue codes in the 042x, 043x, or 044x series), or both, to receive payment under the Medicare Physician Fee Schedule (MPFS).
18. No impact on providers.
19. For OPSS CY 2009, Medicare will package code G0177 into the Mental Health composite (APC 34), if present, but it will not contribute to the Mental Health cap.

Part 2 of Appendix M

1. HCPCS/APC/SI changes were made to various codes per legislation and review as specified by CMS.
 2. See 14 above.
 3. In July 2007, the CPT Editorial Panel released two vaccine codes on the American Medical Association Web site, specifically CPT codes 90681 and 90696 that were implemented in January 2008. Although the vaccines associated with these codes were not approved by the Food and Drug Administration (FDA) until April 3, 2008 (for CPT code 90681) and June 24, 2008 (for CPT code 90696), and Medicare did not assign the codes to separate APCs under the OPSS until the January 2009 update, their payments are retroactive to the FDA approval dates.. Items that are reported using these HCPCS codes with dates of service prior to the date of the FDA approval will be rejected.
 4. See preceding item.
 5. Medicare will implement a mid-quarter non-coverage date for codes 0062T, 0063T, 2526, and 22527.
 6. Medicare has removed code J1051 from the list of procedures for "Females Only."
- 7-21 These items are documentation changes for the I/OCE and are N/A.

Additional Information

The official instruction (CR6315) issued to your Medicare MAC, RHHI, or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1664CP.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.





Long Term Care Hospital (LTCH) Special Project

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: MM6324	Related Change Request (CR) #: 6324
Related CR Release Date: January 16 2009	Effective Date: September 30, 2008
Related CR Transmittal #: R430OTN	Implementation Date: February 17, 2009

Provider Types Affected

Long Term Care Hospitals (LTCH) 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 in LTCHs.

Provider Action Needed

This article is informational in nature and requires no provider action at this time. The article is based on Change Request (CR) 6324 to alert providers that CMS has outlined the requirements for an expanded review of LTCH admissions as required by recent legislation. CMS has selected a sampling contractor (AdvanceMed) to create the study universe of claims for this review. In addition, CMS has selected Wisconsin Physicians Service (WPS) to conduct the review. CR 6324 establishes communication procedures between the sampling contractor (AdvanceMed), LTCH Review Contractor Wisconsin Physicians Service (WPS), FIs, and MACS to avoid duplication of effort in these review processes.

Background

In 2007, the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act (MMSEA), was enacted, The Act included a provision, (Section 114) that expanded review of medical necessity of admissions to long care hospitals and continued stays at such hospitals. The Act also requires error rate calculation, and disallowance of days of medically unnecessary care from the calculation of the LTCH average length of stay (ALOS) as a result of those reviews. For purposes of carrying out the above provision of the MMSEA, CMS must ensure that an appropriate framework for cooperation exists to facilitate the exchange of information and the establishment of communication procedures among the LTCH Sampling Contractor (AdvanceMed), LTCH Review Contractor (WPS), the FIs, and A/B/MACs. CR 6324 establishes this framework.

Additional Information

The official instruction (CR6324) issued to your Medicare A/B MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R430OTN.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.





Claim Status Category Code and Claim Status 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: MM6325	Related Change Request (CR) #: 6325
Related CR Release Date: January 16 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1670CP	Implementation Date: April 6, 2009

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 6325, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background

The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response transactions.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6325 updates the changes in the Claim Status Codes and Claim Status Category Codes from the September, 2008 committee meeting. These updates were posted at <http://www.wpc-edi.com/content/view/180/223/> on November 1, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by April 6, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional Information

The official instruction (CR 6325) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1670CP.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.





Expansion of Medicare Telehealth Services

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: MM6130	Related Change Request (CR) #: 6130
Related CR Release Date: December 24, 2008	Effective Date: January 1, 2009
Related CR Transmittal #: R1654CP and R99BP	Implementation Date: January 5, 2009

Provider Types Affected

Physicians, hospitals, and critical access hospitals (CAHs) submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for telehealth services provided to Medicare beneficiaries.

Provider Action Needed

In the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC), the Centers for Medicare & Medicaid Services (CMS) added three codes to the list of Medicare distant site health services for follow-up inpatient telehealth consultations. This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

Background

CMS added three follow-up inpatient telehealth consultations to the list of Medicare distant site health services as noted in the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC). CMS created these new Healthcare Common Procedure Coding System (HCPCS) codes specific to the telehealth delivery of follow up inpatient consultations to re-establish the ability for practitioners to provide and bill for follow up inpatient consultations delivered via telehealth. These procedure codes are for follow-up inpatient telehealth consultations effective January 1, 2009. These new codes are intended for use by practitioners serving beneficiaries located at qualifying originating sites requiring the consultative input of physicians who are not available for a face-to-face encounter. These HCPCS codes are not intended to include the ongoing E/M services of a hospital inpatient.

The new HCPCS codes are listed in the following table:

HCPCS Code	Descriptor
G0406	Follow-up inpatient telehealth consultation, limited
G0407	Follow-up inpatient telehealth consultation, intermediate
G0408	Follow-up inpatient telehealth consultation, complex

Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to complete an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies would be included as well, consistent with the nature of the problem(s) and the patient's needs.

The physician or practitioner who furnishes the inpatient follow up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow up inpatient consultation and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for consultation services, as described in Chapter 12, Section 30.6.10 of the *Medicare Claims Processing Manual*. Medicare manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site.

Payment for follow up telehealth inpatient consultations would include all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim lab work) and communicating with other professionals or family members. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional Evaluation and Management (E/M) service could be billed for work related to a follow up inpatient telehealth consultation.

Follow up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS G0406 (Follow-up inpatient telehealth consultation, limited). At this level of service, practitioners would typically spend 15 minutes communicating with the patient via telehealth.
- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS G0407 (Follow-up inpatient telehealth consultation, intermediate). At this level of service, practitioners would typically spend 25 minutes communicating with the patient via telehealth.
- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS G0408 (Follow-up inpatient telehealth consultation, complex). At this level of service, practitioners would typically spend 35 minutes or more communicating with the patient via telehealth.

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either the "GT" or "GQ" modifier to identify the telehealth technology used to provide the service. (See Chapter 12, Section 190.6 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> for more information on the use of these modifiers.)

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 270) at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS Web site, and the *Medicare Claims*

Processing Manual (Publication 100-04, Chapter 12, Section 190) at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS Web site.

Additional Information

The official instruction, CR 6130, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the *Medicare Benefit Policy Manual* and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R99BP.pdf> and the second transmittal, which modifies the *Medicare Claims Processing Manual*, is at <http://www.cms.hhs.gov/Transmittals/downloads/R1654CP.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.





New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers' Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional 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: MM5371	Related Change Request (CR) #: 5371
Related CR Release Date: January 9, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1665CP	Implementation Date: July 6, 2009

Provider Types Affected

Physician, providers and suppliers who bill Medicare contractors (carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services related to workers' compensation liability claims

What You Need to Know

In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new MSP code in Medicare's claims processing systems. With the creation of the new MSP code, CMS will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

Background

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates its CWF system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit <http://www.cms.hhs.gov/WorkersCompAgencyServices> on the CMS Web site.

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare Summary Notice (MSN) message 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).

In addition, Medicare will use Reason Code 201, Group Code PR, and Remark Code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence.

Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with “EB” followed by the qualifier WC.

Additional Information

You can find the official instruction, CR 5371, issued to your Medicare contractor at <http://www.cms.hhs.gov/Transmittals/downloads/R1665CP.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.





Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

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: MM6295	Related Change Request (CR) #: 6295
Related CR Release Date: January 30, 2009	Effective Date: May 4, 2009
Related CR Transmittal #: R1676CP	Implementation Date: May 4 2009

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B MACs (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) 6295, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for **ALJ hearing requests** made before January 1, 2009, is **\$120.00**. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is **\$120.00**.

For **Federal District Court** review, the amount remaining in controversy goes from \$1,180.00 for requests on or after January 1, 2008, to **\$1,220.00 for requests on or after January 1, 2009**.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional Information

The official instruction (CR 6295) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.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.





Payment for Co-surgeons in a Method II Critical Access Hospital (CAH)

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: MM6319	Related Change Request (CR) #: 6319
Related CR Release Date: January 30, 2009	Effective Date: January 1, 2008
Related CR Transmittal #: R1672CP	Implementation Date: July 6, 2009

Provider Types Affected

Method II CAHs billing Medicare Administrative Contractors (A/B MACs) and/or Fiscal Intermediaries (FIs) for physicians that have reassigned their billing rights to the CAH on type of bill 85X with revenue codes 96X, 97X, or 98X with modifier 62 for co-surgeon services rendered in a Method II CAH to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6319 and alerts providers that CMS is issuing CR 6319 to highlight the revisions to the *Medicare Claims Processing Manual*, Chapter 4 dealing with payment for co-surgeons in a Method II CAH.

Physicians billing on type of bill 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes 96X, 97X or 98X). Medicare makes a payment for a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. CR 6319 **implements the reduction in payment for co-surgeon services**. See the “Key Points” section for specifics regarding the revisions and the impact on claims for co-surgeon services in a Method II CAH.

Background

When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X). Under some circumstances, the skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient’s condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. **Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a single surgical procedure code.**

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code. The MPFSDB is located at www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the CMS Web site.

The revised *Medicare Claims Processing Manual* Chapter 4 (attached to CR 6319) outlines changes that impact five areas as follows:

1. Coding Co-surgeon Services Rendered in a Method II CAH;
2. Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons;
3. Payment of Co-surgeon Services Rendered in a Method II CAH;
4. Co-surgeon Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages; and
5. Review of Supporting Documentation for Co-surgeon Services in a Method II CAH.

Key Points Regarding Claims for Co-Surgeon Services in a Method II CAH

- Medicare will accept claims for co-surgeon services submitted on type of bill 85X with revenue code 96X, 97X, or 98X if it contains either one claim line with a surgical HCXPCS/CPT code and has the 62 modifier or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and the 62 modifier on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have the 62 modifier. Where only one line has the 62 modifier, Medicare will deny the line without the 62 modifier with the following messages:
 - Medicare Summary Notice (MSN) 16.10 indicating Medicare does not pay for this item or service;
 - Remittance Advice (RA) Remark Code M78, indicating Missing/incomplete/invalid HCPCS modifier;
 - Group Code of CO showing contractual obligation; and
 - Claim Adjustment Reason Code (CARC) 4 denoting that the procedure code is inconsistent with the modifier used or a required modifier is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.
- The MPFSDB must reflect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is “0” indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:
 - MSN message 15.12, indicating Medicare does not pay for two surgeons for this procedure;
 - RA Remark Code N431 to show “service is not covered with this procedure”;
 - A group code of PR, showing patient responsibility; and
 - A CARC of 54 to show “Multiple physicians/assistants are not covered in this case.”
- Medicare contractors will develop co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 for the supporting documentation needed to establish medical necessity when the

HCPCS/CPT code has a payment policy indicator of ‘1’ showing that co-surgeons could be paid depending on supporting documentation.

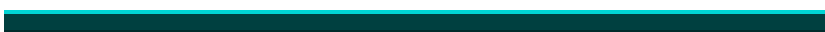
- Medicare contractors will define the appropriate supporting documentation needed to establish medical necessity for co-surgeon services when the HCPCS/CPT code has a payment policy indicator of ‘1’.
- Method II CAHs should remember that they will be liable for non-covered co-surgeon services unless they issue an appropriate advance beneficiary notice (ABN) when the payment policy indicator is ‘1’.
- Medicare contractors will deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is ‘1’.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of ‘1’ when an ABN was issued:
 - An MSN message 36.1 - Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.
 - An RA Remark Code of M38 - The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
 - A group code of PR – Patient Responsibility
 - A CARC code of 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of ‘1’ when an ABN was not issued:
 - MSN message 36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider’s bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.
 - RA Remark Code M27 - The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
 - Group code CO – Contractual Obligation.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85X with RC 96X, 97X or 98X and modifier 62 to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of ‘2’.

- Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:
 - MSN Message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.
 - RA Remark Code N95 – The provider type/provider specialty may not bill this service.
 - Group code PR – Patient Responsibility.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 62 modifier has a payment policy indicator of ‘9’, indicating the co-surgeon concept does not apply.
- Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.
- Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5% of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a Method II CAH, that CAH is paid 115% of that lesser payment amount.

Additional Information

The official instruction (CR 6319) issued to your Medicare FI or A/B MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1672CP.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.





Shipboard Services Billed to the Carrier and Services Not Provided Within the United States

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: MM6217	Related Change Request (CR) #: 6217
Related CR Release Date: October 3, 2008	Effective Date: January 5, 2009
Related CR Transmittal #: R1609CP & R95BP	Implementation Date: January 5, 2009

Note: This article was revised on February 5, 2009, to add the transmittal number of R95BP (see above) and (in the Additional Information section of this article) the Web address for the second transmittal related to CR 6217. The second transmittal contains the revisions to the *Medicare Benefit Policy Manual*. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6217 which announces that CMS wants providers to know that the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* are being revised. Chapter 1, section 10.1.4.7 of the *Medicare Claims Processing Manual* currently states that services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry and that the physician must be registered with the Coast Guard in order for Medicare to make payment. However, section 10.1.4.7 of the manual is not consistent with Medicare law. Therefore, because section 10.1.4.7 of the manual is not consistent with Medicare law, CMS is clarifying that manual section in order to make it consistent with current Medicare law by removing the language that states the vessels must be of American registry and the physician must be registered with the Coast Guard. CMS is also clarifying in the manual that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered. CMS removed the term “and during a period of” covered foreign hospitalization since it implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services are covered both during the time period immediately before the beneficiary is actually admitted to the foreign hospital and during the covered foreign hospitalization itself. In other words, if the foreign hospitalization is covered by Medicare, then the emergency physician and ambulance services that are furnished during the time period that immediately precedes the covered foreign hospitalization are also covered. Be sure your billing staff is aware of these changes.

Key Points of CR6217

The following services furnished aboard a vessel are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United States. If the emergency or

nonemergency services were furnished within the territorial waters of the United States and the physician or supplier refuses to submit the claim on the beneficiary's behalf (or enroll in Medicare, if applicable), then the contractor must follow the Compliance Monitoring instructions outlined in the *Medicare Claims Processing Manual*, chapter 1, section 70.8.8.6B because these claims are not processed as foreign claims. Chapter 1 of the *Medicare Claims Processing Manual* may be reviewed at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the CMS Web site.

- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada. The Compliance Monitoring instructions outlined in the *Medicare Claims Processing Manual*, chapter 1, section 70.8.8.6B do not apply to these claims because they are processed as foreign claims.
- See Chapter 1 section 10.1.4 of the *Medicare Claims Processing Manual* for the definitions of “territorial waters” and “United States.”
- Your Medicare contractors/carriers will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization.

Background

Medicare law (i.e., Section 1862(a)(4) of the Social Security Act (“the Act”)) prohibits payment for items and services furnished outside the United States except for certain limited services (see Section 1814(f) of the Act). The term “United States” means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

The law specifies the following exceptions to the “foreign” exclusion:

1. Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
 - a) the emergency arose within the U.S.; or
 - b) the emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State
2. Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
3. Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Additional Information

To see the official instruction (CR 6217) was issued to your Medicare FI, carrier or A/B MAC via two transmittals. The first transmittal which covers changes to the *Medicare Claims Processing Manual* is at <http://www.cms.hhs.gov/Transmittals/downloads/R1609CP.pdf> on the CMS Web site. The second transmittal, covering the revisions to the *Medicare Benefit Policy Manual*, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R95BP.pdf> on the CMS Web site.

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