

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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Provider Contact Center (PCC) Hours

The Provider Contact Center may be reached Monday through Friday at the following toll-free numbers:

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

Key for Icons:

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

Disclaimer

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

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ICD-9 Notice

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Provider Contact Center – Training Schedule

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

CSR Training Dates	Time
Friday, June 12, 2009	9:00 a.m.- 11:00 a.m. CST
Friday, June 26, 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.





Alabama

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

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

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.	841
777	APASS MODULE REJECTION An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	837
207	INVALID PATIENTS SEX CODE The sex code for the patient was not= M, F, or U.	191
206	INVALID PATIENTS 1ST NAME/INITIAL The first name/initial of the patient on the submitted claim does not match the first name/initial of the beneficiary as we have it in our records.	188
333	INVALID PAT STATUS FOR TYPE BILL The patient's status was invalid for the type bill submitted.	133

Note: The top five reasons for claim rejections (May 2009) for Georgia Medicare Part A providers will be published in the July 2009 *Medicare A Newslines* and each monthly newsletter thereafter.



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:

Navigating the Cahaba GBA Website

Date: Tuesday, June 2, 2009

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

Registration is required for this event

Note: This class is closed; full at this time



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](#).



Subscribe to Cahaba GBA's E-mail Notification Service

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



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

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



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.



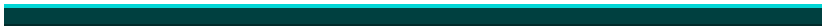
The General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet

The General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, 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/ICD-10_GEM_factsheet.pdf on the CMS website. The fact sheet is also available in print format. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”



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.



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.





Introductory Overview of HIPAA 5010

“An Introductory Overview of HIPAA 5010” is outlined in a MLN Matters® special edition article, SE0904. The implementation of these new HIPAA standards will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation. This introductory article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.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.



Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73x to 77x

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: MM6338	Related Change Request (CR) #: 6338
Related CR Release Date: April 24, 2009	Effective Date: April 1, 2010
Related CR Transmittal #: R477OTN	Implementation Date: April 1, 2010

Provider Types Affected

Federally Qualified Health Centers (FQHCs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A Medicare Administrative Contractors (A MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

On August 5, 2008, the National Uniform Billing Committee (NUBC) voted to change the TOB that is used to identify FQHCs from 73x to 77x effective April 1, 2010. Medicare fee-for-service payer and provider systems will be updated to accommodate this change of bill type. See the ‘Background’ and ‘Additional Information’ sections of this article for further details regarding these changes.

Background

FQHCs from 73x to 77x effective April 1, 2010. The NUBC created the new TOB for FQHCs because TOB 73x, which has historically been used for FQHCs, is technically designed to apply to free-standing clinics of any kind.

Note that when billing the FI or A MAC for FQHC service, TOB 77x will be used for both:

- Free-standing FQHCs, and
- Provider-based FQHCs.

For dates of service (DOS) on or after April 1, 2010, TOB 73x will continue to be a valid bill type for certain non-Medicare claims. See NUBC requirements for further details.


Most Medicare fee-for-service payer and provider systems will need to change in order to accommodate this change of bill type. All Medicare fee-for-service systems will implement the change of the TOB for FQHCs from 73x to 77x effective for all claims with DOS on or after April 1, 2010.

Effective with dates of service on or after April 1, 2010, Medicare will Return To Provider (RTP) any FQHC claims submitted on TOB 73x. Such claims will be returned with group code CO (Contractual Obligation) and adjustment reason code 5 (the procedure code/bill type is inconsistent with the place of service.). If this edit is received, you should resubmit with the 77x bill type.

Additional Information

The official instruction, CR 6338, issued to your FI and A MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R477OTN.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.





New Patient Discharge Status Code 21 to Define Discharges or Transfers to Court/Law Enforcement

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

MLN Matters Number: MM6385	Related Change Request (CR) #: 6385
Related CR Release Date: April 24, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R1718CP	Implementation Date: October 5, 2009

Provider Types Affected

Hospitals 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) 6385 which provides implementing instructions for a new patient discharge status code 21, which defines discharges or transfers to court/law enforcement. This includes transfers to incarceration facilities such as jail, prison, or other detention facility.

Background

The Centers for Medicare & Medicaid Services (CMS) has required Field Locator 17 (Patient Discharge Status Code) on the Uniform Billing Claims Form (UB-04) and its electronic equivalence. The Patient Discharge Status Code indicates the disposition or discharge status of the beneficiary on the submitted claims.

The National Uniform Billing Committee (NUBC) created a new Patient Discharge Status Code 21 to define discharges or transfers to court/law enforcement. Patient Discharge Status Code 21 usage includes transfers to incarceration facilities such as jail, prison or other detention facilities. Medicare systems will accept this code for claims with discharge dates on or after October 1, 2009.

Note that for Inpatient Prospective Payment System (IPPS) hospitals, the post-acute transfer payment policy will not apply to claims that contain Patient Discharge Status Code 21.

Additional Information

The official instruction, CR 6385, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1718CP.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.





Section 148 of The Medicare Improvements for Patients and Providers Act (MIPPA)

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

MLN Matters Number: MM6395	Related Change Request (CR) #: 6395
Related CR Release Date: May 8 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1729CP	Implementation Date: July 6, 2009

Provider Types Affected

Critical Access Hospitals (CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries. Rural Health Clinics (RHCs), Federally Qualified Health Clinics (FQHCs), and Skilled Nursing Facilities (SNFs) may also want to review this article, which clarifies information regarding payment to these entities for laboratory tests performed at an RHC, an FQHC, or a SNF.

What You Need to Know

CR 6395, from which this article is taken, announces a change in the payment methodology for Critical Access Hospitals (CAHs) submitting claims for certain outpatient clinical diagnostic laboratory tests.

As mandated by Section 148 of The Medicare Improvements for Patients and Providers Act (MIPPA), effective for services furnished on or after July 1, 2009, a CAH will be paid 101% of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient for whom these services are billed was not physically present in the CAH at the time the specimen is collected. In such cases, the CAH will receive 101% of reasonable cost for the outpatient clinical diagnostic laboratory test as long as the patient is an outpatient of the CAH and is receiving services directly from the CAH. For purposes of section 148, the patient is considered to be receiving services directly from the CAH if either one of the following qualifications is met: 1) The patient receives outpatient services in the CAH on the same day the specimen is collected, or 2) The specimen is collected by an employee of the CAH. If the patient is physically present in the CAH or a facility that is provider based to the CAH at the time the specimen is collected, neither of the above two conditions need to be met.

For purposes of payment when a patient is located in a SNF and the CAH employee goes to the SNF to collect a specimen, the CAH will only receive payment at 101% of reasonable cost once the patient's Medicare Part A days have expired. Prior to the patient's Part A days expiring, payment for the collection of a lab specimen at a SNF is included in the SNF's bundled payment.

For non-patients, tests are still to be billed on the Type of Bill (TOB) 14X and such claims will be paid based on the clinical laboratory fee schedule.

You should make sure that your billing staffs are aware of these changes..

Background

CR 3835 (Redefined Type of Bill (TOB), 14x, for Non-Patient Laboratory Specimens, issued on October 28, 2005), introduced a new definition of Type of Bill (TOB) 14X, to be used only for non-patient laboratory specimens, effective October 1, 2004; and also provided that Critical Access Hospitals (CAHs)

billing a 14X TOB for a non-patient laboratory specimen would be reimbursed under the Clinical Laboratory Fee Schedule. (You can find the MLN Matters® article related to this CR at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3835.pdf> on the Centers for Medicare & Medicaid Services (CMS) website). Tests for non-patients are still to be billed on the Type of Bill (TOB) 14X and such claims will be paid based on the clinical laboratory fee schedule.

However, CR 6395, from which this article is taken, changes the policy of who is considered an outpatient of a CAH when outpatient clinical diagnostic laboratory services are provided, effective for dates of service **on or after July 1, 2009**. Section 148 of MIPPA provides that the patient for whom the services are provided is no longer required to be physically present in the CAH at the time the specimen is collected; but must be an outpatient of the CAH (as defined by 42 CFR 410.2) as previously noted. If said outpatient requirements are met, a CAH can submit a 85X Type of Bill for outpatient clinical diagnostic laboratory tests for such patients for dates of service on or after July 1, 2009. Such services will be paid at 101% of reasonable cost.

Note that beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

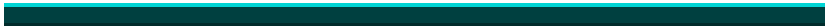
Please be aware that payment to a rural health clinic (RHC)/Federally Qualified Health Clinic (FQHC) for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. If the RHC/FQHC is provider-based, payment for laboratory tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for laboratory tests is made to the practitioner (physician) via the clinical laboratory fee schedule.

Additional Information

You can view CR 6395, the official instruction issued to your FI or MAC, at <http://www.cms.hhs.gov/Transmittals/downloads/R1729CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

The updated *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)), Chapter 13 (Radiology Services and Other Diagnostic Procedures), and Chapter 16 (Laboratory Services), are included as an attachment to CR 6395.

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: May 8 2009	Effective Date: October 1, 2005
Related CR Transmittal #: R1733CP	Implementation Date: April 27, 2009

Note: This article was revised on **May 11, 2009**, to reflect a revised CR 6407 issued by the Centers for Medicare & Medicaid Services on May 8, 2009. The CR release date, transmittal number, and the Web address for accessing CR 6407 were revised. All other information is the same.

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/R1733CP.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.





Surgery for Diabetes National Coverage Determination (NCD)-Revised

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

MLN Matters Number: MM6419 Revised	Related Change Request (CR) #: 6419
Related CR Release Date: May 4, 2009	Effective Date: February 12, 2009
Related CR Transmittal #: R100NCD & R1728CP	Implementation Date: May 18, 2009

Note: This article was revised on **May 5, 2009**, to reflect a revised CR 6419, which was issued by the Centers for Medicare & Medicaid Services on May 4, 2009. The CR transmittal number, release date and the Web address for accessing CR 6419 were revised. All other information remains the same.

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.

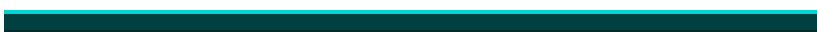
The covered ICD-9 procedure and HCPCS procedure codes are listed in Attachment 1 of the transmittal of CR 6419 containing the *Medicare Claims Processing Manual* revisions. The ICD-9 diagnosis codes reflecting the requisite BMI indexes are also part of that attachment. The ICD-9 diagnosis codes indicating 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/R1728CP.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.





Modification of the Common Working File (CWF) Copybook to Transmit “WC” Qualifier Alpha Codes to Various Systems

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: MM6438	Related Change Request (CR) #: 6438
Related CR Release Date: May 1, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R4870TN	Implementation Date: October 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6438 and is informational only for providers. In order to prevent Medicare’s paying primarily for future medical expenses that should be covered by workers’ compensation Medicare set-aside arrangements (WCMSA), a prior instruction from Medicare, CR 5371, provided your Medicare contractors with instructions on the creation of a new Medicare Secondary Payer (MSP) code in Medicare’s claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) has the capability to discontinue conditional payments for diagnosis codes related to WCMSA settlements.

Background

A 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 “WC” qualifier denotes a Workers’ Compensation Medicare Set-aside Arrangement.) CMS has a review process for proposed WCMSA amounts and updates its systems 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.

Change Request (CR) 5371 added the qualifier of “WC” to distinguish a WCMSA Medicare Secondary Payer (MSP) Auxiliary Record from a WC MSP record. An MLN Matters® article related to CR 5371 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf> on the CMS website.

Even though the “WC” qualifier was added by CR 5371, no adjustment was made to allow for the transfer of the WC modifier’s alpha codes from the CWF system to other important Medicare systems and CR 6438 will implement that transfer.

Additional Information

The official instruction, CR 6438, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R4870TN.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.





Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Coverage and Billing Updates

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: MM6445	Related Change Request (CR) #: 6445
Related CR Release Date: April 24, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R1719CP	Implementation Date: October 5, 2009

Provider Types Affected

All RHCs and FQHCs submitting claims and cost reports to Medicare contractors (Fiscal Intermediaries (FI), and Medicare Administrative Contractors (MAC)) for services and supplies provided to Medicare beneficiaries.

Provider Action Needed

This article describes change request (CR) 6445, which updates billing and cost reporting for the following preventive benefits and vaccines provided by Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) with various effective dates:

- Initial Preventive Physician Examination (IPPE);
- Ultrasound screening for Abdominal Aortic Aneurysm (AAA);
- Individual services for Diabetes Self-Management Training (DSMT) services;
- Individual services for Medical Nutrition Therapy services (MNT); and
- Certain vaccines.

Ensure that your billing and cost reporting staffs are aware of these updates.

Background

For RHCs and FQHCs, professional components of preventive services are part of the overall encounter, and, for Types Of Bill (TOBs) 71x and 73x, have always been billed on lines with the appropriate site of service revenue code in the 052x series. As of April 1, 2005, RHCs and FQHCs were only required to report Healthcare Common Procedure Coding System (HCPCS) codes for a few services. The number of RHC and FQHC services requiring HCPCS coding is increasing for the following reasons: the number of new benefits subject to frequency limits is increasing; for certain preventive benefits, no deductible is applicable on RHC services (all FQHC services are already exempt from application of the deductible.); and the number of circumstances when a provider is eligible to receive payments in addition to the all-inclusive daily encounter rate has increased.

Payment for professional services that meet all of the program requirements is made under the all-inclusive rate. The IPPE and the ultrasound screening for AAA are once in a lifetime benefits. Therefore, HCPCS coding is required to adhere to the statutory limit; to allow for the deductible to be waived when computing payment to RHCs for DOS on or after the effective dates (Note: Deductible is never applied for FQHC services); and, in rare circumstances, depending on the clinical appropriateness of a separate visit, to allow RHCs and FQHCs to receive separate payment for an encounter, in addition to the payment for IPPE or AAA encounter, when they are performed on the same day.

Medicare contractors will not search for and adjust claims already processed, but will adjust claims that you bring to their attention.

Policy Clarifications for IPPEs

Effective for dates of service (DOS) on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series, and must include HCPCS G0402.

For RHCs, the Part B deductible for the IPPE is waived for DOS on or after January 1, 2009. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

Note: The technical component of an electrocardiogram (EKG) performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC or FQHC. Rather, it is billed to Medicare carriers or Part B MACs on professional claims (Form CMS 1500 or 837P) under the practitioner's National Provider Identifier (NPI) following instructions for submitting practitioner claims. The technical component of the EKG performed at a provider-based clinic/center is not a Medicare covered RHC/FQHC service and is not billed by the provider-based RHC or FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's NPI following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy Clarifications for Ultrasound Screening for AAA

Effective for DOS on or after January 1, 2007, RHCs and FQHCs need not apply the Part B deductible when billing for ultrasound screening for AAA using the HCPCS code G0389. The professional portion of the service is billed to the FI or PART A MAC using TOBs 71X and 73X, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS G0389. FQHC services are already exempt from the Part B deductible. Coinsurance is applicable.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or PART B MAC under the practitioner's NPI following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC or FQHC, the technical component of the service can be billed by the base provider to the FI or PART A MAC under the base provider's NPI, following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy Clarifications for DSMT and MNT Services

Effective for DOS on or after January 1, 2006, FQHCs may not bill for group services for DSMT or MNT services as a separate qualifying encounter. Group services do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter and, therefore, cannot be billed as an encounter. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate.

Claims for DSMT group services with HCPCS code G0109 and MNT group services with HCPCS codes 97804 or G0271 will be denied using group code CO and claim adjustment reason code B5 (Program coverage guidelines were not met or exceeded).

FQHCs may bill for DSMT and MNT services when they are provided in a one-on-one face-to-face encounter and billed using the appropriate HCPCS and site of service revenue codes.

- To receive payment for DSMT services, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above.
- To receive payment for MNT services, the MNT services must be billed on TOB 73X and with the appropriate site of service revenue code in the 052X revenue code series and the appropriate HCPCS code (97802, 97803, or G0270). This payment can be in addition to payment for any other qualifying visit on the same date of service as the beneficiary received qualifying MNT services as long as the claim for MNT services contains the appropriate coding specified above.

Separate payment to RHCs for these practitioners and services continues to be precluded. However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals might be considered incident to services in the RHC setting, provided all applicable conditions are met. However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

Policy Clarifications for Vaccines

RHCs and FQHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x/73x claims. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. CR 6445 clarifies that neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC or FQHC claims. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply to this benefit. An encounter cannot be billed if vaccine administration is the only service the RHC or FQHC provides.

Additional Information

The official instruction (CR 6445) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1719CP.pdf> on the CMS website. The revised portions of the Medicare Claims Processing Manual are included in CR 6445.

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





Ensuring Only Clinical Trial Services Receive Fee-for-Service (FFS) Payment on Claims Billed for Managed Care Beneficiaries

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: MM6455	Related Change Request (CR) #: 6455
Related CR Release Date: May 1, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R1723CP	Implementation Date: October 5, 2009

Provider Types Affected

Hospitals submitting outpatient claims to Medicare contractors (Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC)) for outpatient clinical trial services provided to Medicare beneficiaries enrolled in managed care plans are affected.

Provider Action Needed

This article is based on CR 6455, which provides additional clarification about billing and processing claims for outpatient clinical trial services to managed care enrollees.

For beneficiaries enrolled in a managed care plan, institutional providers, like hospitals, must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay for a Medicare managed care patient, the provider must ONLY bill the clinical trial services to Medicare to be processed as though the services were rendered to a Medicare fee-for-service (FFS) patient. (This allows the Medicare claims processing system to pay for the services on a FFS basis and to not apply deductible when the patient is found to be in a managed care plan.) Any outpatient services unrelated to the clinical trial should be billed to the managed care plan. Hospitals should ensure that their billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) has recognized a need to provide additional clarification about billing and processing clinical trial services. CR 6455 updates Medicare system editing to ensure accurate billing, and ultimately correct pricing of clinical trial services provided to managed care beneficiaries.

Medicare policy is to pay for covered clinical trial services furnished to beneficiaries enrolled in managed care plans. The clinical trial coding requirements for managed care enrollee claims are the same as those for regular Medicare FFS claims. However, for beneficiaries enrolled in a managed care plan, institutional providers must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay, the provider must bill ONLY the clinical trial services to Medicare for processing as FFS. (This allows the Medicare claims processing system to not apply deductible when the patient is found to be in a managed care plan.)

Medicare contractors will reject line items that are not related to the clinical trial and, therefore, not payable under FFS for managed care enrollees. Contractors will use the following messages when line-item rejecting:

Medicare Summary Notice:

11.1 - Our records show that you are enrolled in a Medicare health plan. Your provider must bill this service to the plan.

Claim Adjustment Reason Code:

24 - Charges are covered under a capitation agreement/managed care plan.

Group Code:

CO – Contractual Obligation

Additional Information

The official instruction, CR6455, issued to your Medicare FI and/or MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1723CP.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.





Update to List of Medicare Telehealth Services

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

MLN Matters Number: MM6458	Related Change Request (CR) #: 6458
Related CR Release Date: April 24, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R105BP & R1716CP	Implementation Date: May 26, 2009

Provider Types Affected

Hospitals, provider-based renal dialysis facilities, physicians, and practitioners who bill Medicare Carriers, Fiscal Intermediaries (FIs), or Medicare Administrative Contractors (MACs) for End Stage Renal Disease (ESRD)-related Medicare telehealth services.

Provider Action Needed

This article is based on Change Request (CR) 6458, which updates the list of Medicare telehealth services to reflect the coding changes for ESRD-related services that took effect during the 2009 Healthcare Procedural Coding System (HCPCS) update.

The list of approved telehealth services is updated to reflect the deletion of the ESRD-related G-codes and the addition of the CPT codes. The established policy for telehealth services has not changed.

You should use the updated codes and advise your billing staff of the coding changes.

Background

The 2009 HCPCS update added several new Current Procedural Terminology (CPT) procedure codes related to ESRD services and deleted the related G-codes, effective for dates of service on or after January 1, 2009. A number of these ESRD-related services are on the list of approved telehealth services. The list of approved telehealth services has been updated to reflect the deletion of the G-codes and the addition of the CPT codes. The established policy for telehealth services has not changed.

Code Changes

- **Effective January 1, 2009**, carriers and MACs will pay for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier.
- **Effective January 1, 2009**, FIs or MACs will pay for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier by critical access hospitals that have elected Method II on Type of Bill 85X.

Note: Contractors do not have to search their files and reprocess claims for CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961 with dates of service on or after January 1, 2009, but will adjust any claims for these services that you bring to their attention.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6458) issued to your Medicare contractor. That instruction was issued in two transmittals. The transmittal revising the *Medicare Benefit Policy Manual* is at <http://www.cms.hhs.gov/Transmittals/downloads/R105BP.pdf> on the CMS website. The transmittal conveying changes to the *Medicare Claims Processing Manual* is at <http://www.cms.hhs.gov/Transmittals/downloads/R1716CP.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.





Fiscal Year (FY) 2009 Inpatient Prospective Payment System (IPPS) Claims with Medicare Severity Diagnosis Related Group (MS-DRG) 956

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: MM6483	Related Change Request (CR) #: 6483
Related CR Release Date: May 8, 2009	Effective Date: Discharges on or after Oct 1, 2008
Related CR Transmittal #: R492OTN	Implementation Date: April 27, 2009

Provider Types Affected

Inpatient Prospective Payment System (IPPS) Hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)).

Provider Action Needed

This article is based on Change Request (CR) 6483 which provides instructions for Medicare contractors to download the revised FY 2009 IPPS Pricer software and adjust FY 2009 overpaid claims that qualified as a transfer under MS-DRG 956 and had a discharge date on or after October 1, 2008, and were assigned a transfer Pricer return code of '10'. Be sure billing staff is aware of the potential for adjustments of your claims.

Background

The Fiscal Year (FY) 2009 Inpatient Prospective Payment System (IPPS) Final Rule (Table 5; see <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS2009/List.asp> on the Centers for Medicare & Medicaid Services (CMS) website) designated Medicare Severity Diagnosis Related Group (MS-DRG 956; Limb reattachment, hip & femur proc for multiple significant trauma) as a post acute care DRG, not as a special-pay DRG.

MS-DRG 956 incorrectly remained on the list of special-pay post acute care transfer MS-DRGs within the FY 2009 IPPS Pricer. Fiscal Year (FY) 2009 claims that qualified as a transfer under MS-DRG 956 were paid under the special-pay method and, therefore, were overpaid.

CR 6483 instructs that once the latest version of FY 2009 IPPS Pricer software is installed on or about April 27, 2009, Medicare contractors will adjust claims that meet the following criteria:

- Have a discharge date on or after October 1, 2008;
- Were assigned MS-DRG 956; and
- Was assigned a transfer Pricer Return Code 10.

Medicare FIs and MACs will complete these adjustments by August 1, 2009.

Additional Information

The official instruction, CR 6483, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R492OTN.pdf> on the CMS website.



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