

Medicare A Newsline



Important Information from Cahaba Government Benefit Administrators®, LLC
 Cahaba GBA is the J10 A/B Medicare Administrative Contractor

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

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

Disclaimer

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Provider Contact Center – Training Schedule

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

CSR Training Dates	Time
Friday, May 1, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, May 8, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, May 15, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, May 29, 2009	9:00 a.m.- 11:00 a.m. CST

Provider Contact Center Telephone Numbers

- Alabama A: 866-539-5598
- Georgia A: 877-567-3095

Interactive Voice Response (IVR) Inquiries: Georgia Part A Providers and ESRD facilities formerly assigned to Blue Cross Blue Shield of Georgia will continue to dial the same toll-free number (877)567-3095 to reach Cahaba GBA’s Interactive Voice Response (IVR) system, and, if needed, a Customer Service Representative (CSR). The TDD inquiry line toll free number is (877)822-4407.

Our Interactive Voice Response (IVR) system is designed to assist providers in obtaining answers to numerous issues through self-service options. Options on our IVR include information regarding patient eligibility, checks, claims, deductible and other general information. Please note that our CSRs are available to answer questions that cannot be answered by the IVR. CSRs are physically located in Birmingham, Alabama and Savannah, Georgia. When your call is received, it is routed to the next available representative. CSRs are available Monday through Friday 8:00 a.m. until 4:00 p.m. in your time zone.





Educational Article- Bone Mass Measurement (A47207)

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

The following ICD-9 code range has been revised:

- Current range 805.00 – 805.8 has been changed to range 805.00 – 805.7.

Providers are encouraged to review these revisions to ensure compliance. This original article for [Bone Mass Measurements](#) was effective February 1, 2008.



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

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

Note: This information is applicable to Medicare Part A Providers who send their electronic claims submission to the Cahaba GBA 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	549
888	INSTREAM REJECTION There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred	241
333	INVALID PAT STATUS FOR TYPE BILL The patient's status was invalid for the type bill submitted.	200
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.	172



Provider Authentication Requirements—Reminder

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 A: 1-866-539-5598
- GA A: 1-877-567-3095

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.





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:

J10 A/B MAC Post-Transition Open Door Forum- Teleconference

Date: Tuesday, May 12, 2009

Time: 10:00 a.m. - 11:30 a. CST/ 11:00 a.m. - 12:30 p.m. EST

Registration is required for this event



Online Courses

Didn't find what you were looking for? [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated. You may want to bookmark the [Medicare Part A](#) page for the most current Medicare A headlines or to subscribe to the Cahaba GBA, LLC [E-mail Notification Service](#). In addition, our "[Online Courses](#)" are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Appeals Process	Learn about the Medicare appeals process.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Electronic Data Interchange	Learn about the Electronic Data Interchange (EDI) process.
FISS 101: Introduction to FISS	Learn how to access FISS and receive an overview of FISS functions.
Insight into Medicare Coding	Learn the basics about Medicare coding.
Introduction to Medicare Cost Report	Learn the basics about the Medicare Cost Report.
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment	Learn about provider enrollment and how to apply.
Rural Health Clinic Billing	View a presentation on rural health clinic billing.
Skilled Nursing/Swing Bed PPS Consolidated Billing	View a presentation on skilled nursing facility/swing bed prospective payment system (PPS) consolidated billing.
Verifying Beneficiary Eligibility	Learn how to identify various eligibility information by using ELGA and ELGH.

Please note these courses were designed specifically for providers served by Cahaba GBA, LLC. You can find additional national courses under the [Medicare Learning Network](#).



Flu Season

It's 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.



Physician Quality Reporting Initiative (PQRI)

Beginning December 19, 2008, the names of physicians and other health care professionals who reported quality information under the **Physician Quality Reporting Initiative (PQRI)** in 2007 will be available at <http://www.medicare.gov/physician>, the *Physician and Other Healthcare Professional Directory* located on <http://www.medicare.gov/physician>. This information includes all eligible professionals identified by their National Provider Identifier (NPI) who submitted at least one quality data code on their Medicare claims for services furnished between July 1, 2007 and December 31, 2007. For more information on the PQRI and the instructions for reporting and requirements for satisfactory reporting, go to <http://www.cms.hhs.gov/pqri> on the CMS website.



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.



Medicare Provider Authentication Process

Are you ready for the new Medicare provider authentication process at Fiscal Intermediaries (FIs), Carriers, or Medicare Administrative Contractors (MACs)? Effective April 6, 2009, for all Medicare provider telephone and written inquiries to your Medicare claims processing contractors, inquirers will need to give the last five digits of the provider's tax identification number (TIN) in addition to the provider's national provider identifier (NPI) and provider transaction access number (PTAN). In addition, inquirers will only be allowed three attempts to provide the correct NPI, PTAN, and last five digits of the TIN. You can find more information about the new provider authentication requirements for Medicare inquiries to your Medicare claims processing contractors by going to the MLN Matters article related to CR 6139, located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6139.pdf> on the CMS website.



Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

The revised Medicare *Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2008), which offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals, 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/physicianguide.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.



E-Prescribing Program

In October 2008, the Centers for Medicare & Medicaid Services (CMS) and 34 partner organizations hosted a meeting about the mechanics of implementing an e-prescribing program in a practice. Audiotapes and slides are now archived online for continuing education credit. The Massachusetts Medical Society and the American Pharmacist Association are pleased to provide Continuing Medical Education (a maximum of 22.5 AMA PRA Category 1 Credits™, (risk management study for MA Physicians) and Continuing Education for pharmacists (up to 13.25 hours of continuing education credit (1.325 CEUs)). Simply go to http://www.massmed.org/cme/CMS_eprescribing to view the presentations and hear the audiotapes of the program. There are no registration or certificate fees.



E-Prescribing Incentive Program

As of January 1, 2009, eligible professionals can participate in the E-Prescribing Incentive Program by reporting on their adoption and use of an e-prescribing system by submitting information on one e-prescribing measure on their Medicare Part B claims. For the 2009 e-prescribing reporting year, to be a successful e-prescriber and to qualify to receive an incentive payment, an eligible professional must report one e-prescribing measure in at least 50% of the cases in which the measure is reportable by the eligible professional during 2009. There is no sign-up or pre-registration to participate in the E-Prescribing Incentive Program. For more information, visit <http://www.cms.hhs.gov/ERxIncentive/> on the CMS website.



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.



Skilled Nursing Facility Consolidated Billing Web-Based Training Course

The revised *Skilled Nursing Facility Consolidated Billing Web-Based Training Course* (October 2008), which provides general information about Skilled Nursing Facilities (SNF), SNF Consolidated Billing, and under “arrangement agreements” between SNFs and other providers or suppliers, is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network. To access this course, visit http://www.cms.hhs.gov/MLNProducts/01_Overview.asp and select the "Web-Based Training Modules" link from the "Related Links Inside CMS" Section located at the bottom of this web page.



Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Physicians and non-physician practitioners in all States and Washington, D.C. can now use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet. CMS will make Internet-based PECOS available next year to organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers). For information about Internet-based PECOS, including important information that physicians and non-physician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll/> on the CMS website.



Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting

The Centers for Medicare & Medicaid Services (CMS) has recently updated the Educational Resources section (http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp) of the Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting web site to include the audio file and transcript from the Hospital-Acquired Conditions and Hospital Outpatient Healthcare-Associated Conditions Listening Session held on Thursday, December 18, 2008.



Instructions for the Implementation of the Internet-Based Provider Enrollment, Chain and Ownership System (PECOS)

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: MM6231	Related Change Request (CR) #: 6231
Related CR Release Date: October 24, 2009	Effective Date: November 24, 2008
Related CR Transmittal #: R271PI	Implementation Date: November 24, 2008

Provider Types Affected

All physicians, providers, and suppliers who submit CMS-855 applications into the PECOS system via the Internet to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers or Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 6231 and alerts providers to the fact that the information about Internet-based PECOS applications provided in previously issued Change Request (CR) 5954 is now incorporated into Centers for Medicare & Medicaid Services (CMS) Medicare Program Integrity Manual Chapter 10—Medicare Provider/Supplier Enrollment, which is available at <http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf> on the CMS website. CMS emphasizes that none of the material in CR 5954 is changing in any way; the material is simply being shifted to chapter 10.

Background

CR6231 describes the PECOS CMS-855 applications. Specifically, this directive incorporates all of the instructions contained in CR 5954 into the *Medicare Program Integrity Manual* Chapter 10—Medicare Provider/Supplier Enrollment. Consequently, CR6231 rescinds and replaces CR 5954.

Key Points of CR 6231

Effective immediately CMS has incorporated the instructions regarding PECOS applications into the *Medicare Program Integrity Manual* Chapter 10. The instructions are as follows:

- If the provider fails to submit a signed and dated certification statement to the Medicare contractor within 15 calendar days of the date on which it submitted its Internet-based PECOS CMS-855 to the contractor, the contractor may reject the application.
- For initial CMS-855 applications sent via the Internet-based PECOS, it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in by the 15th day. The signatures of the other authorized and delegated officials will be collected through the normal application development process.

- If the provider submits an undated certification statement or a certification statement on which the Web Tracking ID does not match that in PECOS, the Medicare contractor will treat it as a non-submission.
- If your contractor determines that additional or clarifying information is needed, the contractor will send an e-mail to the provider: (1) requesting said data along with, as necessary, a signed and dated certification statement; and (2) listing a date(s) by which the information and certification statement, respectively, must be submitted to the contractor.
- Note that your contractor may, at its discretion, initiate a follow-up contact with you after sending the e-mail, but is not required to do so.
- If the provider fails to submit the requested additional/clarifying information and the accompanying certification statement within 30 calendar days from the date the contractor sent the e-mail, the contractor may reject the provider's application.
- If the contractor receives the additional/clarifying information from the provider, the contractor will not recommence its processing of the application until the accompanying certification statement is received in the contractor's provider enrollment department.
- The provider must submit all applicable supporting documentation (e.g., licenses, CMS-588) with its Internet-based PECOS application. (It is not necessary, however, for the provider to submit the supporting documentation: (1) in the same package as the certification statement, or (2) prior to its submission of the certification statement.)

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6231) issued to your Medicare A/B MAC, FI, carrier or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R271PI.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.





Outpatient Therapy Caps with Exceptions in Calendar Year (CY) 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: MM6321 Revised	Related Change Request (CR) #: 6321
Related CR Release Date: February 13, 2008	Effective Date: January 1, 2009
Related CR Transmittal #: R1678CP	Implementation Date: April 6, 2009

Note: This article was revised on March 10, 2009, to clarify the Advance Beneficiary Notice (ABN) language on page 2. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6321 which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy cap exceptions for 2009 and updates the dollar amount of the therapy caps for 2009. Be sure billing staff is aware of the updates.

Background

The Balanced Budget Act of 1997 established limits on outpatient therapy services. These limits change annually. The Deficit Reduction Act of 2005 allowed CMS to establish an exceptions process, which began January 1, 2006 and was extended by later legislation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) **extended the exceptions process for therapy caps through December 31, 2009. CR 6321 makes no change to the exceptions process.**

CR 6321 revises the Medicare Claims Processing Manual Chapter 5, Section 10.2 (The Financial Limitation) to include the outpatient therapy cap exceptions for 2009. The revised manual chapter is included as attachment to CR6321, and the following is extracted from that attachment:

Financial limitations on outpatient therapy services, as described in the Medicare Claims Processing Manual (Chapter 5, Section 10.2 (The Financial Limitation)) were \$1740 in 2006, \$1780 in 2007, and \$1810 for 2008.

For 2009,

- **The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1840.00; and**
- **The separate limit for occupational therapy is \$18400.00.**

An **Advance Beneficiary Notice of Noncoverage (ABN)** is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements before the cap is reached. The ABN

informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. **Since therapy that exceeds the cap is statutorily excluded from Medicare coverage, the ABN is not required.** However, the ABN may be used on a voluntary basis to inform the beneficiary of potential liability for therapy that exceeds the cap.

Note: The ABN-G is no longer effective as of March 1, 2009. The revised ABN (CMS-R-131) must now be used and the revised ABN is available for download at <http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip> on the CMS website.

Additional Information

The official instruction, CR 6321, issued to your carrier, FI, MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1678CP.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.





New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers' Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

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

MLN Matters Number: MM5371 Revised	Related Change Request (CR) #: 5371
Related CR Release Date: March 20, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1703CP & 65MSP	Implementation Date: July 6, 2009

Note: This article was revised on March 20, 2009, to reflect a revised transmittal related to CR 5371. The CR was changed to clarify some of the requirements. The CR release date, transmittal numbers (see above), and the Web address for accessing that transmittal were changed. All other information remains the same.

Provider Types Affected

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

Background

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

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

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

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

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

Additional Information

You can find the official instruction (CR 5371) issued to your Medicare contractor in two transmittals: <http://www.cms.hhs.gov/Transmittals/downloads/R1703CP.pdf>, and <http://www.cms.hhs.gov/Transmittals/downloads/R65MSP.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 Medicare Claims Processing Manual (Publication 100-04), Chapter 15, 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: MM6347	Related Change Request (CR) #: 6347
Related CR Release Date: March 6, 2009	Effective Date: April 1, 2009
Related CR Transmittal #: R1696CP	Implementation Date: April 6, 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.

Provider Action Needed

This article is based on Change Request (CR) 6347 which implements significant changes to the *Internet Only Manual Publication 100-04, Chapter 15*. Most of the changes in CR 6347 have already been communicated via prior change requests and related MLN Matters articles. The key purpose of CR 6347 is to eliminate references to the reasonable charge payment methodology and the transition to the Ambulance Fee Schedule, which took place from April 2002 until December 2006, in the actual Medicare manual. Please make sure your staff is familiar with these changes.

Background

Medicare has revised the *Medicare Claims Processing Manual, Chapter 15 – Ambulance* section. Some sections have been added and other sections have been renumbered. Most of the added information has been conveyed in prior MLN Matters articles related to ambulance services.

Key Points:

The most important changes for providers of ambulance services are listed as follows:

References to statues and regulations have been updated as follows:

Section 1861(s) (7) of the Social Security Act (Act) establishes an ambulance service as a Medicare Part B service. Payment for ambulance services is addressed at Section 1834(l) of the Act. Coverage rules are addressed at 42 Code of Federal Regulations (CFR), Section 410.40. Additional rules, including rules regarding vehicular and staffing requirements, are specified at 42 CFR 410.41. Payment rules under the fee schedule established in 2002 are specified at 42 CFR Part 414, Subpart H (414.601 et seq.). Payment rules for ambulance services furnished by a Critical Access hospital (CAH) or by an entity owned and operated by a CAH are specified at 42 CFR 413.70(b) (5). Other general Medicare provisions apply to ambulance services. See Title XVIII of the Act and 42 CFR Parts 400 to 429 to determine applicability.

References to Centers for Medicare & Medicaid Services (CMS) manual instructions for ambulance providers have been updated as follows:

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the *Medicare Benefit Policy Manual*, Chapter 10, which is available at <http://www.cms.hhs.gov/manuals/downloads/bp102c10.pdf> on the CMS website.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the *Medicare Program Integrity Manual*, Chapter 6 at <http://www.cms.hhs.gov/manuals/downloads/pim83c06.pdf> on the CMS website.

A summary of the ambulance services benefit has been provided in the revised manual as follows:

Ambulance services are covered under Medicare Part B. However, a Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

- Actual transportation of the beneficiary occurs.
- The beneficiary is transported to an appropriate destination.
- The transportation by ambulance must be medically necessary, i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated.
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.
- The transportation is not part of a Part A service.

Other requirements specified in CR6347 or in the above-cited CMS Manuals may also apply to the provider/supplier or to a particular transport or billing.

New and revised definitions related to ambulance claims processing have been added as follows:

- **A/MAC** - For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for institutionally-based ambulance providers billed on CMS-1450 Form (UB04) and/or a Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant ANSI X12N 837I electronic transaction.
- **B/MAC** - For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for ambulance suppliers billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction.
- **Date of Service** - The date of service (DOS) of an ambulance service is the date that the loaded ambulance vehicle departs the point of pickup (POP). 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 the date of the 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 the date of the vehicle's takeoff.
- **Provider** - For the purposes of this Chapter 15 of the *Medicare Claims Processing Manual* only, the term "provider" is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient

rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e) of the Act, a fund.

- **Supplier** - For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term supplier is defined as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse based ambulance, etc., that provides Part B Medicare covered ambulance services and is enrolled as an independent ambulance supplier.

Claims Jurisdiction

Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

Adjustments for Fee Schedule (FS) Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2009. For ground ambulance transport services furnished where the POP is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors.

Billing Instruction Reminder Information

Independent ambulance suppliers may bill on CMS-1500 Form or the ANSI X12N 837P data set. These claims are processed using the Multi-Carrier System (MCS).

Institution based ambulance providers may bill on CMS-1450 Form or the ANSI X12N 837I. These claims are processed using the Fiscal Intermediary Shared System (FISS).

Institutional providers and suppliers must report an origin and destination modifier for each ambulance trip provided in Healthcare Common Procedure Coding System (HCPCS)/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

- D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
- E = Residential, domiciliary, custodial facility (other than 1819 facility);
- G = Hospital based end stage renal disease (ESRD) facility;
- H = Hospital;
- I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- J = Freestanding ESRD facility;
- N = Skilled nursing facility;
- P = Physician's office;
- R = Residence;
- S = Scene of accident or acute event;
- X = Intermediate stop at physician's office on way to hospital (destination code only)

In addition, institutional providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

- QM - Ambulance service provided under arrangement by a provider of services; or
- QN - Ambulance service furnished directly by a provider of services.

While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination.

Additional Information

The official instruction, CR 6347, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1696CP.pdf> on the CMS website. The revised portions of Chapter 15 of the *Medicare Claims Processing Manual* are attached to CR6347.

A version of the Ambulance Fee Schedule is also posted to the CMS website (http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp) for public consumption.

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





Providers Submitting Information Regarding Medicare Beneficiaries Entitled to Medicare Advantage (MA) for Fiscal Year (FY) 2006 for the Medicare/Supplemental Security Income (SSI)

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: MM6329	Related Change Request (CR) #: 6329
Related CR Release Date: March 6, 2009	Effective Date: Discharges on or after October 1, 2005 through September 30, 2006
Related CR Transmittal #: R1695CP	Implementation Date: July 6, 2009

Provider Types Affected

Inpatient Prospective Payment System (IPPS) hospitals that received Disproportionate Share Hospital (DSH) and Inpatient Rehabilitation Facilities (IRF)) that received Low Income Patients (LIP) payments and which provided care to Medicare Advantage (MA) Beneficiaries during FY 2006. IPPS hospitals that did not receive DSH payments and IRFs that did not receive LIP payments may also want to review this article.

What You Need to Know

Change Request (CR) 6329, from which this article was taken, advises hospitals that received DSH payments and IRFs that received LIP payments are required to submit informational only bills to your Medicare contractor (fiscal intermediary (FI) or Medicare Administrative Contractor (MAC)) for the MA beneficiaries that you treated on or after October 1, 2005 through September 30, 2006 (FY 2006). IPPS hospitals and IRFs that did not receive such payments have the option of submitting FY 2006 informational claims for MA patients, but they are not required to do so. These claims are needed to ensure that the SSI data for FY 2006 accurately reflects MA patient days for purposes of DSH or LIP calculations. Hospitals must submit their FY 06 claims between July 1, 2009 and November 30, 2009.

Teaching hospitals should have already submitted their MA claims with Condition Codes 04 and 69 in order to be reimbursed for their Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) payment. Therefore, teaching hospitals must not re-submit MA claims and are not affected by CR 6329.

Background

Part of the calculation that Medicare uses to determine whether a hospital is eligible for DSH/LIP add-on payments is based on the percentage of days for which the Medicare Part A entitled beneficiary received SSI payments from the Social Security Administration (SSA).

Effective July 1, 2009, IPPS hospitals and IRFs must submit informational only bills to your Medicare contractor for the MA beneficiaries that you treated on or after October 1, 2005 through September 30, 2006 (FY 2006).

Specifically, hospitals and IRFs need to submit informational only claims (**Covered 11X Type of Bill (TOB)**, not 110), showing Medicare Fee-for-Service (FFS) as the primary payer, no Medicare Secondary Payer (MSP), condition code 04, the beneficiary's Medicare Health Insurance Claim (HIC) number, and all other required Medicare fee-for-service claim data elements needed for the inpatient claim for MA

beneficiary discharges on or after October 1, 2005 through September 30, 2006. In addition, IRFs will also need to append Case Mix Group (CMG) A9999 to the Revenue Code 0024 line and include the discharge date in the 'service date' field.

You should be aware that:

1. Teaching hospitals should have already submitted their MA claims with Condition Codes 04 and 69 in order to be reimbursed for their Indirect Medical Education (IME) payment. Therefore, teaching hospitals must not re-submit MA claims and are not covered under this instruction; and
2. IPPS hospitals and IRFs that did not qualify for DSH/LIP payments in FY 2006 have the option to submit FY 2006 MA claims, but are not required to do so.

Also please note that your Medicare contractors will override timely filing for covered 11X TOBs, will suppress the Medicare Summary Notice (MSN) on covered 11X TOBs when Condition Code 04 is present, remove deductible; and will reject claims that contain Condition Code 04 and no MA record exists in Medicare's files for the beneficiary.

Additional Information

You can find more information about capturing MA days in SSI information for DSH or LIP calculations during Fiscal Year (FY) 2006 by going to CR 6329, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1695CP.pdf> on the CMS website.

You will find the updated *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), Sections 20.3 (Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients) and 140.2.4.3(Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)) as an attachment to that CR.

Also, the IPPS regulations on DSH are located in 42 CFR 412.106 which you can read at http://edocket.access.gpo.gov/cfr_2003/octqtr/pdf/42cfr412.106.pdf and the Inpatient Rehabilitation Facility (IRF) PPS regulations on Low-Income Patients (LIP) are located in 42 CFR 412.624(e)(2), which is at http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr412.624.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.





Healthcare Provider Taxonomy Codes (HPTC) Update

The Healthcare Provider Taxonomy Codes (HPTC) set is maintained by the National Uniform Claim Committee (NUCC) for standardization classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes/taxonomy> in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

HIPAA requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type of physician, practitioner, or supplier specialty for a claim. Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.

Although the NUCC generally posts their updated on the WPC webpage three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

CMS Change Request 6382





J10 A/B Medicare Administrative Contractor New Workload Numbers

The purpose of this Change Request (CR) is to notify all interested parties that the Centers for Medicare and Medicaid Services (CMS) needs to change the contractor workload numbers for the Part A and Part B workloads in the States of Alabama, Georgia, and Tennessee when that workload is transitioned to the J10 A/B MAC. These changes need to be made because certain CMS applications need to individually identify each workload. These workloads will be transitioned to the J10 A/B MAC as indicated below.

<u>PART A</u>	<u>MAC Workload No.</u>	<u>Effective Date</u>	<u>Current Contractor No.</u>
Alabama	10101	5/18/2009	00010
Georgia	10201	5/04/2009	00101
Tennessee	10301	8/03/2009	00390

<u>PART B</u>	<u>MAC Workload No.</u>	<u>Effective Date</u>	<u>Current Contractor No.</u>
Alabama	10102	5/04/2009	00510
Georgia	10202	8/01/2009	00511
Tennessee	10302	8/29/2009	05440

The Part B Tennessee workload is currently processed in the same CICS user acceptance testing (UAT) and production region as the Part B Idaho workload. While the Part B TN workload will be processed by the Jurisdiction 10 (J10) A/B MAC, the Part B Idaho workload will be processed by the J2 A/B MAC. Accordingly, these two workloads will need to be split into separate CICS UAT and production regions. It is CMS' intent to split this workload on August 29, 2009 and simultaneously transition both workloads to their appropriate MACs.

Please note that the effective date of all transitions will fall on Monday, with the exception of the Part B Georgia and Tennessee transitions which, due to the software being used to create and populate those CICS production regions, will have effective dates that fall on a Saturday.

Cahaba Government Benefit Administrator, LLC, will be the Jurisdiction 10 A/B MAC. It currently processes the Alabama A and B, and Georgia B workloads, and it is located at the following address.

Cahaba GBA
300 Corporate Parkway
Birmingham, AL 35242

The Georgia Part A workloads is currently processed by:
BCBS Georgia – Medicare
PO Box 9048
2357 Warm Springs Road
Columbus, GA 31908

The Tennessee Part A workloads is currently processed by:
Riverbend
730 Chestnut Street
Chattanooga, TN 37402

The Tennessee Part B workload is currently processed by:
CGS Government Services
2 Vantage Way
Metro Center
Nashville, TN 37228

The following applications or entities will need to accommodate the new MAC workload numbers for both testing and production: BESS, CAFM, CERT, CMIS, the CMS BALTIMORE DC, COBA & COBC, CROWD, PIES, CSAMS, CWF, DCS, ECRS, FISS, HCIS, HIGLAS, IRIS, the Local Coverage Determination (LCD) Database, LOLA, NGD, the NPI crosswalk, QIES (formerly known as OSCAR), PECOS, PIMR, PORS, PS&R, the PSC, PSOR, PULSE, REMAS, REMIS, STAR, and the Expert Claims Processing System or ECPS (formerly known as SuperOps).

In the event any of these MAC transitions need to be delayed, the CMS will provide as much notice as possible to the above system owners, but no less than five business days prior to the planned effective date. The above listed systems will need to be able to accommodate such a delay to the start of the MAC transition.

Finally, the CMS is studying how best to transition to the applicable MACs the workload covered by contractor workload number 52280, which was formerly processed by Mutual of Omaha and is currently processed by Wisconsin Physicians Service (WPS). The CMS will notify all parties as soon as its instructions are final.

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.

CMS Change Request 6436





Instructions for Utilizing 837 Professional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part B Claims (This CR rescinds and fully replaces CR6211)

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: MM6427	Related Change Request (CR) #: 6427
Related CR Release Date: March 27, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R67MSP	Implementation Date: July 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6427 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions. CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

What You Need to Do

Include your CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements,

- Physician and suppliers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic Remittance Advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the CMS Internet Only Manuals 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Additional Information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> 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.





Instructions on Utilizing 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims (This CR Rescinds and Fully Replaces CR 6275)

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: MM6426	Related Change Request (CR) #: 6426
Related CR Release Date: March 27, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R66MSP	Implementation Date: July 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 services provided to Medicare beneficiaries.

What You Need To Know

CR 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their use of data reported in ANSI ASC X12N 837 institutional CAS segments for MSP Part A Claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the ‘Background’ and ‘Additional Information’ sections of this article for further details regarding these changes.

Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary’s primary insurance. Medicare’s secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is Obligated to Accept as Payment in Full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to

make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements;
- Providers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 Institutional claim.

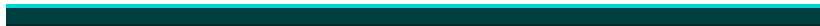
Adjustments made by the payer are reported in the CAS segment on the 835 Electronic Remittance Advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as Value Code 44 in the 2300 HI Value Information. This amount is also known as the Obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the CMS Medicare Secondary Payer Manual and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional Information

You can find the official instruction (CR 6426) issued to your FI, RHHI, or MAC by visiting <http://www.cms.hhs.gov/transmittals/downloads/R66MSP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated Medicare Secondary Payer (MSP) Manual, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

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





Medicare Claims Processing Manual Clarifications for Skilled Nursing Facility (SNF) and Therapy 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: MM6407	Related Change Request (CR) #: 6407
Related CR Release Date: March 27, 2009	Effective Date: October 1, 2006
Related CR Transmittal #: R1706CP	Implementation Date: April 27, 2009

Provider Types Affected

Skilled Nursing Facilities and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6407, which includes clarifications to the Medicare Claims Processing Manual for Skilled Nursing Facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

Change Request (CR) 6407 provides clarifications and updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new Current Procedural Terminology (CPT) code 95992 (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per Day*) is bundled under the Medicare Physician Fee Schedule (MPFS).

Regardless of whether CPT code 95992 is billed alone or in conjunction with another therapy code, **separate Medicare payment is never made for this code**. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 (“Payment is included in the allowance for another service/procedure.”). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that **both full and partial benefits exhaust claims must be submitted by SNFs monthly**. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1. Full benefits exhaust claims: no benefit days remain in the beneficiary’s applicable benefit period for the submitted statement covers from/through date of the claim; and
2. Partial benefits exhaust claims: only one or some benefit days, in the beneficiary’s applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 (SNF no-payment bill type).

Additional Information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1706CP.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.





Incorporation of Physician Fee Schedule Regulatory Changes Into Chapter 10 of the Program Integrity Manual (PIM)

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

MLN Matters Number: MM6310 Revised	Related Change Request (CR) #: 6310
Related CR Release Date: April 15, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R289PI	Implementation Date: April 1, 2009

Note: This article was revised on **April 16, 2009**, to reflect a revision made to CR 6310. Specifically, the Centers for Medicare & Medicaid Services modified two requirements of CR 6310. The specific change in this article is in the last bullet point under “Timeframes for reporting changes of information”. That bullet point was changed to show that an overpayment may be assessed. Previously, it stated an overpayment will be assessed. The CR release date, transmittal number, and the Web address for accessing the CR have also been revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

All Medicare physicians, providers, and suppliers, as well as those who are considering applying to participate in the program should be aware of the new rule and of upcoming changes to the Medicare enrollment process.

Background

Change Request (CR) 6310 implements regulatory changes found in the CY 2009 Medicare Physician Fee Schedule final rule with comment (CMS-1403-FC). Significant changes are summarized below.

Effective date of Medicare billing for physicians, certain non-physician practitioners, and Physician and Non-Physician Practitioner Organizations

- Carriers and Part A and Part B Medicare Administrative Contractors (A/B MACs) will establish the effective date of Medicare billing privileges (see 42 CFR 424.520(d)) for physicians, non-physician practitioners, and physician or non-physician practitioner organizations. Physicians, non-physician practitioners and physician and non-physician practitioner organizations will no longer be allowed to establish retrospective Medicare effective billing dates.
- Carriers and A/B MACs will establish an effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and physician and non-physician practitioner organizations (e.g., clinics/group practices).

- The effective date of Medicare billing privileges for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. Note: The date of filing for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement that were both processed to completion.
- The individuals and organizations identified above may, however, retrospectively bill for services when:
 - The supplier has met all program requirements, including state licensure requirements, **and**
 - The services were provided at the enrolled practice location for up to-
 - 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
 - 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

Timeframes for Reporting Changes of Information

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph; the following changes must be reported within 30 days:
 - A change of ownership;
 - A final adverse action; or
 - A change in practice location.
- If an individual or organization identified above does not comply with the reporting requirements relating to, respectively, final adverse actions and practice location changes, the supplier may be assessed an overpayment back to the date of the final adverse action or change in practice location.

Application Rejections and Denials for Physician and Certain Non-Physician Practitioner Applications

- Carriers and A/B MACs will deny, rather than reject, incomplete applications submitted by physicians, non-physician practitioners, and physician or non-physician practitioner organizations.
- This change will allow the individuals and organizations identified above to preserve their effective date of filing by submitting a corrective action plan or an appeal and submitting the missing information/documentation to allow the carrier or A/B MAC to adjudicate the enrollment application to completion.

Revocation Effective Dates

- A revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction, (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that the Centers for Medicare & Medicaid Services (CMS) or its contractor determined that the provider or supplier is no longer operational.
- Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., clinic/group practices) consisting of the individuals previously identified, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

Requirements for Maintaining Ordering and Referring Documentation

- Carriers or A/B MACs may revoke the billing privileges of any provider or supplier that fails to comply with Medicare's ordering and referring documentation requirements as specified in 42 CFR 424.5216 (f).
- Such revocation is also possible in cases where the physician or non-physician practitioner fails to maintain written ordering and referring documentation for seven (7) years from the date of service.
- Off-site or electronic storage of the ordering and referring documentation described in 42 CFR §424.516(f) is not precluded, as long as these records are readily accessible and retrievable.

Other Changes

- Final adverse action is defined.

Additional Information

The official instruction (CR 6310) issued to your carrier, FI, and A/B MAC, regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R289PI.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.





Surgery for Diabetes National Coverage Determination (NCD)

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: MM6419	Related Change Request (CR) #: 6419
Related CR Release Date: April 17, 2009	Effective Date: February 12, 2009
Related CR Transmittal #: R100NCD and R1711CP	Implementation Date: May 18, 2009

Provider Types Affected

All hospitals and physicians who bill Medicare Carriers, Fiscal Intermediaries (FIs), or Medicare Administrative Contractors (MACs) for bariatric surgery procedures.

Provider Action Needed

Providers are advised that the Centers for Medicare & Medicaid Services (CMS) has developed the following NCD entitled Surgery for Diabetes:

- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) in Medicare beneficiaries who have type 2 diabetes mellitus (T2DM) and a body mass index (BMI) <35 are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and therefore are not covered by Medicare.
- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB are covered for Medicare beneficiaries who have T2DM and a BMI \geq 35. Additionally, CMS determines that T2DM is a comorbidity related to obesity as defined in Publication 100-03, NCD Manual, Section 100.1. In addition, the procedure must be performed at an approved facility. A list of approved facilities may be found at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage> on the CMS website.

Ensure that your billing staffs are informed of these changes for preparing claims for covered or non-covered bariatric surgery.

Background

CMS has a specific NCD at section 100.1 (attached to CR 6419), Bariatric Surgery for Treatment of Morbid Obesity, effective February 21, 2006. That NCD covers open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB for persons with a BMI \geq 35 having one or more comorbidities associated with obesity, and have been previously unsuccessful with medical treatments for obesity. The only change to this NCD is the clarification that effective February 12, 2009, T2DM is considered a comorbidity for purposes of bariatric surgery for the treatment of morbid obesity.

NOTE: This NCD does not change related NCDs in the NCD Manual at sections 40.5 (Obesity), 100.8 (Intestinal Bypass Surgery), or 100.11 (Gastric Balloon for Treatment of Obesity). In addition, treatments for obesity alone remain non-covered, as does use of the open or laparoscopic sleeve gastrectomy, open

adjustable gastric banding, and open and laparoscopic vertical banded gastroplasty procedures, regardless of the patient's BMI or comorbidity status.

The covered ICD-9 procedure and HCPCS procedure codes are listed in Attachment 1 of the transmittal of CR 6419 containing the *Medicare Claims Processing Manual* revisions. The ICD-9 diagnosis codes reflecting the requisite BMI indexes are also part of that attachment. The ICD-9 diagnosis codes indicating T2DM are listed in Attachment 2 of that same transmittal.

The remittance advice for claims for bariatric surgery that are denied or rejected by Medicare because the patient's BMI was <35 will contain a Claim Adjustment Reason Code of 167 (This (these) diagnosis(es) is (are) not covered.), a Remittance Advice Remark Code of N372 (Only reasonable and necessary maintenance/service charges are covered.), and a Group Code of OA (Other adjustments).

Additional Information

The official instruction, CR 6419, issued to your carrier, FI, or MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is at <http://www.cms.hhs.gov/Transmittals/downloads/R1711CP.pdf> on the CMS website. The second transmittal modifies the NCD Manual and it is available at <http://www.cms.hhs.gov/Transmittals/downloads/R100NCD.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.





Hospice Cap Calculations Letters and Administrative Appeals

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

MLN Matters Number: MM6400	Related Change Request (CR) #: 6400
Related CR Release Date: April 3, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1708CP	Implementation Date: July 6, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6400 which requires Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap. The letter you receive will include the inpatient and aggregate cap calculation results. Additionally, it will include appeals language in every determination of program reimbursement letter. If you have exceeded the cap, the letter will include a demand for repayment.

Background

The law governing payment for hospice care subjects hospice payments to two statutory caps:

- A cap on payments for inpatient days, described in Section 1861(dd)(2)(A)(iii) of the Social Security Act and
- An aggregate cap on total payments, described in Section 1814(i)(2)(A)-(C).

These statutory caps limit total hospice payments during a cap year. Payments in excess of either cap must be refunded. Currently, after the end of the cap year, the applicable contractor (RHHI, FI, or A/B MAC) computes both cap amounts, and determines the amount of program reimbursement for each hospice provider they serve.

Important Information:

The latest hospice cap amount for the cap year ending October 31, 2008 is \$22,386.15. The hospice cap is discussed further in the *Medicare Claims Processing Manual* (Chapter 11 - Processing Hospice Claims, Section 80.2) which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the Centers for Medicare & Medicaid Services website. Your contractor (RHHI, FI, or AB MAC) will issue a letter to notify you of the results of the contractor's cap calculations and to serve as your determination of program reimbursement. If there is a cap overpayment, there will be an accompanying demand for repayment.

Administrative Appeals:

As indicated in section 418.311 of 42 CFR, if you believe that your payments have not been properly determined, you may request a review from the applicable contractor if the amount in controversy is \$1,000 or more, but less than \$10,000, or from the Provider Reimbursement Review Board (PRRB) if the amount in

controversy is \$10,000 or more. Appeal requests must be in writing and be filed within 180 days from the date of the determination. Your appeal rights are discussed further in the *Medicare Claims Processing Manual* (Chapter 11 - Processing Hospice Claims, Section 80.3), which is attached to CR 6400.

Additional Information

The official instruction, CR 6400, issued to your RHHI, FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1708CP.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.





Billing Routine Costs of Clinical Trials

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: MM6431	Related Change Request (CR) #: 6431
Related CR Release Date: April 10, 2009	Effective Date: July 10, 2009
Related CR Transmittal #: R1721CP	Implementation Date: July 10, 2009

Provider Types Affected

Physicians and non-physician practitioners submitting claims to Medicare Administrative Contractors (MACs) and carriers for clinical trials.

Provider Action Needed

This article is based on Change Request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

Background

CR 6431 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trials). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the QV or Q1 modifier is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor will not consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:
 - Claims adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication; and
 - As least one Remark Code, which may be comprised of either:
 - The Remittance Advice Code (M76, Missing/incomplete/invalid diagnosis or condition) or
 - National Council for Prescription Drug Programs Reject Reason Code.

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

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30;
- Report a secondary diagnosis code of V70.7; and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
 - QA/QR for dates of service before January 1, 2008; or
 - Q0 for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
 - QV for dates of service before January 1, 2008; or
 - Q1 for dates of service on or after January 1, 2008.

Institutional providers should also note that they must not bill outpatient clinical trial services and non-clinical trial services on the same claim for Medicare beneficiaries enrolled in managed care plans.

Additional Information

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1710CP.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.





Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)

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: MM6207	Related Change Request (CR) #: 6207
Related CR Release Date: March 27, 2009	Effective Date: April 27, 2009
Related CR Transmittal #: R1707CP	Implementation Date: April 27, 2009

Provider Types Affected

Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) facilities, and Rural Health Clinics (RHCs) that are currently enrolled with a Fiscal Intermediary (FI) or a Medicare Administrative Contractor (MAC), and FQHCs, RHCs, and ESRD facilities that are planning to submit an 855 initial enrollment application.

Provider Action Needed

This article is based on Change Request (CR) 6207, which describes initial enrollment policy for assignment of FQHCs, ESRD facilities, and RHCs.

What You Need to Know

As FQHCs, ESRD facilities, and RHCs seek to enroll in the Medicare program, they should file their enrollment applications with the legacy FI or MAC that covers the state where they are located. Exceptions to the geographic assignment rule are set forth in MM 5979, which can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. This represents a shift from legacy-world assignment policy where there existed regional and national FIs for these distinct provider types.

What You Need to Do

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

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 911) amended the Social Security Act (the Act; Title XVIII) to add Section 1874A (Contracts with Medicare Administrative Contractors (MACs)) which replaces the prior Medicare intermediary and carrier contracting authorities formerly found in Sections 1816 and 1842 of the Act. CMS procured the first Part A/B Medicare Administrative Contractor (A/B MAC) in 2006 and continues to award the fifteen A/B MAC contracts. The process of moving workload from legacy contractors to the MACs continues.

The MMA also repealed the provider nomination provision of the Social Security Act and replaced it with the geographic assignment rule. Generally, a provider or supplier will be assigned to the MAC that covers the state where the provider or supplier is located. Exceptions to the geographic assignment rule are described in MM 5979, which can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf> on the CMS website.

In the legacy FI environment, FQHCs, RHCs, and ESRD facilities were concentrated within the workloads of several regional and national FIs.

Most of the providers that were assigned to regional or national FIs represent “Out-of-Jurisdiction Providers” (OJPs). An OJP is defined as a provider that is not currently serviced by the FI or MAC that covers the state where the provider is located. Regional and national Medicare contractors for FQHCs, RHCs, and ESRD facilities will not exist in the MAC environment.

FQHCs

Most FQHCs are currently within the workload serviced by National Government Services (NGS) Wisconsin. The Jurisdiction 6 MAC will absorb this workload. FQHCs in the NGS workload will be transferred to their destination MACs during the OJP migration. The destination MAC will not always be the geographic MAC.

Indian Health Service (IHS) facilities will be assigned to the Jurisdiction 4 MAC. For purposes of CR 6207, “tribal FQHC” means a Medicare FQHC operated by a tribe or tribal organization under the Indian Self-Determination Act (25 USCS 40(b)) or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 USCS 13). All other freestanding FQHCs, not meeting that tribal description, will be assigned to the MAC that covers the state where the facility is located.

CMS is implementing the geographic assignment rule for initial enrollment FQHCs now to avoid creating additional OJPs. An initial enrollment for an IHS FQHC will be submitted to the Jurisdiction 4 MAC. A new, non-tribal FQHC will submit its initial CMS-855A application to the FI or MAC that covers the state where the facility is located.

Some classes of FQHCs may present latent challenges for the geographic assignment rule. However, CMS will make accommodations for these providers. For example, if an initial enrollment FQHC satellite is located in the jurisdiction of a MAC other than the audit MAC, then the geographic MAC will service the claims, and the audit MAC will service the cost report.

RHCs and ESRD Facilities

RHCs and many ESRD facilities have been serviced by a limited set of regional FIs in the legacy environment. Those legacy FI workloads will be absorbed by incoming MACs. Out-of-jurisdiction RHCs and ESRD facilities will be transferred to their destination MACs during the OJP migration. An initial enrollment for a RHC or ESRD facility will be submitted to the MAC or FI that serves the state where the RHC or ESRD facility is located.

Note: If the FQHC, RHC or ESRD facility is provider-based, it will be assigned to the FI or MAC that covers the state where the main provider is located.

Misfiled CMS 855-A Applications

If a FQHC, RHC or ESRD facility submits a CMS-855A initial application to an incorrect Medicare contractor, the receiving contractor will mail the application to the appropriate contractor and notify the provider that its application has been sent to the new contractor and that all future questions regarding the application should be directed to the new contractor.

Internet-based PECOS

FQHCs, RHCs, and ESRD facilities will not be able to use Internet-based PECOS for the filing of CMS-855A initial applications, changes of ownership, or changes of information. Only paper forms will be accepted for these transactions.

The following is a table that summarizes the changes of CR 6207:

Facility	New Enrollment Applications
FQHC	FI/MAC covering the state where they are located
RHC	FI/MAC covering the state where they are located
ESRD	FI/MAC covering the state where they are located
IHS FQHC	J4 MAC
Provider-based FQHC	FI/MAC servicing the main pr

Additional Information

The official instruction (CR 6207) issued to your Medicare contractor, regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1707CP.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 Capital to Inpatient Prospective Payment System (IPPS) Indirect Medical Education (IME) and Long Term Care Hospital (LTCH) Provisions from the American Recovery and Reinvestment Act (ARRA) of 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: MM6444	Related Change Request (CR) #: 6444
Related CR Release Date: March 27, 2009	Effective Date: February 17, 2009
Related CR Transmittal #: R466OTN	Implementation Date: April 6, 2009

Provider Types Affected

Inpatient Acute Care Hospitals and LTCHs that bill Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article discusses provisions of the American Recovery and Reinvestment Act (ARRA) that impact capital Inpatient Prospective Payment System (IPPS) payments to hospitals for Indirect Medical Education (IME) and changes to certain LTCH Prospective Payment System (PPS) payment policies. Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed with an incorrect payment amount for IME and/or short-stay outlier claims of LTCHs with a teaching program. **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 six months of Pricer software installation at your contractor. That installation is scheduled to occur on or before April 6, 2009.

Background

The ARRA was signed into law on February 17, 2009. Change Request (CR) 6444 provides a summary of the legislation as well as implementation instructions on certain provisions that affect the Medicare Fee-for-Service program.

The first key point of the legislation affects capital IPPS IME payments for fiscal year (FY) 2009. Beginning in FY 2009, hospitals were to receive 50 percent of the capital IME adjustment provided under the current formula. Section 4301(b)(1) of the ARRA removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009. The AARA also explicitly specifies that the elimination of the capital IME adjustment in FY 2010 and subsequent years is not to be affected. Therefore, beginning in FY 2010 and after, under current law, hospitals will no longer receive a teaching adjustment under the capital IPPS. This provision also affects LTCH PPS payments as part of the Short Stay Outlier (SSO) calculation. The revision to the capital IPPS IME adjustment for FY 2009 provided for by section 4301(b)(1) of the ARRA also affects the payments for some SSO cases from LTCHs with teaching programs since the calculation of the “IPPS comparable amount” component of the SSO “blend” option must also be revised to reflect the change to the capital IME adjustment for FY 2009 provided for in the ARRA. In the same way as with the SSO calculation, changes to the capital IME payments specified by the ARRA of 2009 affect LTCH PPS payments governed by the “25 percent” threshold payment adjustments. Under these policies, those cases in excess of the applicable thresholds are paid an amount based on an amount **equivalent** to what would be

paid under the IPPS. Therefore, the revision to the capital IPPS IME adjustment for FY 2009 provided for in section 4301(b) would apply to those LTCHs with teaching programs.

A second key point of the legislation affects LTCHs. The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 placed a moratorium on new LTCHs or new LTCH satellites and expansions in the number of beds in existing LTCHs, effective December 29, 2007. MMSEA allowed for limited exceptions to the moratorium. The ARRA makes one additional exception to the moratorium that will allow existing LTCHs to expand the number of beds in the LTCH or its satellite if the hospital obtained a certificate of need for an increase in beds in a State for which such certificate of need is required that was issued on or after April 1, 2005, and before December 29, 2007.

A third key point of the legislation also affects LTCHs. As noted above, CMS regulations create special payment provisions for LTCHs or LTCH satellites that receive more than 25 percent of their admissions from a single referral source. The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located. The ARRA also extended the increase in percentages under the 25 percent threshold policy to include “grandfathered” LTCH satellites, i.e., those in existence prior to October 1, 1999 and changed the implementation date of all changes to the 25 percent threshold payment adjustment from the date of enactment of the MMSEA (December 29, 2007), to either July 1, 2007 or October 1, 2007, as appropriate for the specific provision.

Additional Information

The official instruction (CR 6444) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R466OTN.pdf> on the CMS website.

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