

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



April 2009

Vol. 16, No. 7

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



The Inside Story

News From Cahaba GBA

	Disclaimer.....	2
	Provider Contact Center Training Schedule.....	3
	Local Coverage Determination (LCD)- Drugs and Biologicals: Gemcitabine Hydrochloride (Gemzar®) (L1008).....	3
	Draft Local Coverage Determination (LCD) for Surgery: Kyphoplasty and Vertebroplasty (DL29580) RESCINDED.....	4
	AL-Top Five Reasons for Claim Rejections for February 2009.....	4
	Reminder of New Provider Authentication Requirements- Effective April 6, 2009.....	5
	Medicare Credit Balance Quarterly Reminder.....	6
	Quarterly Provider Update.....	7
	Postpayment On-Site Reviews.....	7
	Claims for Medicare Beneficiaries in State of Local Custody Under a Penal Authority.....	8
	Unsolicited/Voluntary Refunds.....	9
	Medicare A Newsline Quality Survey.....	59

Cahaba GBA Learning Corner

	Education Events.....	10
	Online Courses.....	11

News From CMS

	News Flash Messages from CMS.....	12
--	-----------------------------------	----

News From CMS continued

	Clarification of Date of Service (DOS) of Ambulance Services.....	15
	Heartbreath Test for Heart Transplant Rejection.....	16
	Payments to Institutional Providers with Multiple Service Delivery Locations.....	18
	Clarification on Use of National Drug Codes (NDCs) In 837 I Billing.....	20
	Inpatient Prospective Payment System Wage Index For Fiscal Year (FY) 2009- Corrections.....	21
	New Provider Authentication Requirements- Revised	23
	Shipboard Services.....	26
	April 2009 Quarterly Average Sales Price (ASP) Drug Pricing Update and Revisions.....	29
	Internet Only Manual Publication 100-02 Update.....	33
	April 2009 Integrated Outpatient Code Editor (I/OCE) Specifications- Version 10.1.....	36
	April 2009 Update to the Hospital Outpatient Prospective Payment System (OPPS).....	39
	April 2009 Update Medicare Physician Fee Schedule... ..	46
	Disclosure of Physician Ownership in Hospitals.....	51
	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2009.....	53
	Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update.....	55

Key for Icons:

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

The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC as their Fiscal Intermediary or Regional Home Health Intermediary. The CPT codes, descriptors and other data only are copyright © 2008 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

Disclaimer

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

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

American Medical Association Notice and Disclaimer

CPT codes, descriptors and other data only are copyright 2008 American Medical Association. All rights reserved.

ICD-9 Notice

The ICD-9-CM codes and descriptors used in this material are copyright 2008 under uniform copyright convention. All rights reserved.



Provider Contact Center – Training Schedule

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

CSR Training Dates	Time
Friday, April 17, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, April 24, 2009	9:00 a.m.- 11:00 a.m. CST



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

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

The following ICD-9 code has been added:

- 199.1

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

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



Draft Local Coverage Determination (LCD) for Surgery: Kyphoplasty and Vertebroplasty (DL29580) RESCINDED

Cahaba Government Benefit Administrators®, LLC (Cahaba) has rescinded its draft LCD for Surgery: Kyphoplasty and Vertebroplasty (DL29580) during the J10 Medicare Administrative Contractor (MAC) transition. Accordingly, please do not submit any comments on this draft. The J10 transition is expected to last through September 2009.

This change is effective April 1, 2009. Cahaba GBA will post a new version of the draft at a later date.



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

The top five reasons for claim rejections in **February 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.	872
777	APASS MODULE REJECTION An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	615
207	INVALID PATIENTS SEX CODE Patient's gender code on the submitted claim was blank or not equal to M, F, or U.	212
333	INVALID PAT STATUS FOR TYPE OF BILL The patient's status was invalid for the type bill submitted.	181
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.	175





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

Beginning **April 6, 2009**, when you call either the Interactive Voice Response (IVR) system, or select to speak with a customer service representative (CSR), you must provide the following three data elements before protected health information can be disclosed:

- National Provider Identifier (NPI);
- Provider Transaction Access Number (PTAN) (often referred to as OSCAR or Legacy); and
- Last 5-digits of your tax identification number (TIN).

Please have this information available before you call the Provider Contact Center:

- AL: 1-866-539-5598

The IVR and the CSRs will validate the above information to properly authenticate callers before disclosing protected health information.

Validation

The validation process ensures that there is an association between the NPI, PTAN and the last 5-digits of the TIN. The IVR will prompt you to re-enter the information if the validation fails. However, no more than three attempts will be allowed. If the NPI, PTAN and TIN continue to fail the validation process, you will need to access the [National Plan and Provider Enumeration System \(NPPES\)](#) Web site to verify the accuracy of the NPI, PTAN and TIN that is associated with your provider.

Written Inquiries

The above data 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). In addition, the letterhead must include and match, either, the NPI, PTAN, or the last 5-digits of the TIN. Written inquiries submitted without this information will be returned to the provider requesting the submission of the required elements for proper authentication.

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) Website.





Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **April 30, 2009**, for the quarter ending **March 31, 2009**.

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

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

Medicare Part A Credit Balance Reporting

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

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





Quarterly Provider Update

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

The purpose of the Quarterly Provider Update is to:

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

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

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

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



Postpayment On-Site Reviews

A postpayment review is one of the activities performed by our Medical Review staff and is a comprehensive review of individual beneficiary medical records. This review of records may be conducted either on-site at your facility or in our Medical Review department. Please be aware that if a review is conducted on-site at your facility, the Medicare Medical Review staff person who visits your facility must show your staff a photo identification indicating their affiliation with Cahaba GBA, LLC.

Verifying proper identification is important before allowing access to your patient’s medical records. For additional information about postpayment reviews, refer to §3.6.2 in [Chapter 3 of the Medicare Program Integrity Manual, Publication 100-8](#).





Processing Requirements for Claims for Medicare Beneficiaries in State or Local Custody Under a Penal Authority

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4(b), respectively.

Regulations at 42 CFR 411.4(b) state that “Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody; and
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.”

The Centers for Medicare & Medicaid Services (CMS) established claim level editing using data received from the Social Security Administration (SSA). Specifically, the data contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will provide the Medicare contractor with the date span covered.

Policy

As indicated above, Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute according to regulations at 42 CFR 411.4(b). Therefore, items and services furnished to beneficiaries in state or local government custody will be denied.

However, providers and suppliers that provide services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of a condition code 63.

For additional information, refer to the [Medicare Claims Processing Manual \(CMS Pub. 100-04\), Chapter 1, §10.4](#).





Unsolicited/Voluntary Refunds

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: MM3274	Related Change Request (CR) #: 3274
Related CR Release Date: July 30, 2004	Effective Date: October 1, 2004/January 1, 2005
Related CR Transmittal #: 50	Implementation Date: October 1, 2004/January 3, 2005

Provider Types Affected

All Medicare providers

Provider Action Needed

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

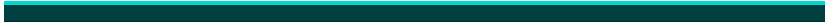
Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

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





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:



“The Medicare Part A Appeals Process” - Webinar

Date: April 16, 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](#).



Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet

The revised publication titled **Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet (October 2008)**, which provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”



Flu Season

It's Not Too Late to Give and Get the Flu Shot! In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Don't Get the Flu. Don't Give the Flu. Remember - Influenza and pneumococcal vaccinations plus their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0838 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf> on the CMS website.



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 website. 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.



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](#).



Acute Inpatient Prospective Payment System Fact Sheet

The revised **Acute Inpatient Prospective Payment System Fact Sheet (January 2009)**, which provides general information about the Acute Inpatient Prospective Payment System (IPPS) including IPPS payment rates and how IPPS payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf> on the CMS website.



Home Health Prospective Payment System Fact Sheet (December 2008)

The revised **Home Health Prospective Payment System Fact Sheet (December 2008)**, which provides information about coverage of home health services and elements of the Home Health Prospective Payment System, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) at <http://www.cms.hhs.gov/MLNProducts/downloads/HomeHlthProspPymtfctsht09-508.pdf> on the CMS Medicare Learning Network website.



Outpatient Code Editor (OCE) Web-Based Training (WBT)

Revised in January 2009 -- The **Outpatient Code Editor (OCE) Web-Based Training (WBT)**, which is made available by the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN), can help healthcare professionals, and medical administrative staff, to understand the OCE utilized under the Outpatient Prospective Payment System (OPPS), as well as other payment systems. This WBT addresses the OCE in the Fiscal Intermediary Standard System (FISS). It can be accessed by going to <http://www.cms.hhs.gov/MLNGenInfo/> on the CMS website. Then, scroll to the "Related Links Inside CMS" section and select Web Based Training (WBT) Modules . You will find the "Outpatient Code Editor WBT" from the list provided.



Ambulance Fee Schedule Fact Sheet

The revised **Ambulance Fee Schedule Fact Sheet (January 2009)**, which provides general information about the Ambulance Fee Schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508-09.pdf on the CMS website.



2009 Physician Quality Reporting Initiative (PQRI)

The reporting period for the **2009 Physician Quality Reporting Initiative (PQRI)** has begun. Eligible professionals choosing to participate in the 2009 PQRI through claims-based submission of individual quality measures should have started submitting appropriate 2009 Quality Data Codes on qualifying Part B claims with a date of service of January 1, 2009 or later. Information on the 153 2009 PQRI measures, release notes, detailed specifications, and a guide to assist implementing PQRI measure reporting are available at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp on the CMS website. Information on alternative reporting periods and reporting criteria for satisfactory reporting of measures groups can be found at http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp and registry-based information can be found at http://www.cms.hhs.gov/PQRI/20_Reporting.asp on the CMS website.



Clarification of Date of Service (DOS) of Ambulance 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: MM6372	Related Change Request (CR) #: 6372
Related CR Release Date: February 13, 2009	Effective Date: March 13, 2009
Related CR Transmittal #: R1682CP	Implementation Date: March 13, 2009

Provider Types Affected

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

Impact on Providers

Providers of ambulance services should note the clarifications made by CR 6372, as noted in this article. Specifically, CR 6372 clarifies the proper date of service to use on claims, especially in situations where the beneficiary dies.

Background

CR 6372 provides clarification of CMS policy towards Dates Of Service (DOS) for ambulance services, especially in regard to a beneficiary's date of death.

The clarifications for providers of ambulance services are listed as follows:

- The date of service of an ambulance service is the date that the loaded ambulance vehicle (ground or air) departs the point of pickup, except in cases where the beneficiary is pronounced dead as noted below.
- In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is considered to be the date of the ambulance vehicle's dispatch.
- In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is considered to be the date of the ambulance vehicle's takeoff.

Failure to code dates of service correctly in these situations could result in the denial of the claim.

Additional Information

The official instruction, CR 6372, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1682CP.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.



Heartsbreath Test for Heart Transplant Rejection

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: MM6366 Revised	Related Change Request (CR) #: 6366
Related CR Release Date: March 12, 2009	Effective Date: December 8, 2008
Related CR Transmittal #: R1697CP and R99NCD	Implementation Date: April 6, 2009

Note: This article was revised on March 12, 2009, to reflect a revised transmittal related to Change Request (CR) 6366. The CR release date, transmittal number (see above), and the Web address for accessing that transmittal were changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6366 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) determined that the **Heartsbreath Test is not reasonable and necessary** under section 1862(a)(1)(A) of the Social Security Act, **and is non-covered for dates of service on or after December 8, 2008**. See the ‘Background’ and ‘Additional Information’ sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately define the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare beneficiaries.

Key Points of CR 6366

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally **non-covered**. This coverage change to Current Procedural Terminology (CPT) Code 0085T, breath test for heart transplant rejection, will be effective with the April 1, 2009, quarterly update of the Medicare Physician Fee Schedule Database.
- Effective with the April 1, 2009, quarterly update of the Integrated Outpatient Code Editor, CPT code 0085T, breath test for heart transplant rejection, is no longer payable by Medicare.

- When denying claims for CPT code 0085T, Medicare contractors will use:
 - **Medicare Summary Notice (MSN) message 16.10:** Medicare does not pay for this item or service,
 - **Claim Adjustment Reason Code 50:** These are non-covered services because this is not deemed a medical necessity by the payer;
 - **Claim Adjustment Remark Code MA 51:** Missing/Incomplete/Invalid Procedure Code(s); and,
 - **N386:** This decision was based on an 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 website.

(If you do not have Web access, contact your Medicare contractor to request a copy of the NCD.)

- For beneficiaries who choose to have this procedure anyway, providers shall issue an Advance Beneficiary Notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the NCD Manual stating that the Heartbreath test is not reasonable and necessary for Medicare beneficiaries. Medicare never pays for this test and the beneficiary would be held financially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
 - Medicare Contractors will include the Group Code **CO** (contractor obligation) or **PR** (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their files, but may go back and adjust claims that are brought to their attention.

Additional Information

The official instruction (CR 6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The first conveys the revised claims processing instructions and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1697CP.pdf> on the CMS website. The second transmittal conveys the change to the National Coverage Determinations Manual and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.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.





Payments to Institutional Providers with Multiple Service Delivery Locations

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: MM6300	Related Change Request (CR) #: 6300
Related CR Release Date: February 13, 2009	Effective Date: October 1, 2007
Related CR Transmittal #: R1681CP	Implementation Date: July 6, 2009

Provider Types Affected

Hospitals and other institutional providers who bill Medicare Administrative Contractors (MACs) or Fiscal Intermediaries (FIs) for providing services, which are paid under the Medicare Physician Fee Schedule (MPFS), to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 6300, from which this article is taken, instructs your MAC or FI to assign payment localities based on the ZIP code of the actual service facility location, rather than the main provider address, when such services are paid under the MPFS. On such claims submitted via the 837 institutional claim to MACs or FIs, Medicare will use the nine-digit ZIP code reported in the 2310E loop, when present, to determine the payment locality to apply to payments for MPFS and anesthesia services. See the ‘Background’ section, below, for details.

Background

Since institutional providers have historically operated from a single physical location, the provider files in Medicare’s Fiscal Intermediary Shared System (FISS) contain only a provider’s single master address. Where a nine-digit ZIP code is required, this master address has been used to determine the fee amount for services that are paid under the Medicare Physician Fee Schedule (MPFS).

Increasingly, however, hospitals are operating off-site outpatient facilities and other institutional outpatient service providers are operating multiple satellite offices. Sometimes these facilities are in different payment locations than the parent provider. In order for MPFS and anesthesia payments to be accurate, the nine-digit ZIP code of the off-site or satellite facility should be used to determine the locality.

Change Request (CR) 5243 (released January 2007) instructed Medicare outpatient service providers to report the nine-digit ZIP code of the actual service facility location in the 2310E loop of the 837 Institutional claim transaction; however, because there is no corresponding field in its internal claim record to carry a service facility nine-digit ZIP code, FISS has not been able to implement this change.

CR 6300, from which this article is taken, instructs FISS to map the nine-digit service facility ZIP code reported in data element N403 of loop 2310E of an incoming 837 institutional claim to a payer-only value code in order to capture the ZIP code of the service facility when it differs from the main provider address. This will make the data available to the payment logic in FISS so proper payment can be made based on the MPFS.

Notes:

- 1) Medicare contractors will pay MPFS and anesthesia services using the nine-digit service facility ZIP code (described above) for claims that you submit electronically via the institutional 837, but will continue to use the ZIP code associated with your master address to determine the payment location on claims that you submit via Direct Data Entry or paper formats.
- 2) When you bring to your MAC or FI's attention timely claims that were paid inaccurately because the service facility ZIP code was lacking, your MAC or FI will adjust the claims by appending the value code and the service facility ZIP code that you specify.

Additional Information

The official instruction, CR 6300, issued to your MAC or FI is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1681CP.pdf> on the Centers for Medicare & Medicaid Services (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.





Clarification on Use of National Drug Codes (NDCs) in 837 I Billing

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

MLN Matters Number: MM6330	Related Change Request (CR) #: 6330
Related CR Release Date: February 13, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R446OTN	Implementation Date: July 6, 2009

Provider Types Affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), or Medicare Administrative Contractors (MAC)) for drugs, especially new drugs provided under the Outpatient Prospective Payment System (OPPS).

What You Need to Know

Change Request (CR) 6330, from which this article is taken, specifies how quantities of drugs are to be reported and then processed by Medicare when the National Drug Code (NDC) is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR 6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

Background

As provided by CR 3287 issued May 28, 2004 (*MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code*); Medicare hospitals, subject to the Outpatient Prospective Payment System (OPPS), may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the Units Field, while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

Additional Information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which can be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

You might also want to review the MLN Matters article related to CR 3287, which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.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.



Corrections to the Inpatient Prospective Payment System Wage Index for Fiscal Year (FY) 2009

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

MLN Matters Number: MM6363	Related Change Request (CR) #: 6363
Related CR Release Date: February 13, 2009	Effective Date: October 1, 2008
Related CR Transmittal #: R447OTN	Implementation Date: May 18, 2009

Provider Types Affected

Inpatient Acute Care hospitals who bill Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries. See below for the list of affected hospitals.

Provider Action Needed

This change only impacts hospitals which chose to notify CMS that they wished to revise the decision that CMS made on their behalf regarding their FY 2009 wage index. (See the ‘Background’ section of this article for more details and a list of specific hospitals affected.) Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed using an incorrect wage index. **You need take no action to initiate the reprocessing of the claims.** You should notify your billing office staff that adjustments to payments will be made within the next 90 days.

Background

Due to the extension of section 508 in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Centers for Medicare & Medicaid Services (CMS) stated in its final rule, published August 19, 2008, that due to the timing of the extension, CMS would be unable to recompute the FY 2009 wage index for any hospital reclassified under section 508 and special exception hospitals in time for inclusion in the FY 2009 wage index. Instead, CMS stated that we would publish the final wage FY 2009 wage index in a separate notice and that it would analyze the data for hospitals in areas affected by the MIPPA extension and make decisions on behalf of hospitals that we believe would result in the highest FY 2009 wage index for which they are eligible. Hospitals were allowed 15 days from the date of the separate notice, published October 3, 2008, to notify CMS if they wished to revise the decision that CMS made on their behalf.

The following list shows the provider numbers of hospitals who requested a reversal of the decision that CMS made on its behalf and their new wage index and Geographic Adjustment Factor (GAF):

050069, 050168, 050173, 050193, 050224, 050226, 050230, 050348, 050426, 050526, 050543, 050548, 050551, 050567, 050570, 050580, 050589, 050603, 050609, 050678, 050693, 050720, 050744, 050745, 050746 and 050747 have a new wage index of 1.2032 and a GAF of 1.1351. Hospital 250078 has a new wage index of 0.8418 and a GAF of 0.8888 and hospital 260110 has a corrected wage index of 0.8992 and a corrected GAF of 0.9298.

Additional Information

The official instruction (CR 6363) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R447OTN.pdf> on the CMS website.

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





Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries

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

MLN Matters Number: MM6139 Revised	Related Change Request (CR) #: 6139
Related CR Release Date: March 4, 2009	Effective Date: April 6, 2009
Related CR Transmittal #: R25COM	Implementation Date: April 6, 2009 for providers

Note: This article was revised on March 5, 2009, to reflect the revised CR 6139, which CMS re-issued on March 4, 2009. (The effective and implementation dates for providers were previously changed to April 6, 2009 by Transmittal R23COM on February 10.) In this revision of the article, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.

Provider Types Affected

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

What You Need to Know

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

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication:

- 1) Your National Provider Identifier (NPI);
- 2) Your Provider Transaction Access Number (PTAN); and
- 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

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

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

Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

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

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

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

- **Authentication of Providers with No NPI**

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

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

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

- **Beneficiary Authentication**

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

- 1) Last name,
- 2) First name or initial,
- 3) Health Insurance Claim Number (HICN), and
- 4) Either date of birth (eligibility, next eligible date, Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim)) or date of service (claim status, CMN/DIF (post-claim)).

- **Written Inquiries**

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

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the

provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either the NPI, the PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**

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

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at <http://www.cms.hhs.gov/Transmittals/downloads/R25COM.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.





Shipboard Services Billed to the Carrier and Services Not Provided Within the United States. Change Request (CR) 6327 rescinds and fully replaces CR 6217

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: MM6327	Related Change Request (CR) #: 6327
Related CR Release Date: February 13, 2009	Effective Date: March 13, 2009
Related CR Transmittal #: R1677CP and R102BP	Implementation Date: March 13, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6327 which clarifies payment for shipboard services billed to Medicare contractors and services not provided within the United States.

What You Need to Know

CR 6327 revises the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. **CR 6327 rescinds and fully replaces CR 6217.**

What You Need to Do

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

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at http://www.ssa.gov/OP_Home/ssact/title18/1814.htm and Section 1862(a)(4) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet). The law specifies the following are exceptions to the “foreign” exclusion:

- 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:
 - The emergency arose within the U.S, or
 - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another State;

- 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;
- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes 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, the territorial waters adjoining the land areas of the United States.

The *Medicare Claims Process Manual* (Chapter 1, Section 10.1.4.7; see <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the Centers for Medicare & Medicaid Services (CMS) website) 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
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, **CMS is clarifying Section 10.1.4.7 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 Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the *Medicare Claims Processing Manual* and Chapter 16, Section 60 of the *Medicare Benefit Policy Manual* to show **that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered.** The term "**and during a period of**" covered foreign hospitalization 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.

You can find the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional Information

The official instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1677CP.pdf> and the second modifies the *Medicare Benefit Policy Manual* and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102BP.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.





April 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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

MLN Matters Number: MM6380	Related Change Request (CR) #: 6380
Related CR Release Date: February 20, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1685CP	Implementation Date: April 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6380 which informs Medicare contractors that on or after December 16, 2008, the January 2009 Average Sales Price (ASP) file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. In addition, on or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the Centers for Medicare & Medicaid Services (CMS) ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

Background

The Medicare Modernization Act of 2003 (Section 303(c); see <http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf> on the CMS website) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. The vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology. Pricing for compounded drugs is performed by your local Medicare contractor.

CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by the Social Security Act (Section 1847A; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the internet). As part of this effort, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purposes of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. Specifically, CMS considers:

- The Food and Drug Administration (FDA) approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) first sold in the United States after October 1, 2003, or
- A single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “Not Otherwise Classified, (NOC)” HCPCS codes.

ASP Methodology

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Integrated Outpatient Code Editor (IOCE) through separate instructions.

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End Stage Renal Disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5%. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4%. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106% of the ASP. CMS will update these payment allowance limits quarterly.

Exceptions to this general rule as summarized below.

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits were not updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical

equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of \$0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of \$0.164 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

Note: At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS website.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005. Your Medicare contractor, at their discretion, may contact CMS to obtain payment limits for new drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly Payment Files

On or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the CMS ASP webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6380 (April 1, 2009) for the dates of service noted in the table that follows.

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

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

The official instruction, CR 6380, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1685CP.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.





Updates to the Internet Only Manual Publication 100-02, Chapter 10 (of the Medicare Benefit Policy Manual)

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: MM6380	Related Change Request (CR) #: 6380
Related CR Release Date: February 20, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1685CP	Implementation Date: April 6, 2009

Provider Types Affected

Ambulance providers and suppliers submitting claims to Medicare Contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for ambulance services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6318 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR6318 to highlight the revisions to the *Medicare Benefit Policy Manual*, Chapter 10 - Ambulance Services. The article is informational in nature, since CR 6318 revises that manual to incorporate information previously released via Transmittal AB-02-130 and updates to the *Medicare Claims Processing Manual*, Chapter 15, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS website.

Key Points

The key updates made to Chapter 10 of the *Medicare Benefit Policy Manual* are as follows:

- **Chapter 10/Section 10.4.** Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, Medicare contractors approve claims only if the beneficiary’s medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).
 1. **Fixed Wing Air Ambulance (FW):** Fixed wing air ambulance is furnished when the beneficiary’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.
 2. **Rotary Wing Air Ambulance (RW):** Rotary wing air ambulance is furnished when the beneficiary’s medical condition is such that transport by ground ambulance, in whole or in part,

is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

- **Chapter 10/Section 10.4.2.** Medical **reasonableness** is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. A list of examples of cases for which air ambulance could be justified is available in section 10.4.2, which is attached to CR 6318. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.
- **Chapter 10/Section 20/20.1.2 - Beneficiary Signature Requirements.** Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:
 1. The beneficiary's legal guardian;
 2. A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
 3. A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs;
 4. A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary;
 5. A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4); and/or
 6. A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service.

Note: A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

- **Chapter 10/Section 30.1.1.** This section is revised to add information regarding Advanced Life Support (ALS) assessments. The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the

standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Additional Information

The official instruction (CR6318) issued to your Medicare FI, carrier or MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R103BP.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.





April 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.1

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: MM6413	Related Change Request (CR) #: 6413
Related CR Release Date: March 13, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1700CP	Implementation Date: April 6, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6413, which describes changes to the Integrated Outpatient Code Editor. Be sure billing staffs are aware of these changes.

Background

CR 6413 describes changes to the April 2009 Integrated Outpatient Code Editor (I/OCE). Attached to CR 6413 are lengthy specifications for the I/OCE (Attachment A) and the Summary of Data Changes (Attachment B).

Note: A summary of the changes for April 2009 is within Appendix M of Attachment A of CR 6413 and that summary is captured in the following key points.

Key Points of CR 6413 Based on Preliminary Summary of Data Changes and Appendix M of the I/OCE Specifications (Attached to CR 6413)

Medicare has made the following I/OCE logic changes for April (note: ALL of the logic changes are detailed in the specifications in CR 6413):

- Status indicator U (to SI =H) was added to the criteria for edit 38
- The program was modified to ignore procedures that had SI changed from Q(#) to N - in subsequent logic for purposes of assigning composite APC
- The program was modified to apply edit 80 to bill type 76X
- The program was modified to remove TOB 14X from mental health (MH) processing

**Medicare has made the following Healthcare Common Procedure Coding System/Ambulatory Payment Class/Status Indicator (HCPCS/APC/SI) changes:
Added APCs (for providers paid under OPPS)**

- APC 01253 (Triamcinolone A inj PRS-free), with a Status Indicator (SI) = K has been added effective January 1, 2009.
- APC 09247 (Inj, iobenguane, I-123, dx) and 09249 (Inj, certolizumab pegol) with a SI = G have been added effective April 1, 2009.

APC SI Changes

- APC 01236 and 01238 previously had SIs = K and now both have new SIs of G.

New HCPCS

- HCPCS C9249, with a SI = G has been added effective April 1, 2009, with an APC of 09249.
- HCPCS K0739 and K0740 with SI = Y have been added effective April 1, 2009.
- HCPCS S3865, S3866, S3870 with SI = E have been added effective April 1, 2009.

Deleted HCPCS/Current Procedural Terminology (CPT) Procedure Codes

- HCPCS S8190 has been deleted effective April 1, 2009.

HCPCS Changes to APC and/or SI

- 18 E-codes from E0250 to E0310 were changed from SI=E to SI=Y effective July 1, 2006 (see Attachment B for the full list)
- HCPCS 0085T had an old APC of 00340 but was changed to APC 00000 with a new SI = E effective January 1, 2009.
- HCPCS 0529F, 0540F, 1170F, 3016F, 3455F, 3470F, 3471F, 3472F, 3475F, 3476F, 3570F, 4148F, 4149F, 4192F, 4193F, 4194F, 4195F, 4196F, 4267F were changed from SI= E to SI = M effective January 1, 2009.
- HCPCS 0575F, 4270F, 4271F, 4279F, 4280F were changed from SI= M to SI = E effective January 1, 2009.
- HCPCS J3300 had an old APC of 00000 but was changed to APC 01253 with a new SI = K effective January 1, 2009.
- HCPCS 90649 and 90716 were changed from SI= B to SI = M effective April 1, 2009.
- HCPCS C9247 had an old APC of 00000 but was changed to APC 09247 with a new SI = G effective April 1, 2009.
- HCPCS E0315 was changed from SI= E to SI = Y effective April 1, 2009.
- HCPCS E1340 was changed from SI= Y to SI = E effective April 1, 2009.
- HCPCS J0641 and J8705 were changed from SI= K to SI = G effective April 1, 2009.

HCPCS Edit Changes

- HCPCS 0193T was added to the list of Female Procedures effective January 1, 2009.

HCPCS Termination Date Changes

- HCPCS 0085T has a new Termination Date of December 7, 2008)

Edit Assignments

- HCPCS 27027, 27057, 35535, 35570, 35632, 35633, 35634, 49652, 49653, 49654, 49655, 49656, 49657, 50546, 64455, 64632, 65756 were added to the conditional bilateral list effective January 1, 2009.

Modifier Additions

- Modifier K8 is a valid modifier effective April 1, 2009.

Revenue Code Additions

- Revenue Codes 0951 and 0952 are valid and have SI = E effective October 1, 2000.
- Revenue Code 0392 is valid and has SI = E effective April 1, 2007.

CCI Edit Information

- **Version 15.0 of the National Correct Coding Initiatives has been implemented effective with this April 2009 version of the I/OCE.**
- **The following language was added to the specs:** “In some instances, both codes in a CCI code pair may be allowed if an appropriate modifier is used that describes the circumstances when both services may be allowed. The code pairs that may be allowed with a modifier are identified with a modifier indicator of “1”; code pairs that are never allowed, whether or not a modifier is present, are identified with a modifier indicator of “0”. (Modifiers that are recognized/used to describe allowable circumstances are: 25, 27, 58, 59, 78, 79, 91, E1-E4, F1-F9, FA, LC, LD, RC, RT, T1-T9, and TA).

Additional Information

The official instruction (CR 6413) issued to your Medicare MAC, RHHI, or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1700CP.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.





April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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

MLN Matters Number: MM6416	Related Change Request (CR) #: 6416
Related CR Release Date: March 13, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1702	Implementation Date: April 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6416 which describes changes to the OPPS to be implemented in the April 2009 OPPS update. Be sure your billing staff are aware of these changes.

Background

Change Request (CR) 6416 describes changes to and billing instructions for payment policies implemented in the April 2009 OPPS update. The April 2009 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request.

April 2009 revisions to I/OCE data files, instructions, and specifications are provided in CR 6413, April 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.1.” Upon release of CR 6413, a related MLN Matters article will be available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6413.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPPS Updates for April 2009

1. Pass-Through Devices and Non Pass-Through Devices Included in Kits

Manufacturers frequently package a number of individual items used with a device in a particular procedure in a kit. Generally, to avoid complicating the device pass-through category list unnecessarily and to avoid the possibility of double coding, CMS has not established HCPCS codes for such kits. However, hospitals may purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items should be separately billed using applicable HCPCS codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits. This information can also be found in the revised *Medicare Claims Processing Manual*, Chapter 4, Section 60.4 (General Coding and Billing Instructions and Explanations) which is included as an attachment to CR 6416.

In cases of devices that are described by 1) device category HCPCS codes whose pass-through status has expired or 2) device category HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their

line-item charge for the associated device/device category HCPCS code that is assigned status indicator “N” for packaged payment. That is, hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned status indicator “N.” In the case of a device kit, should a hospital choose to report the device charge alone under a device/ device category HCPCS code with status indicator “N,” the hospital should report charges for other items that may be included in the kit on a separate line on the claim. Hospitals may use the same revenue code to report all components of the kit. This information can also be found in the *Medicare Claims Processing Manual*, Chapter 4, Section 61.1 (Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures) which is included as an attachment to CR 6416.

Hospitals are advised to continue to report all HCPCS codes that describe packaged items and services that were provided, unless CPT instructions or CMS provide other guidance. Further, hospitals should include charges for packaged items or services described and reported by those HCPCS codes with status indicator “N” on their claims when those codes can be appropriately reported, so that the costs associated with the packaged items or services can then be added to the costs of separately payable procedures on the same claims when establishing the annual payment rates for the separately payable services under the OPSS.

2. Further Clarification Related to Billing for Medical and Surgical Supplies

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the *Medicare Benefit Policy Manual*, Chapter 15, Sections 120 and 130 and take-home surgical dressings; see <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS Web site) described by HCPCS codes with status indicators other than “H” or “N,” are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPSS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is packaged into payment for the associated procedures under the OPSS in accordance with 42 CFR 419.2(b)(4) (see <http://www.gpoaccess.gov/cfr/retrieve.html> on the internet).

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

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

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the

hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.

3. Billing for Inherently Bilateral Procedures

Inherently bilateral procedures represent services that are performed bilaterally. Often, the word “bilateral” appears in the HCPCS code long descriptor. Since the implementation of the OPSS on August 1, 2000, inherently bilateral procedure codes have been included in the I/OCE as a table that is used in applying edit 17 (inappropriate specification of bilateral procedure). I/OCE edit 17 occurs when a bilateral procedure code appears on the claim form more than once per day on the same date for the same patient. Recently, CMS received reports of a clinical scenario where a bilateral procedure may be performed more than once per day on the same date for the same patient. For only those instances that involve more than one bilateral procedure and are medically necessary and appropriate, hospitals are advised to report the procedure code with a modifier -76 (repeat procedure or service by same physician) in order for the claim to process correctly. Appending modifier -76 to one of the reported bilateral HCPCS code indicates that the bilateral procedure or service was repeated on the same day for the same patient. CMS expects these types of claims to be uncommon and will be monitoring claims to ensure that this is the case.

4. Billing for Processing and Storage of Blood and Blood Products

CMS updated (and included as an attachment to CR 6416) the *Medicare Claims Processing Manual*, Chapter 4, Section 231.1 and Section 231.2) to include Revenue Code 0392 (Blood Processing/Storage; Processing and Storage) as an acceptable revenue code for billing blood processing and storage charges. Most OPSS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself. These hospitals should follow the instructions outlined in Section 231.1, which require using Revenue Code 0390 (Blood Processing/Storage), 0392 (Blood Processing/Storage; Processing and Storage), or 0399 (Blood Processing /Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS).

OPSS providers that incur a charge for the blood or blood product itself in addition to the charge for processing and storage should follow the coding requirements outlined in Section 231.2, which instructs hospitals to report charges for the blood or blood product itself using Revenue Code series 038X (excluding 0380) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPSS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines.

5. Billing for Autologous Stem Cell Transplant Procedures

CMS updated (and included as an attachment to CR 6416) the *Medicare Claims Processing Manual*, Chapter 3, Section 90.3.3) to clarify billing for allogeneic stem cell transplant acquisition services, which are billed and payable under Part A, and to clarify billing for autologous stem cell transplant procedures, which may be billed and payable under either Part A or Part B. CMS also revised (and included as an attachment to CR 6416) Chapter 4, Section 231.10 on billing for autologous stem cell transplant procedures.

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 or another appropriate cost center.

CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPSS when provided in the hospital outpatient setting of care. CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPSS when provided to hospital outpatients.

Payment for stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2009

For Calendar Year (CY) 2009, payment for nonpass-through drugs and biologicals is made at a single rate of ASP+4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP+6 percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the second quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2009 OPSS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most

recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2009 release of the OPSS PRICER.

Note: The updated payment rates, effective April 1 2009, will be included in the April 2009 update of the OPSS Addendum A and Addendum B, which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS website.

b. Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2009

Three drugs and one diagnostic radiopharmaceutical have been granted OPSS pass-through status effective April 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

Table 1- Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2009

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/09
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	9247	G
C9249*	Injection, certolizumab pegol, 1 mg	9249	G
J0641	Injection, levoleucovorin calcium, 0.5 mg	1236	G
J8705	Topotecan, oral, 0.25 mg	1238	G

NOTE: The HCPCS code identified with a “*” indicates that this is a new code effective April 1, 2009.

c. Adjustment to Status Indicator for HCPCS Code J3300 For CY 2009

As stated in the CY 2009 OPSS/ASC correction notice, CMS erroneously assigned a packaged status indicator (SI = “N”) to HCPCS code J3300, Injection, triamcinolone acetonide, preservative free, 1 mg, for CY 2009. To correct this error, CMS is updating the payment rate in the OPSS PRICER retroactively to January 1, 2009 to reflect the updated separately payable status of HCPCS code J3300 (SI = “K”) for CY 2009. HCPCS code J3300 is assigned to APC 1253 (Triamcinolone A inj PRS-free) with a payment rate of \$3.18 for the first quarter of CY 2009. If this payment rate changes for the second quarter of CY 2009, CMS will include the pricing update for HCPCS code J3300 in the corresponding update for other separately payable drugs and biologicals for the April 2009 OPSS PRICER.

d. Recognition of Multiple HCPCS Codes For Drugs

Prior to January 1, 2008, the OPSS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPSS assigned a status indicator “B” indicating that another code existed for OPSS purposes. For example, if drug X has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and status indicator “B” to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPSS. However, beginning January 1, 2008, the OPSS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

e. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not,

hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPSS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

f. Correct Reporting of Units for Drugs

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

g. Introduction of Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPSS and will be assigned status indicator “G.” As finalized in the CY 2009 OPSS/ASC final rule with comment period, payment for diagnostic radiopharmaceuticals with pass-through status during CY 2009 will be made according to the established ASP methodology. Therefore, beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106 percent of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product’s wholesale acquisition cost (WAC). Further, if WAC data are not available, payment will be made at 95 percent of the average wholesale price (AWP).

Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 by the corresponding nuclear medicine procedure’s portion of its APC payment associated with “policy packaged” drugs (offset amount) so no duplicate radiopharmaceutical payment is made. The “policy packaged” portions of the CY 2009 APC payments may be found on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/06_Annual_Policy_File.asp#TopOfPage in the

download file labeled “2009 OPSS Offset Amounts by APC.” Pass-through payment for the diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. Effective for services furnished on and after April 1, 2009 but before the date that HCPCS code C9247 expires from pass-through status, CMS will reduce the payment for HCPCS code C9247 by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is packaged into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

When HCPCS code C9247 is billed on a claim with one or more nuclear medicine procedures, the OPSS Pricer will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim. Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPSS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill. Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPSS Pricer will select the nuclear medicine procedure with the single highest offset amount and will adjust the selected offset amount by the wage index of the hospital submitting the claim. When a claim has more than one occurrence of C9247, the OPSS Pricer will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through radiopharmaceutical on the claim and adjust the total offset amount by the wage index of the hospital submitting the claim. The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

7. OPSS Pricer Changes

New Pass-Through Diagnostic Radiopharmaceutical Offset logic will be added (see section “6.g”. above) along with the April Average Sales Pricer (ASP) APC updates.

8. Coverage Determinations

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

Additional Information

The official instruction, CR 6416, issued to your FI, A/B MAC, and RHHI regarding this change is available at <http://www.cms.hhs.gov/transmittals/downloads/R1702CP.pdf> on the Centers for Medicare & Medicaid Services (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.



April Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)

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

MLN Matters Number: MM6397	Related Change Request (CR) #: 6397
Related CR Release Date: March 4, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R1691CP	Implementation Date: April 6, 2009

Provider Types Affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 6397 which amends payment files that were issued to contractors based upon the 2009 Medicare Physician Fee Schedule (MPFS) Final Rule. Physical therapists should pay particular attention to the ‘Background’ section” regarding the billing of Canalith repositioning procedures.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

Canalith Repositioning

In the 2009 MPFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) discussed a newly created CPT code, 95992, describing canalith repositioning procedures. CMS indicated that, prior to the new CPT code, this service was billed by physicians as part of an Evaluation and Management service, and by other practitioners, primarily therapists, using existing codes. CMS assigned the code a status indicator of B (bundled), and stated that bundling this code is most appropriate because this service is currently being paid for as part of an Evaluation and Management (E and M) service. However, since therapists also provide this service and they cannot bill for E and M services, they should continue to bill CPT code 97112 for this service.

2009 Physician Quality Reporting Initiative (PQRI) Program

CMS identified a technical problem affecting twenty Quality-Data Codes (QDCs) used for reporting thirteen quality measures through the claims-based method for the 2009 Physician Quality Reporting Initiative (PQRI). These twenty QDCs are new codes for the 2009 PQRI. The CPT II codes and the 2009 PQRI measures affected are listed below.

CPT II Code	Measure #	Measure
3250F	99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3250F	100	Colorectal Cancer Resection Pathology Reporting: pT

		Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3570F	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
3016F	173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
3455F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4195F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4196F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
3470F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3471F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3472F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
1170F	178	Rheumatoid Arthritis (RA): Functional Status Assessment
3475F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
3476F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
0540F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4192F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4193F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4194F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4148F	183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
4149F	184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV
0529F	185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
4267F	186	Wound Care: Use of Compression System in Patients with Venous Ulcers

In most instances, the technical problem has caused line items containing any of the QDCs listed above to reject/return as unprocessable. In those circumstances, the Eligible Professional (EP) received a message other than N365 indicating that the procedure code was not accepted for reporting purposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

CMS is actively working with the carriers and A/B MACs to address this issue. All carriers and A/B MACs will be able to accept the affected codes within the next 3 weeks. Once this has been accomplished, submission of the affected CPT II codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers and A/B MACs could accept the affected CPT II codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of 1st Quarter (i.e., January 1,

2009 – March 31, 2009) QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes. The two basic options for EPs are:

A. Do not seek correction of the submitted codes which were returned unprocessed.

As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers and A/B MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the 2% incentive payment with respect to the entire reporting period.

B. Seek correction of the submitted codes that were returned unprocessed.

In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009 and after and received a message other than N365 on their remittance advice, can call their carrier or A/B MAC and request a correction beginning April 1, 2009. In this case the EP should be prepared to give specific claim information to the carrier or A/B MAC, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected measures using the Measures Group Consecutive Method during the first three months of 2009 may find that it is worthwhile to pursue correction.

Note: PQRI reporting and performance rate analysis for ONLY the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first 3 months of 2009 will be evaluated. Thus, the determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

Other specific changes included in the April Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6397. That CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1691CP.pdf> on the CMS website. Key changes, however, are summarized as follows:

These Current Procedural Terminology /Healthcare Common Procedure Coding System (CPT/HCPCS) codes are assigned a Procedure Status = M as follows:

0529F, 0540F, 1170F, 3016F, 3250F, 3455F, 3470F, 3471F, 3472F, 3475F, 3476F, 3570F, 4148F, 4149F, 4192F, 4193F, 4194F, 4195F, 4196F, 4267F, G8489, G8490, G8491, G8492, G8493, G8494.

These CPT/HCPCS codes are assigned a Procedure Status = I as follows:

0575F, 4270F, 4271F, 4279F, 4280F.

Physicians/providers should also note the following:

CPT/HCPCS

93351 Global

ACTION

Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Short Descriptor: Stress tte complete

93351 TC

Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Short Descriptor: Stress tte complete

93351 26

Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Short Descriptor: Stress tte complete

Descriptor Changes

The long descriptor has been revised for the following codes:

CPT Code	Revised Long Descriptor	Revised Short Descriptor
G0248	Demonstration, prior to initiation 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's ability to perform testing and report results	N/A
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; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests	N/A
G0250	Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests	N/A


Change in Procedure Status for CPT code 0085T

Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath Test used to predict heart transplant rejection is nationally non-covered. CPT code 0085T, breath test for heart transplant rejection, is assigned procedure status of N and is no longer payable by Medicare.

Additional Information

The official instruction, CR 6397, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1691CP.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.





Disclosure of Physician Ownership in Hospitals

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: MM6306	Related Change Request (CR) #: 6306
Related CR Release Date: March 6, 2009	Effective Date: June 8, 2009
Related CR Transmittal #: R58GI	Implementation Date: June 8, 2009

Provider Types Affected

Physician-owned hospitals and physicians with hospital ownership interests who bill Medicare fiscal intermediaries (FI), carriers, or Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries in those physician-owned hospitals

What You Need to Know

Change Request (CR) 6306, from which this article is taken, announces that:

- Physician-owned hospitals are required to disclose to their patients the names of the physician owners and the names of immediate family members of the physician who have an ownership or investment interest in the hospital; and
- Physicians are required to disclose to their patients at the time of referral if they (or their immediate family members) have an ownership or investment interest in the hospitals to which they refer patients for treatment.

Hospitals that fail to disclose this information to patients may lose their provider agreements to participate in the Medicare program, and physicians who fail to disclose this information to patients may lose their hospital medical staff memberships.

You should make sure that you have appropriate hospital physician-ownership disclosure procedures in place and that you are providing appropriate disclosures to your patients.

Background

The Code of Federal Regulations Title 42, Volume 3, Section 489.3 defines a physician-owned hospital as any participating hospital (as defined in section 489.24) in which a physician, or their immediate family member, has an ownership or investment interest. Pursuant to Section 489.3, hospitals that do not have any physician owners who refer patients to the hospital are exempt from these disclosure requirements.

Section 5006 of the Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, required the Secretary of Health and Human Services (HHS) to develop a “strategic and implementing plan” to address certain issues related to physician investment in specialty hospitals. Accordingly (in order to allow patients to make informed decisions regarding their treatment and to decide if the existence of a hospital-related financial relationship suggests a conflict of interest that may not be in their best interest), in the August 8, 2006 final report to Congress on this requirement, the Centers for Medicare & Medicaid Services (CMS) stated the adoption of a disclosure requirement that would require both hospitals and physicians to disclose

to patients whether the hospital is physician-owned and if the referring physician is a physician owner of the hospital.

Specifically, the FY 2008 and FY 2009 Inpatient Prospective Payment System (IPPS) regulations require hospitals to disclose to patients whether they are physician-owned, and if so, to disclose the physician owners' names. This ownership or investment interest may be through equity, debt, or other means (including an interest in the entity that holds an ownership or investment interest in the hospital.) In disclosing this ownership relationship, hospitals must furnish written notice to each patient at the beginning of their hospital stay, or outpatient visit, that the hospital is physician-owned. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital, and that the list of physician owners or their immediate family members (who have an ownership or investment interest in the hospital) is available upon request and must be provided to the patient at the time of the request.

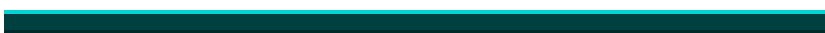
These regulations also require each physician who is a member of the hospital's medical staff to agree (as a condition of continued medical staff membership or admitting privileges), to disclose to all patients that he or she refers to the hospital (in writing at the time of the referral), any ownership or investment interest that he/she, or an immediate family member, holds in the hospital.

You should be aware that if a physician-owned hospital fails to disclose physician ownership information as required, it may lose its provider agreement to participate in the Medicare program. Similarly, if a physician fails to disclose his/her hospital ownership or investment information, he or she may lose hospital medical staff membership.

Additional Information

The official instruction issued to your Medicare Carrier, FI, or MAC, CR 6306, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R58GI.pdf> on the CMS website. If you are interested in reading about physician hospital ownership disclosure in the Code of Federal Regulations Title 42, Volume 3, Section 489.3, you can find it at http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr489.3.pdf on the Internet.

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





Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2009

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

MLN Matters Number: MM6383	Related Change Request (CR) #: 6383
Related CR Release Date: February 13, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1684CP	Implementation Date: April 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6383 which announces the changes that will be included in the April 2009 release of Medicare’s edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in January 2009. See the ‘Background’ section of this article for further details regarding these changes.

Background

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

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

CR 6383 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for April 2009 as described below. These changes become effective for services furnished on or after April 1, 2009 and are as follows:

For Blood Counts:

- Add ICD-9-CM codes 525.71, 525.72 and 525.73 to the list of ICD-9-CM codes that do not support medical necessity for Blood Counts (190.15) NCD.

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM codes 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.

For Prothrombin Time (PT):

- Add ICD-9-CM codes 414.3, 535.70, and 535.71 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

For Serum Iron Studies:

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70, and 535.71 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

For Blood Glucose Testing:

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.

For Lipid Testing:

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, and 208.92 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

For Fecal Occult Blood Test (FOBT):

- Add ICD-9-CM codes 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD.

Additional Information

The official instruction (CR 6383) issued to your Medicare MAC, carrier, or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1684CP.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.





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

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

MLN Matters Number: MM6383	Related Change Request (CR) #: 6383
Related CR Release Date: February 13, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1684CP	Implementation Date: April 6, 2009

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), durable medical equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

Change Request (CR) 6336, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2009 for Medicare. Be sure billing staff are aware of these changes.

Background

Two code sets—the **Group** and the **Reason and Remark Code** sets—must be used to report payment adjustments in remittance advice transactions. For Medicare, remark codes must also be used when appropriate to report additional explanation for any adjustment or to provide general policy information. The reason codes are also used in some Coordination-Of-Benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated at the same time and posted at <http://www.wpc-edi.com/Codes> on the Internet. The lists below summarize the latest changes to these lists, as announced in CR 6336.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at <http://www.cmsremarkcodes.info> on the Internet. Note that this website does not replace the Washington Publishing Company (WPC) site. That site is <http://www.wpc-edi.com/Codes> and should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

New Codes - CARC:

Code	Current Narrative	Effective Date
226	Information requested from the Billing/Rendering Provider	9/21/2008

	was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason code.)	
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	09/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	09/21/2008

Modified Codes – CARC:

Code	Current Modified Narrative	Effective Date
148	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason code.)	07/01/2009

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	07/01/2009
B18	This procedure code and modifier were invalid on the date of service.	03/01/2009

New Codes - RARC:

Code	Current Narrative	Medicare Initiated?
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	NO
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	NO
N507	Plan distance requirements have not been met.	NO
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.	NO
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.	NO
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	NO
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	NO
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	YES
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim	YES

information.	
--------------	--

Modified or Deactivated Codes - RARC

There are no modified or deactivated RARC codes in CR 6336.

Additional Information

To see the official instruction (CR 6336) issued to your Medicare Contractor refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1674CP.pdf> on the CMS website. For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website. If you use the Medicare Remit Easy Print software from your Medicare Contractor, you may need to download the updated version when it is available on April 6, 2009.

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





Medicare A Newslines Quality Survey

Please take a moment to let us know your thoughts regarding this issue of the *Medicare A Newslines*.

Your Name (optional): _____

Telephone Number (optional): _____

Please rate the publication by circling the number of your choice.
(10 = Excellent, 5 = Satisfactory, 1 = Unacceptable)

1. Usefulness of the information.

10 9 8 7 6 5 4 3 2 1

2. Organization and layout of the information.

10 9 8 7 6 5 4 3 2 1

3. Design and physical appearance of the publication.

10 9 8 7 6 5 4 3 2 1

4. Value of *Medicare A Newslines* as a reference item.

10 9 8 7 6 5 4 3 2 1

5. Do you use the website to obtain copies of the Medicare newsletter?

Yes _____ No _____

6. What can we do to make *Medicare A Newslines* a more effective publication?

Thank you for your time.

Please fax or mail your response to:

Cahaba Government Benefit Administrators, LLC
Provider Outreach and Education
PO Box 12967
Birmingham, Alabama 35202
Fax: 912 921-3066