

# 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)

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
- Tennessee A: 877-567-7271

### 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.

<b>CSR Training Dates</b>	<b>Time</b>
Friday, August 7, 2009	9:30 a.m.- 11:30 a.m. CST/10:30 a.m.- 12:30 p.m. EST
Friday, August 21, 2009	9:30 a.m.- 11:30 a.m. CST/10:30 a.m.- 12:30 p.m. EST

## **Provider Contact Center Telephone Numbers**

- Alabama A: 866-539-5598
- Georgia A: 877-567-3095
- Tennessee A: 877-567-7271

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 Customer Service Representatives (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 June 2009

The top five reasons for Alabama Medicare Part A claim rejections in **June 2009** are:

Claim Rejection	Description	Number of Claims
777	<b>APASS MODULE REJECTION</b> An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	843
888	<b>INSTREAM REJECTION</b> 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.	808
205	<b>INVALID PATIENTS LAST NAME</b> The last name submitted for the beneficiary does not match the last name we have on record for the HIC number submitted.	804
207	<b>INVALID PATIENTS SEX CODE</b> The sex code for the patient was not = M, F, or U	183
333	<b>INVALID PAT STATUS FOR TYPE BILL</b> The patient's status was invalid for the type bill submitted.	154

Note: The top five reasons for claim rejections for **Tennessee Medicare Part A** providers will be published in the *Medicare A Newsline* and each monthly newsletter thereafter once claims data is available.



## Georgia

### Top Electronic Data Interchange (EDI) Claim Rejections for June 2009

The top five reasons for Georgia Medicare Part A claim rejections in **June 2009** are:

Claim Rejection	Description	Number of Claims
888	<b>INSTREAM REJECTION</b> 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.	7,240
205	<b>INVALID PATIENTS LAST NAME</b> The last name submitted for the beneficiary does not match the last name we have on record for the HIC number submitted.	1,177
777	<b>APASS MODULE REJECTION</b> An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	1,029
351	<b>VAL AMT 44 MUST BE &gt; 0 &amp; &lt; TOT CHG</b> The amount submitted must be greater than zero and less than the total charge.	460
207	<b>INVALID PATIENTS SEX CODE</b> Patient's gender was missing or not equal to M, F, or U	442

Note: The top five reasons for claim rejections for **Tennessee Medicare Part A** providers will be published in the *Medicare A Newslines* and each monthly newsletter thereafter once claims data is available.

# Cahaba Government Benefit Administrators (GBA) Email Notification Service

We are encouraging everyone to enroll in the Cahaba GBA E-mail Notification Service, including ALL office associates. You will receive timely CMS and Medicare contractor news detailing policy, benefits, claims submission, claims processing and education event updates. Having the most current information will help you avoid costly and time-consuming claim processing interruptions in your practice.

We try very hard not to send out multiple messages in a given day; however, some urgent topics require us to email you which means you may receive several different messages in a day. We also consolidate messages when possible.

This service is FREE. You will need a valid e-mail address to subscribe. The e-mail address can be your own personal e-mail address or a general e-mail address used by your organization. There is no limit on the number of people or individual e-mail addresses that can subscribe from your organization.

## How to Subscribe

To subscribe for e-mail notification, use the following steps:

- Subscribe to the Cahaba GBA E-mail Notification Service at: <http://www.cahabagba.com/forms/subscribeForm.htm>.
- Complete the Subscription Form. The required fields are marked with an asterisk (\*). The form also requests general information about you and your organization. Next, select from a list of general topics, Medicare A topics or Medicare B topics that interest you. Select none, or as many as you like. If you choose not to make a selection, you will receive electronic e-mail notifications related to all topics.
- Click on the “Sign Up for News” button.
- You will receive an e-mail confirmation message from “cahaba\_news” to confirm your subscription. Simply reply to the message to confirm.
- You will receive another e-mail message announcing that you have successfully subscribed to the Cahaba GBA E-mail Notification Service.

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**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.

<b>Course Title</b>	<b>Description</b>
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.



### **Medicare Preventive Service Quick Reference Information**

The revised Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing Chart (revised March 2009), which provides billing and coding information related to adult immunizations, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf) on the CMS website. Printed copies will be available at a later date.



### **Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting- Recently Updated**

The Centers for Medicare & Medicaid Services (CMS) has recently updated the Educational Resources section ([http://www.cms.hhs.gov/HospitalAcqCond/07\\_EducationalResources.asp](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.



### **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.



## **Rural Health Clinic Fact Sheet**

The revised Rural Health Clinic Fact Sheet (April 2009), which provides information about Rural Health Clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, 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/RuralHlthClinfctsht.pdf> on the CMS website.

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## **Swing Bed Fact Sheet**

The Swing Bed Fact Sheet (revised April 2009), which provides information about the requirements hospitals and Critical Access Hospitals must meet in order to enter into a swing bed agreement under which they can use beds, as needed, to provide either acute or Skilled Nursing Facility care, is now available in downloadable format from the Medicare Learning Network at

<http://www.cms.hhs.gov/MLNProducts/downloads/SwingBedFactsheet.pdf> on the Centers for Medicare & Medicaid Services website.

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## **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.

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### **Medicare Dependent Hospital Fact Sheet**

The Medicare Dependent Hospital Fact Sheet (April 2009), which provides the criteria that rural hospitals must meet in order to be classified as a Medicare Dependent Hospital, 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/MedDependHospfctsh508.pdf> on the CMS website.

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### **Medicare Disproportionate Share Hospital Fact Sheet**

The revised Medicare Disproportionate Share Hospital Fact Sheet (April 2009), which provides information about methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH payment adjustment formulas, can be accessed at [http://www.cms.hhs.gov/MLNProducts/downloads/2009\\_mdsh.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/2009_mdsh.pdf) on the Centers for Medicare & Medicaid Services website.

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**Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgery or Other Invasive Procedure Performed on the Wrong Body Part; and Surgical or Other Invasive Procedure Performed on the Wrong Patient- 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>.

<b>MLN Matters Number:</b> MM6405 Revised	<b>Related Change Request (CR) #:</b> 6405
<b>Related CR Release Date:</b> July 24, 2009	<b>Effective Date:</b> January 15, 2009
<b>Related CR Transmittal #:</b> R1778CP	<b>Implementation Date:</b> July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

**Note:** This article was revised on **July 27, 2009**, to reflect a revised CR 6405, which the Centers for Medicare & Medicaid Services issued on July 2, 2009. The first third bullet point in the Inpatient Claims section of this article has been added to reflect a similar addition to CR 6405. The CR release date and transmittal numbers were revised. The Web addresses for accessing the CR 6405 transmittals are also changed in this article. All other information remains the same.

**Provider Types Affected**

Physicians, other practitioners, and providers billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

**Impact To You**

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the *Medicare Benefit Policy Manual (BPM)* Chapter 1, sections 10 and 180 and Chapter 16, section 120. This is pursuant to the National Coverage Determinations (NCDs) made as part of CR 6405.

**What You Need To Know**

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

## What You Need to Do

Make sure that your billing staff is aware of these new billing and claim requirements.

## Background

In 2002, the National Quality Forum (NQF) published Serious Reportable Events in Healthcare: A Consensus Report, which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” (That report is available at <http://www.qualityforum.org/pdf/reports/sre.pdf> on the Internet.) These events and subsequent revisions to the list became known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non-cover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the *Medicare Benefit Policy Manual (BPM)* Chapter 1, sections 10 and 180, and Chapter 16, section 120. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

**NOTE:** Related services do not include performance of the correct procedure.

## Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

**NOTE:** Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

## **Beneficiary Liability**

Generally, a beneficiary liability notice such as an Advance Beneficiary Notice of Non-coverage (ABN) or a Hospital Issued Notice of Non-coverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the non-covered item/service. (The *Medicare Claims Processing Manual* is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS website.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the non-covered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the non-covered surgical error that would not be considered a related service to the non-covered surgical error (see Chapter 1, Sections 10 and 180, and Chapter 16, Section 120, of the Benefit Policy Manual).

## **Implementation**

### **Inpatient Claims**

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and,
- The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
- Both the covered and non-covered claim must have a matching Statement Covers Period.

The non-covered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in Form Locator (FL) 80 (Remarks), or the 837i (electronic) claim form, Loop 2300, one of the applicable 2-digit surgical error codes as follows:

- MX – for a wrong surgery on patient;
- MY – for surgery on the wrong body part; or
- MZ – for surgery on the wrong patient.

The claim for the non-covered services will be denied using:

- **Claim adjustment reason code (CARC) 50** - These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- **Group Code CO** - Contractual Obligation.

### **Outpatient, Ambulatory Surgical Centers (ASCs), Other Appropriate Bill Types and Practitioner Claims**

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- **CARC 50** – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- **Group Code - CO** – Contractual Obligation

### **Related Claims**

Within 5 days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and

MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the National Coverage Determination related to this issue and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf> on the CMS website. The other transmittal presents the *Medicare Claims Processing Manual* revision and instructions. That transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1778CP.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.





## 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)- 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>.

<b>MLN Matters Number:</b> MM6426 Revised	<b>Related Change Request (CR) #:</b> 6426
<b>Related CR Release Date:</b> June 26, 2009	<b>Effective Date:</b> October 1, 2009
<b>Related CR Transmittal #:</b> R70MSP	<b>Implementation Date:</b> October 5, 2009

**Note:** This article was revised on June 29, 2009, to reflect the revised CR 6426, which was re-issued on June 26, 2009. The CR was revised to change the effective and implementation dates to October 1, 2009, and October 5, 2009, respectively. The CR release date, transmittal number and CR Web address were also changed. All other information remains the same.

### 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 (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/R70MSP.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.





## Billing Routine Costs of Clinical Trials- 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>.

<b>MLN Matters Number:</b> MM6431- Revised	<b>Related Change Request (CR) #:</b> 6431
<b>Related CR Release Date:</b> June 26, 2009	<b>Effective Date:</b> For claims with dates of service on or after January 1, 2008 and processed after September 28, 2009
<b>Related CR Transmittal #:</b> R1761CP	<b>Implementation Date:</b> September 28, 2009

**Note:** This article was revised on June 29, 2009, to reflect a revised CR 6431, issued by the Centers for Medicare & Medicaid Services (CMS) on June 26, 2009. The transmittal number, CR release date, and the Web address for accessing CR 6431 have changed. In addition, the implementation date was changed to September 28, 2009. All other information is the same.

### 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 after September 28, 2009 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.

#### **Additional Information**

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1761CP.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.





**Method of Payment for Extended Stay Services Under the Frontier Extended Stay Clinic (FESC) Demonstration, Authorized by Section 434 of the Medicare Modernization Act (MMA)**

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>.

<b>MLN Matters Number:</b> MM6452	<b>Related Change Request (CR) #:</b> 6452
<b>Related CR Release Date:</b> December 12, 2008	<b>Effective Date:</b> October 1, 2009
<b>Related CR Transmittal #:</b> R61DEMO	<b>Implementation Date:</b> October 1, 2009

**Provider Types Affected**

Specific Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), or Tribally Owned clinics that are part of the FESC demonstration project and billing Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for extended stay services rendered to Medicare beneficiaries in remote frontier areas.

**Impact on Provider**

This article is based on CR 6452 and outlines the payment instructions and policy rules for the FESC demonstration project, which impacts a very limited number of providers as identified in this article.

**Background**

Section 434 of the MMA established the Frontier Extended Stay Clinic (FESC) Demonstration Project to test the feasibility of providing extended stay services to remote frontier areas under Medicare payment and regulations. A FESC must be located in a community which is:

1. At least 75 miles away from the nearest acute care hospital or critical access hospital; or
2. Is inaccessible by public road.

FESCs are designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time.

Under rules established for the demonstration, clinics participating under the FESC demonstration will be allowed to keep patients for extended stays in situations where weather or other circumstances prevent transfer. Extended stays up to 48 hours are permitted for patients who do not meet the Centers for Medicare & Medicaid Services (CMS) inpatient hospital admission criteria but who need monitoring and observation for a limited period of time. According to the rules, there can be no more than four patients under this criterion at any one time at any single facility and the FESC demonstration will last for three years.

The following five clinics/tribal facilities are eligible for the demonstration

<b>Clinic</b>	<b>Town</b>	<b>Clinic Type</b>
Inter-island Medical Center	Friday Harbor, WA	RHC
Cross Road Medical Center	Glenallen, AK	FQHC
Iliuliuk Family & Health Services	Unalaska, AK	FQHC
Alicia Roberts Medical Center	Prince of Wales Island, AK	Tribal Facility
Haines Health Center	Haines, AK	Tribal Facility

A listed clinic must receive certification from CMS before it can bill for services to the MAC or FI. Certification signifies a clinic's adherence to the requirements for services, staffing, life safety codes and other factors.

### **Key Points**

For each chosen clinic:

- The clinic will be paid for extended stays in four hour increments after an initial four hour stay. Subject to a screening for medical necessity, Medicare payment will only occur for stays that last at least four hours. For these stays, which equal or exceed four hours, demonstration payment will also apply to the first four hours of the stay.
- The clinic may provide services to:
  - Patients with an emergency medical condition who require an extended stay due to weather or other conditions that preclude transport to an acute care hospital.
  - Ill or injured patients who receive an extended stay because a physician, nurse practitioner or physician assistant determines that they do not meet Medicare inpatient hospital admission criteria but do need monitoring and observation, and determines that they can be discharged within 48 hours.
- The code G9140 will indicate the length of stay for each Medicare patient from the point of time that he/she is seen by the clinic. This code will measure four-hour units of time.
- The FI and/or A/B MAC will calculate Medicare payment specific to the demonstration from the G-code. Payment will be made through the same mechanism for RHC and FQHC payments, but the demonstration payment will be separable for accounting purposes.
- A claim that can be distinctly measured as greater than the four hour unit will be either rounded up or down to the closer four hour multiple, (i.e., a claim that reads 300 minutes should reflect one four hour unit; a claim of 420 minutes should reflect two, four hour units)
- The revenue codes are 516, 519, 0529 and 0510 and the applicable bill types are 13X, 71X, and 73X.
- The FI and/or AB MAC will conduct a medical necessity screening of each Medicare patient who equals or exceeds four hours from the time he/she is originally seen by the clinic.
- The FI and/or AB MAC will make a Medicare payment under the demonstration if:

- The patient’s stay equals or exceeds four hours; and
  - There is no documentation of weather or transportation issues; and
  - The FI and/or A/B MAC determines under its medical review that the patient’s condition has been evaluated by a physician, physician assistant, or nurse practitioner and is of sufficient risk to warrant continued observation in the clinic. **OR**
  - There is documentation of a transfer or weather or transportation conditions preventing transfer; and
  - The patient’s stay equals or exceeds four hours.
- There is a four hour payment rate for each FESC selected for the demonstration. These rates are based on the 2007 Ambulatory Payment Classification for observation services, and they incorporate wage and cost-of-living adjustments. The four hour payment rates for the clinics for 2009 are:

Tribal Clinics	Alicia Roberts Medical Center (Prince of Wales Island, Alaska)	\$541.24
	Haines Health Center (Haines, Alaska)	\$541.24
Federally Qualified Health Centers	Cross Road Medical Center (Glenallen, Alaska)	\$541.24
	Iliuliuk Family and Health Services (Unalaska, Alaska)	\$541.24
Rural Health Clinics	Inter-island Medical Center (Friday Harbor, Washington)	\$479.74

For subsequent years of the demonstration, these payment amounts will be updated by the market basket adjustment, which is applicable to the outpatient prospective payment system.

- The FI and/or MAC will use the following instructions to conduct the medical necessity screening to determine whether the patient meets these requirements:
  - All medical conditions will be eligible;
  - The patient’s time from the point when he/she is seen by the clinic staff must be documented on the medical record;
  - A beneficiary’s observation time must be documented on the medical record;
  - The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, physician assistant, or nurse practitioner; and
  - The medical record must include documentation that the physician, physician assistant, or nurse practitioner explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

- For those claims designated for payment under the demonstration the FI and/or A/B MAC will make a demonstration payment specific to each provider. This payment will be the rate of payment per time unit multiplied by the number of time units (four hour units) in the stay.
- Except for Indian Health Service and tribally owned and operated clinics, the FI and/or AB/MAC will apply a 20 percent coinsurance on Medicare beneficiaries receiving the extended stay services (i.e., services in the clinic beyond the first four hours.)
- For Indian Health Service and tribally owned and operated clinics, there will be no coinsurance.
- There will be no deductible for extended stay services.
- The Centers for Medicare & Medicaid Services (CMS) will design a form that each participating clinic will use to document weather conditions or other circumstances that prevent a transfer will conduct additional retrospective reviews of two circumstances pertaining to patient stays:
  1. CMS will verify the weather conditions for stays longer than 12 time units by retrospectively assessing documentation provided by clinics; and
  2. The clinic should report to CMS at any time when there are more than four Medicare patients who are each in the clinic for more than four hours. If the clinic reports there are more than four patients at one time, it must complete the form documenting weather or other conditions that prevent transfer. CMS will conduct audits of these records at least once every three months and determine whether the clinic is in compliance with the rule. Neither the FI nor the A/B MAC has responsibility for monitoring these records.
- The FI and/or A/B MAC will pay claims on an automated basis, and post-payment review will occur as is standard for RHCs and FQHCs.

### **Additional Information**

To see the official instruction (CR 6452) issued to your Medicare FI or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R61DEMO.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.





## July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)- 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>.

<b>MLN Matters Number:</b> MM6492- Revised	<b>Related Change Request (CR) #:</b> 6492
<b>Related CR Release Date:</b> June 23, 2009	<b>Effective Date:</b> July 1, 2009
<b>Related CR Transmittal #:</b> R107BP and R1760CP	<b>Implementation Date:</b> July 6, 2009

**NOTE:** This article was revised on June 24, 2009, to reflect changes made to CR 6492, which was re-issued as Transmittal 1760 on June 23. In the Recurring Update Notification attachment to the original CR 6492, **Q4115** was incorrectly identified as a newly payable HCPCS in the hospital outpatient setting effective July 1, 2009 in Table 3. **HCPCS Code Q4115 is not payable in the hospital outpatient setting. HCPCS Code Q4115 has been removed from Table 3 and the text identifying the number of new drug codes for July, immediately preceding Table 3 has been changed from three to two.** All other information remains the same.

### 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 and which are paid under the OPSS.

### Provider Action Needed

This article is based on Change Request (CR) 6492 which describes changes to and billing instructions for various payment policies implemented in the July 2009 OPSS update. Be sure billing staffs are aware of these changes.

### Background

CR 6492 describes changes to and billing instructions for various payment policies implemented in the July 2009 OPSS update and it affects the *Medicare Claims Processing Manual* Chapter 1, Section 50.3; Chapter 4, Sections 10 and 290; and Chapter 17, Section 90.3. It also updates the *Medicare Benefits Policy Manual* (Chapter 6, Section 20.6) to clarify the existing policy.

July 2009 revisions to the Integrated Outpatient Code Editor (I/OCE) data files, instructions, and specifications are provided in CR 6480 (July 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.2).” Upon release of CR 6480 a related MLN Matters article will be available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6480.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

## Key OPSS Updates for July 2009

### 1. Changes to Procedure and Device Edits for July 2009

Procedure to device edits require that when a particular procedural Healthcare Common Procedure Coding System (HCPCS) code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits

require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

## 2. Outlier Reconciliation

CMS updated the *Medicare Claims Processing Manual* (Chapter 4, Section 10.7.2) to more explicitly identify distinctions between the OPSS outlier reconciliation policy and those of other payment systems. CMS made changes to note that the OPSS outlier reconciliation criteria use OPSS specific-information, specifically 1) the Cost-to-Charge Ratio (CCR) is the OPSS CCR used to make OPSS outlier payments and 2) total outlier payments are total OPSS outlier payments. These changes clarify the manual language to eliminate confusion that the OPSS reconciliation might consider Inpatient Prospective Payment System (IPPS) or other payment system CCRs or total outlier payments across payment systems.

## 3. Updated Pricer Logic for Certain Blood Products

The January 2009 OPSS Pricer contained a programming error that may result in the underpayment or overpayment of certain blood products that are eligible for the blood deductible when billed together on the same claim. The whole blood and packed red cells described by the following HCPCS codes are eligible for the blood deductible:

HCPCS Codes Eligible for the Blood Deductible			
P9010	P9022	P9040	P9056
P9016	P9038	P9051	P9057
P9021	P9039	P9054	P9058

The blood deductible is applied to these products only when the hospital incurs a charge for the blood product itself, in addition to a charge for processing and storage. The January 2009 OPSS Pricer programming error affects only those claims on which more than one of the blood product HCPCS codes listed above appears, when at least one of those codes is not subject to the blood deductible because the hospital did not incur a charge for the blood product itself.

Specifically, an underpayment or overpayment may occur when the following conditions are met:

- 1) More than one blood product that is eligible for the blood deductible (i.e., whole blood and packed red cells) appears on the claim;
- 2) At least one of the blood products appearing on the claim that is eligible for the blood deductible is not subject to the blood deductible due to the absence of payment adjustment flag (PAF) 5 and 6 indicating the hospital incurred a charge for the blood itself (the Integrated Outpatient Code Editor applies PAF 5 or 6 to blood lines eligible for the blood deductible when the hospital reports charges for the blood product itself using Revenue Code series 038X (excluding 0380) in addition to charges for processing and storage services using Revenue Code 0390, 0392, or 0399);
- 3) The dates of service fall on or after January 1, 2009, but prior to July 1, 2009; and
- 4) The claim was processed for payment prior to the installation of the July 2009 OPSS Pricer on July 6, 2009.

This programming error has been corrected in the July 2009 OPSS Pricer. Providers who think they may have received an incorrect payment as a result of this programming error may voluntarily submit claims to their contractors for repayment following the implementation of the July 2009 OPSS Pricer on July 6, 2009.

#### 4. Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

As discussed in the CY 2006 OPSS final rule with comment period (70 FR 68567; see <http://www.gpoaccess.gov/fr/retrieve.html> on the Internet), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPSS and were created by us in response to applications for new technology services. Therefore, on July 1, 2009, CMS will implement in the OPSS four Category III CPT codes that the AMA released in January 2009 for implementation in July 2009. The codes, along with their status indicators and Ambulatory Payment Classifications (APCs), are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2009 OPSS Update that is posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

**Table 1--Category III CPT Codes Implemented as of July 1, 2009**

HCPCS	Long Descriptor	APC	SI
0199T	Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report	0215	S
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles	0049	T
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needle	0050	T
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine		C

#### 5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

CMS reminds hospitals that under the OPSS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used

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

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

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

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

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2009 release of the OPPS PRICER. The updated payment rates, effective July 1 2009 will be included in the July 2009 update of the OPPS Addendum A and Addendum B, which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

**b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2009**

Nine drugs and biologicals have been granted OPPS pass-through status effective July 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

**Table 2-Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2009**

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/09
C9250*	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	9250	G
C9251*	Injection, C1 esterase inhibitor (human), 10 units	9251	G
C9252*	Injection, plerixafor, 1 mg	9252	G
C9253*	Injection, temozolomide, 1 mg	9253	G
C9360*	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	9360	G

C9361*	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	9361	G
C9362*	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	9362	G
C9363*	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	9363	G
C9364*	Porcine implant, Permacol, per square centimeter	9364	G

**NOTE:** The HCPCS codes identified with an “\*” indicate that these are new codes effective July 1, 2009.

**c. New HCPCS Codes Effective for Certain Drugs and Biologicals**

Two new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting for July 2009. These codes are listed in Table 3 below and are effective for services furnished on or after July 1, 2009.

**Table 3- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2009**

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/09
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	1268	K
Q4116	Skin substitute, alloderm, per square centimeter	1270	K

**d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 through March 31, 2009**

The payment rates for several HCPCS codes were incorrect in the January 2009 OPPS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the July 2009 OPPS PRICER, effective for services furnished on January 1, 2009, through implementation of the April 2009 update. If you have claims that were processed prior to April 1, 2009 with these codes for services on or after January 1, 2009, but prior to April 1, 2009, you may ask your Medicare contractor to adjust the claims.

**Table 4-Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 Through March 31, 2009**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1441	K	7049	Filgrastim 480 mcg injection	\$304.27	\$60.85
J1740	K	9229	Ibandronate sodium injection	\$136.35	\$27.27
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,135.12	\$427.02
J7513	K	1612	Daclizumab, parenteral	\$341.09	\$68.22

#### **e. Recognition of Multiple HCPCS Codes For Drugs**

Prior to January 1, 2008, the OPSS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPSS assigned a status indicator “B” indicating that another code existed for OPSS purposes. For example, if drug X has 2 HCPCS codes, one for a 1 ml dose and a second for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and status indicator “B” to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPSS. However, beginning January 1, 2008, the OPSS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

#### **f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices**

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the biological is packaged into the payment for the associated procedure.

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

#### **g. Correct Reporting of Units for Drugs**

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

#### **h. Unit Correction – HCPCS code J9181, Etoposide, 10 mg**

Table 5 ‘HCPCS Code Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008’ listed in Transmittal 1657, Change Request (CR) 6320, issued December 31, 2008, incorrectly

listed the number of units in the long code descriptor for HCPCS code J9181, Etoposide ,10 mg. HCPCS code J9181 which is assigned status indicator ‘N’ in CY 2009 under the OPPS, is the code for 10 mg of etoposide, while HCPCS code J9182 was discontinued effective January 1, 2009. Providers may review the short and long HCPCS code descriptors in the HCPCS file that is available at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/> on the CMS website.

## **6. Clarification Related to the Appropriate Use of HCPCS Code C9399**

CMS revised the *Medicare Claims Processing Manual* (Chapter 17, Section 90.3) to clarify the appropriate use of HCPCS code C9399. Specifically, HCPCS code C9399 should be used by hospitals when billing a new drug or biological that has been approved by the FDA on or after January 1, 2004 and for which a product-specific HCPCS code has not been assigned. Beginning on or after the date of FDA approval, hospitals may bill for the drug or biological using C9399, Unclassified drug or biological. Hospitals will report in the ANSI ASC X-12 837 I in specific locations, or in the “Remarks” section of the CMS 1450:

- The National Drug Code (NDC);
- The quantity of the drug that was administered (expressed in the unit of measure applicable to the drug or biological); and
- The date the drug was furnished to the beneficiary.

Medicare contractors will manually price the drug or biological at 95 percent of the Average Wholesale Price (AWP). They will pay hospitals 80 percent of the calculated price and will bill beneficiaries 20 percent of the calculated price, after the deductible is met. Drugs and biological that are manually priced at 95 percent of AWP are not eligible for outlier payment.

## **7. Changes to Nuclear Medicine Procedure-to-Radiolabeled Product Edits for July 2009**

Nuclear medicine procedure-to-radiolabeled product edits require that when a nuclear medicine procedure HCPCS code is billed, the claim must also contain an appropriate radiolabeled product. Failure to pass these edits will result in the claim being returned to the provider. Nuclear medicine procedure-to-radiolabeled product edits require that a claim that contains one of a specified set of nuclear medicine codes be returned to the provider if it fails to contain an appropriate radiolabeled product code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

## **8. Clarification Related to Observation Services**

CMS updated the *Medicare Claims Processing Manual* (Chapter 4, Section 290) and the *Medicare Benefit Policy Manual* (Chapter 6, Section 20.6) to clarify that a hospital begins billing for observation services, reported with HCPCS code G0378, at the clock time documented in the patient’s medical record, which coincides with the time that observation services are initiated in accordance with a physician’s order for observation services. Editorial changes to the manuals remove references to “admission” and “observation status” in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term “admission” is typically used to denote an inpatient admission and inpatient hospital services. For payment purposes, there is no payment status called “observation”. Observation care is an outpatient service, ordered by a physician and reported with a HCPCS code.

## **9. Clarification Related to Condition Code 44**

The changes to the *Medicare Claims Processing Manual* (Chapter 1, Section 50.3) incorporate information and guidance published in MLN Matters article SE0622, published March, 2006, which you

can review at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf> on the CMS website. MLN Matters article SE0622 provided clarification to Transmittal 299, CR 3444, issued September 10, 2004. You can also review the revised Chapter 1 (Section 50.3) of the *Medicare Claims Processing Manual*, which is included as an attachment to CR 6492, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1745CP.pdf> on the CMS website.

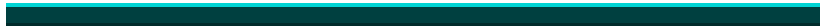
## **10. Coverage Determinations**

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

### **Additional Information**

The official instruction, CR 6480, was issued to your FI, MAC, and RHHI in two transmittals. The first transmittal modifies the *Medicare Benefit Policy Manual* and is at <http://www.cms.hhs.gov/Transmittals/downloads/R107BP.pdf> on the CMS website. The second transmittal modifies the *Medicare Claims Processing Manual* and it is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1760CP.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.





## **ESRD: Placement of a List of Diagnostic Tests that are Considered End Stage Renal Disease (ESRD) Related in Publication 100-04, Chapter 16- 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>.

<b>MLN Matters Number:</b> MM6515- Revised	<b>Related Change Request (CR) #:</b> 6515
<b>Related CR Release Date:</b> July 10, 2009	<b>Effective Date:</b> July 31, 2009
<b>Related CR Transmittal #:</b> R1769CP	<b>Implementation Date:</b> July 31, 2009

**NOTE:** Note: This article was revised on **July 13, 2009**, to reflect the revised CR 6515 issued by the Centers for Medicare & Medicaid Services on July 10, 2009. The effective and implementation dates of CR 6515 were revised to July 31, 2009. Also, the CR release date, transmittal number, and Web address for viewing CR 6515 were revised. All other information is the same.

### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, 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 informational in nature and conveys that the purpose of Change Request (CR) 6515 is to place a listing of diagnostic tests that are considered ESRD-related as Exhibit 1 (new) at the end of Chapter 16 of the Medicare *Claims Processing Manual*.

### **Background**

Change Request (CR) 6515 places the listing of diagnostic tests that are considered End Stage Renal Disease (ESRD)-Related as Exhibit 1 (formerly Attachment 1 in CR 2906) at the end of Chapter 16 of the *Medicare Claims Processing Manual*. This listing was inadvertently omitted from the manual during the implementation of CR 2906 (Transmittal 69, January 25, 2004; see <http://www.cms.hhs.gov/transmittals/downloads/R69CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website).

The purpose of CR 2906 was to address specific areas of concerns regarding Medicare system edits for Skilled Nursing Facilities (SNF) Consolidated Billing (CB) to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for ESRD at an Independent Provider-based dialysis facility. One of the areas of concern was that providers and suppliers needed a listing of diagnostic tests that are considered ESRD-Related that would require the “CB” modifier. Consequently, a list defining specific diagnostic tests as ESRD-Related was included in CR 2906. This list applies only to SNF CB. According to CR 2906, any diagnostic services related to the beneficiary’s ESRD treatment/care must be submitted using the “CB” modifier, however, if these services are not on the list labeled as Attachment 1 in CR 2906 or the list being added to the Medicare Claims Processing Manual by CR6515, your Medicare contractor may require supporting medical documentation.

To view the list being added to the end of Chapter 16 of the *Medicare Claims Processing Manual*, see CR6515, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1763CP.pdf> on the CMS website.

**Additional Information**

The official instruction, CR 6515, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.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 the Redesigned Provider Statistical and Reimbursement (PS&R) System

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>.

<b>MLN Matters Number:</b> MM6519	<b>Related Change Request (CR) #:</b> 6519
<b>Related CR Release Date:</b> June 12, 2009	<b>Effective Date:</b> July 13, 2009
<b>Related CR Transmittal #:</b> R153FM	<b>Implementation Date:</b> July 13, 2009

### Provider Types Affected

All providers who submit institutional claims to Medicare Administrative Contractors (MACs) or Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on Change Request (CR) 6519, which notifies providers that the Centers for Medicare & Medicaid Services (CMS) has redesigned the PS&R (PS&R Redesign) and the new system is now operational. Be sure that your reimbursement staffs are aware of these changes.

### Background

CR 6519 describes changes to the Provider Statistical & Reimbursement (PS&R) system. This is a CMS system that accumulates and reports Medicare Part A claims data into categories needed for Medicare cost reporting. Providers utilize PS&R reports to accumulate statistical and payment data to prepare their Medicare cost reports, and FIs and MACs use this data to settle the cost reports.

The current PS&R system (Legacy PS&R) has been in use for over twenty years. CMS has redesigned the system and it is now operational. The PS&R Redesign is a centralized, web-based application programmed using current technology. It includes enhancements that will improve access and delivery, as well as increase the system's flexibility.

### Key Points of CR 6519

- The PS&R Redesign will be utilized for filing and settling all cost reports with fiscal years ending on January 31, 2009 and later. Cost reports with fiscal years ending prior to January 31, 2009 will continue to be filed and settled with the Legacy PS&R system. Due to this transition, the Legacy PS&R will not produce reports containing dates of service after January 30, 2009. Reports for fiscal years containing claims with a service through date of January 31, 2009 and later must be produced by the PS&R Redesign.
- If you receive interim PS&R reports, you may experience a short interruption in obtaining your interim reports during this transition. Interim reports are not a requirement and are not necessary for cost reporting. The transition to the PS&R Redesign will not impact or delay submission of cost reports.
- The PS&R Redesign will allow all users (Providers, FIs/MACs, CMS) the ability to download summary PS&R reports via the Internet. Users will be able to log on to the system and request their

summary reports on an as-needed basis. FIs/MACs will no longer produce and distribute these summary reports to their providers. It will be the provider’s responsibility to obtain their own reports needed for their cost report. Providers will also be able to request detailed PS&R reports (reconciliation reports) via the internet, but due to the sensitive data contained within these reports, the FIs/MACs will continue to securely deliver these reports to providers. FIs/MACs may continue to charge a reasonable fee for the generation of the detail reports, in excess of 1 per year.

- The PS&R Redesign web page is located at <http://www.cms.hhs.gov/PSRR/> on the CMS website. This site contains an overview of the system, user manuals, quick guides, and other helpful information.
- The PS&R Redesign will utilize Individuals Authorized Access to CMS Computer Systems (IACS) for authentication and security purposes. All users must first establish an IACS account and also be approved for PS&R access prior to attempting to access the PS&R Redesign. IACS allows users to obtain one ID and password needed to access multiple web-based systems, one of which is the PS&R system. Information regarding the IACS process is located at <http://www.cms.hhs.gov/IACS> on the CMS website. The IACS web page contains descriptions of the processes and links to user guides that will assist with registration. There are also MLN Matters® articles that may provide additional guidance on the use of IACS. Those articles are at
  - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf>;
  - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf>; and
  - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf> on the CMS website.
- Providers and Medicare contractors must use IACS to gain access to the PS&R Redesign. The Provider IACS verification process includes the submission of supporting documentation, and may take weeks to complete the entire process. Providers should begin their IACS registration using the following schedule, to ensure that they will be able to access IACS and PS&R well in advance of the cost report due date:

<b><u>Cost Report Fiscal Year End</u></b>	<b><u>Begin IACS Registration</u></b>
January 31, 2009 – April 30, 2009	As soon as possible
May 1, 2009 – June 30, 2009	June 1, 2009
July 1, 2009 – August 31, 2009	August 1, 2009
September 1, 2009 – September 30, 2009	September 1, 2009
October 1, 2009 – January 30, 2010	November 1, 2009

- The PS&R Web page, <http://www.cms.hhs.gov/PSRR/>, contains a “Registration Tips” document that should assist with the addition of PS&R access to the user’s IACS account. The document is located in the “Download” section of the Provider Community and FI/MAC Community links.
- Note that the first person to register for a provider organization must be the provider’s designated Security Official (SO). This person is then responsible for all other users in that provider’s organization. As soon as the SO registers, submits all documentation, and receives approval from CMS, that SO may then approve other users within his/her organization to access IACS to the PS&R system. While the SO may approve users for access to IACS and the PS&R, the SO cannot access the PS&R application.

- If the provider and SO have previously registered for another IACS application, they need not complete the initial registration again.
- If a provider is part of a chain, each provider within the chain must register separately.
- If an SO represents multiple providers, they may add the additional providers to their IACS account without having a separate IACS account for each provider. However, each provider will be vetted using the normal CMS approval process.
- To register in IACS, go to <https://applications.cms.hhs.gov> and read the warning message, then click “Enter CMS Applications Portal” and click the “Account Management” tab. This last click takes you to IACS web-based training and a link for “New User Registration”. Select the “Provider/Supplier Community” to begin the process.
- Providers must produce the Summary PS&R reports needed to file cost reports ending on or after January 31, 2009. There are many variations of report requests that can be made in the new system, which you may customize as you become familiar with the system (see user guides and training materials).
- Providers approved for IACS will access the PS&R application at <https://psr-ui.cms.hhs.gov/psr-ui> on the CMS website.
- The earliest data accessible in PS&R Redesign is one full year of service dates beginning with the first cost report period ending January 31, 2009 and later (i.e. a June 30, 2009 fiscal year end provider’s first accessible data is July 1, 2008 – June 30, 2009). CMS suggests you use a paid-through date that is approximately 30 days prior to the due date of your cost report. This will ensure that claims which may have been paid after the fiscal year end will be included in the PS&R. CMS also encourages you to attempt to run reports in advance to ensure that you can access the data needed for your cost report.
- Within the PS&R Redesign, users will find web-based training (WBT), help screens, and user manuals that will assist you in becoming more familiar with the system.
- Chapter 8 of the Medicare Financial Management Manual has been modified to include the updated information pertaining to the PS&R Redesign. That revision is attached to CR 6519. The PS&R technical information, located in Chapter 9 of that manual will be modified soon to include PS&R Redesign specific information.
- Any user that has questions regarding IACS should contact the IACS help desk, External User Services (EUS), at 866-484-8049, or [EUSsupport@cgi.com](mailto:EUSsupport@cgi.com). Any providers’ PS&R application specific questions will continue to be directed to their FI/MAC.

### **Additional Information**

The official instruction (CR 6519) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R153FM.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.



## Claim Status Category Code and Claim Status Code Update

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

<b>MLN Matters Number:</b> MM6525	<b>Related Change Request (CR) #:</b> 6525
<b>Related CR Release Date:</b> June 12, 2009	<b>Effective Date:</b> July 1, 2009
<b>Related CR Transmittal #:</b> R1756CP	<b>Implementation Date:</b> July 6, 2009

### Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

### Provider Action Needed

This article, based on CR 6525, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on the Internet on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on March 1, 2009. Medicare will implement those changes on July 6, 2009 as a result of CR6525.

### Additional Information

The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.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.





## Correction to Fiscal Year (FY) 2009 Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Weights

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>.

<b>MLN Matters Number:</b> MM6552	<b>Related Change Request (CR) #:</b> 6552
<b>Related CR Release Date:</b> June 19, 2009	<b>Effective Date:</b> June 3, 2009
<b>Related CR Transmittal #:</b> R1758CP	<b>Implementation Date:</b> July 6, 2009

### Provider Types Affected

This article applies to Long Term Care Hospitals (LTCHs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries and which are paid under the LTCH prospective payment system (PPS).

### Provider Action Needed

Change request (CR) 6552 alerts providers that the Centers for Medicare & Medicaid Services (CMS) will issue a new LTCH PPS Pricer for the remainder of this Fiscal Year (FY) that contains the revised relative weight table. CMS has instructed Medicare contractors to hold LTCH PPS claims with discharges on or after June 3, 2009 until the updated Pricer is in production. Be sure your billing staff is aware of this update.

### Background

In an Interim Final Rule with Comment period (IFC) published in the *Federal Register* on June 3, 2009, CMS implemented revised MS-LTC-DRG relative weights for payment under LTCH PPS for federal FY 2009. The FY 2009 MS-LTC-DRG relative weights were revised due to the misapplication of the established budget neutrality methodology. The revised FY 2009 MS-LTC-DRG relative weights presented in Table 11 of that IFC are effective for the remainder of the FY. To review Table 11 go to [http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/FY\\_2009\\_LTC-DRG\\_Weight\\_Table\\_\(CMS-1337-IFC\).zip](http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/FY_2009_LTC-DRG_Weight_Table_(CMS-1337-IFC).zip) and open the Excel file that is retrieved at that link.

**Note:** This revision to the FY 2009 MS-LTC-DRG relative weights did not affect the calculation of the geometric mean length of stay and the short-stay outlier (SSO) threshold for FY 2009 that were presented in Table 11 of the FY 2009 IPPS final rule.

### Key Points

- The revised LTCH Pricer will be effective for discharges on or after June 3, 2009.
- The specific dates for the remainder of FY 2009 for LTCH PPS discharges are for those occurring on or after June 3, 2009 through September 30, 2009.
- Medicare contractors will release held claims for processing once the LTCH Pricer is in production.

**Additional Information**

The official instruction, CR 6552, issued to your Medicare FI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1758CP.pdf> on the CMS website.

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