

Medicare A Newsline



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

September 2009

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

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Key for Icons:

	All Providers		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

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

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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.

CSR Training Dates	Time
Friday, September 11, 2009	9:30 a.m.- 11:30 a.m. CST/10:30 a.m.- 12:30 p.m. EST
Friday, September 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 Medicare Part A Top Electronic Data Interchange (EDI) Claim Rejections for July 2009

Audit trails show which of your claims were accepted by the Cahaba GBA Part A processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See [Audit Trail Explanations](#) for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part A EDI Services is providing you with the top five reasons for claim rejections. For the month of **July 2009**, these are:

Claim Rejection	Description	Number of Claims
359	INVALID PATIENT STATUS FOR TYPE BILL An inpatient or outpatient type bill was submitted with an inappropriate patient status..	927
777	APASS MODULE REJECTION An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	545
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.	404
333	INVALID PAT STATUS FOR TYPE BILL A patient status of 30 was submitted with a Type-Of-Business code of 721 or 724.	140
207	INVALID PATIENTS SEX CODE The sex code for the patient was not = M, F, or U	101

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 once claims data is available.



Georgia Medicare Part A Top Electronic Data Interchange (EDI) Claim Rejections for July 2009

Audit trails show which of your claims were accepted by the Cahaba GBA Part A processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See [Audit Trail Explanations](#) for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part A EDI Services is providing you with the top five reasons for claim rejections. For the month of **July 2009**, these are:

Claim Rejection	Description	Number of Claims
888	INSTREAM REJECTION There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred.	4,258
777	APASS MODULE REJECTION An undefined error has occurred. Contact EDI Services at (866) 582-3253 for more information	1,149
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.	757
351	VAL AMT 44 MUST BE > 0 & < TOT CHG The amount submitted must be greater than zero and less than the total charge.	318
207	INVALID PATIENTS SEX CODE Ú æ c ã ^ } c q • Á * ^ } á ^ Á quãto M, (F,ã, U ã	249

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 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. 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.
- You will receive an e-mail message 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.

Your e-mail address will not be shared with other subscribers or given to advertisers, and once subscribed, you can unsubscribe from the list at any time. Please review our [Privacy Policy](#) for more information.



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.



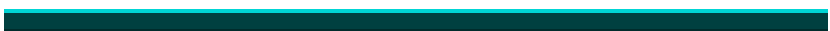
E-Prescribing Incentive Program

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.

The Centers for Medicare & Medicaid Services (CMS) announces that two new section pages have been created on the *2009 Electronic Prescribing (E-Prescribing) Incentive Program* web page on the CMS website.

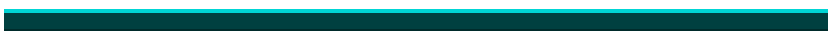
E-Prescribing Measure Section Page - This page contains several resources including: Measure Specifications; new Claims-Based Reporting Principles and a Sample E-Prescribing Claim. To access this page, visit http://www.cms.hhs.gov/ERxIncentive/06_E-Prescribing_Measure.asp on the CMS website.

Educational Resources Section Page – This page contains MLN Matters articles; E-Prescribing Incentive Program fact sheets; a link to Medicare’s Practical Guide to the E-Prescribing Incentive Program, and information on how to receive continuing education credit related to the E-Prescribing Incentive Program. To access this page, visit http://www.cms.hhs.gov/ERxIncentive/09_Educational_Resources.asp on the CMS website.



Medicare Billing Information for Rural Providers, Suppliers, and Physicians

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





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

The *General Equivalence Mappings of 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.”



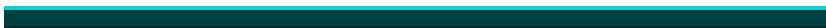
2009 Physician Quality Reporting Initiative (PQRI)

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



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.





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.



Rural Referral Center Fact Sheet

The revised *Rural Referral Center Fact Sheet* (April 2009), which provides information about Rural Referral Center program requirements, 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/RuralRefCtrfctsh2008.pdf> on the CMS website.



Medicare Learning Network

A new video explaining the **Medicare Learning Network (MLN)** and its benefits to Fee-For-Service healthcare providers is now available for download. This video, approximately seven minutes in length, is suitable for self instruction or for use during provider education events. National associations and organizations may want to consider posting this video to their websites to educate their membership on the products and services of the MLN. You can access the video at http://www.cms.hhs.gov/MLNGenInfo/downloads/MLN_Long_Video.zip on the CMS website Please note the large file size, [ZIP, 44.1MB], as download speeds will vary based on your internet connection.



HIPAA 5010

A HIPAA 5010 Special Edition MLN Matters provider education article is now available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf> on the CMS website. This Special Edition article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.



HIPAA 5010- CMS Website

The Centers for Medicare & Medicaid Services (CMS) has launched its website for agency-wide information and education on Versions 5010, D.0 and 3.0. As you may already know, Version 5010 is the new version of the X12 standards for HIPAA transactions; version D.0 is the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions; and version 3.0 is a new NCPDP standard for Medicaid pharmacy subrogation. Visit the new website at <http://www.cms.hhs.gov/Versions5010andD0> to view background information on the new standards, regulatory information, the latest outreach messages from CMS, educational resources, resources specific to D.0 and 3.0, as well as implementation information for the Medicare Fee-For-Service systems. CMS plans to add additional information as it becomes available so bookmark the site today!



Critical Access Hospital Fact Sheet

The revised *Critical Access Hospital Fact Sheet* (April 2009), which provides information about eligible Critical Access Hospital (CAH) providers; CAH designation; CAH payments; reasonable cost payment principles that do not apply to CAHs; election of Standard Payment Method or Optional (Elective) Payment Method; Medicare Rural Pass-Through funding for certain anesthesia services; Health Professional Shortage Area Incentive payments; Physician Scarcity Area Bonus payments; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact Critical Access Hospitals; and grants to states under the Medicare Rural Hospital Flexibility Program, can be accessed at <http://www.cms.hhs.gov/MLNProducts/downloads/CritAccessHospfctsht.pdf> on the Centers for Medicare & Medicaid Services website.



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 on the Centers for Medicare & Medicaid Services website.



Reporting Non-Tax Withholding Due to Federal Payment Levy Program (FPLP)

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: MM6228	Related Change Request (CR) #: 6228
Related CR Release Date: June 12, 2008	Effective Date: January 1, 2009
Related CR Transmittal #: R503OTN	Implementation Date: October 5, 2009

Provider Types Affected

Physicians and providers who bill Medicare carriers, Fiscal Intermediaries (FI), and Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries.

What You Need To Know

CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) in addition to collecting for overdue taxes (effective October 1, 2008), the Centers for Medicare & Medicaid Services (CMS) will also levy non-tax debt offsets against Medicare providers to repay unpaid debts owed to other Federal agencies, such as educational loans.

Make sure that your billing staffs are aware that both tax and non-tax debt, subject to Federal Payment Levy Program (FPLP), will be withheld from Medicare payments.

If you have a question about the **non-tax** payment reduction, call the Treasury Department's Financial Management Service (FMS) at 1-800-304-3107.

Background

The Taxpayer Relief Act of 1997 authorized the Federal Payment Levy Program (FPLP), which the Internal Revenue Service (IRS) and the Treasury Department's Financial Management Service implemented in July 2000. This program gives CMS the authority to collect overdue taxes through a levy on certain federal payments; including those made to providers, contractors, and vendors doing business with the government.

The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to fully implement the FPLP for Medicare payments for overdue taxes, and extends it to also include a levy for non-tax debt.

CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice) issued on August 15, 2008, covers the implementation of the debt levy for overdue taxes, effective October 2008. (A related MLN Matters article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS website.), CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) non-tax debt offsets will also be levied against Medicare providers to repay unpaid debts owed to other Federal agencies, such as from educational loans.

Should you owe such taxes and/or debt, and your payments are reduced:

- For tax levy (effective October 1, 2008), your Medicare remittance advice will reflect the provider level adjustment code (PLB) of “WU” in the PLB03-1 data field (however, in the HIPAA 835, PLB reason code “LE” will replace currently used WU for: Third Party Payment (TPP) - Garnishments, including attorneys, Child Support, Alimony, Secondary Corporation, and Change of Ownership). In addition, the toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field.
- For non-tax debt levy (effective October 1, 2009), your Medicare remittance advice will reflect the PLB code of “ZZ” in the PLB03-1 data field, and the amount of the withholding can be found in the PLB04 field. In addition, the toll-free FMS number will appear in the PLB03-2 data field.

Notes:

- 1) Due to current privacy rules and regulations, the IRS is the only agency that can discuss the tax-related debt question with you, and FMS/Treasury is the only agency that can discuss the non-tax debt issue with you. Thus, if you have questions, contact them at the toll-free numbers just mentioned, instead of contacting your Medicare contractor.
- 2) Please observe that the toll-free IRS telephone number for questions regarding tax-related withholding is not the same as the toll-free FMS/Treasury toll-free telephone number for non-tax withholding questions.

You may find the following details about non-tax FPLP withholding of interest:

- CMS may reduce federal payments subject to the non-tax levy by 100 percent, (or the exact amount of the non-tax debt owed if it is less than 100 percent of the payment); and this levy is continuous until the non-tax debt is paid in full, or other arrangements are made to satisfy the debt.
- The Medicare Provider Payment Offset priority order is: 1) Medicare accounts receivable (AR) debt, 2) FPLP Offsets for Federal Tax debt at 15% maximum of the payable amount, 3) Administrative Offsets for Federal Non-Tax debt at 100% of the payable amount, and 4) Third-Party Payments (TPP).
- Within each payment offset priority category, CMS will collect the oldest debts first, namely the FPLP Offsets for Federal Tax debt and the Administrative Offsets for Federal Non-Tax debt.
- CMS will implement a minimum \$25 threshold for tax and non-tax debt offsets.
- The Treasury Department will process refunds to providers from CMS over-collections of FPLP Federal Tax debt or Administrative Offsets for Federal Non-Tax debt.

Additional Information

You can find the official instruction, CR 6228, issued to your carrier, FI, or MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R503OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You may also want to review the article related to CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice), which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS website.

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





Payment for Co-Surgeons in a Method II Critical Access Hospital (CAH)- 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: MM6319 Revised	Related Change Request (CR) #: 6319
Related CR Release Date: July 29, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R1781CP	Implementation Date: July 6, 2009

Note: This article was revised on **July 29, 2009**, to reflect a revision made to CR 6319. That CR was revised to replace a reference to Remark Code M78 with a reference to Remark Code N180. The CR release date, transmittal number, and Web address for accessing CR 6319 were also revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

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

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

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

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

- Medicare will accept claims for co-surgeon services submitted on type of bill 85X with revenue code 96X, 97X, or 98X if it contains either one claim line with a surgical HCPCS/CPT code and has the 62 modifier or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and the 62 modifier on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have the 62 modifier. Where only one line has the 62 modifier, Medicare will deny the line without the 62 modifier with the following messages:
 - **Medicare Summary Notice (MSN) 16.10** indicating Medicare does not pay for this item or service;
 - **Remittance Advice (RA) Remark Code N180**, indicating This item or service does not meet the criteria for the category under which it was billed;
 - **Group Code of CO** showing contractual obligation; and
 - **Claim Adjustment Reason Code (CARC) 4** denoting that the procedure code is inconsistent with the modifier used or a required modifier is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.
- The MPFSDB must reflect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is “0” indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:
 - **MSN message 15.12**, indicating Medicare does not pay for two surgeons for this procedure;
 - **RA Remark Code N431** to show “service is not covered with this procedure”;

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

reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

- **Group code CO** – Contractual Obligation.
- **CARC code 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85X with RC 96X, 97X or 98X and modifier 62 to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of ‘2’.
- Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:
 - **MSN Message 21.21** – This service was denied because Medicare only covers this service under certain circumstances.
 - **RA Remark Code N95** – The provider type/provider specialty may not bill this service.
 - **Group code PR** – Patient Responsibility.
 - **CARC code 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 62 modifier has a payment policy indicator of ‘9’, indicating the co-surgeon concept does not apply.
- Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.
- Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5% of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a Method II CAH, that CAH is paid 115% of that lesser payment amount.

Additional Information

The official instruction (CR 6319) issued to your Medicare FI or A/B MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1781CP.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)- 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: MM6395 Revised	Related Change Request (CR) #: 6395
Related CR Release Date: July 30, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1782CP	Implementation Date: July 6, 2009

Note: This article was revised on **July 31, 2009**, to reflect that CR 6395 was revised on July 30, 2009. The CR release date and transmittal number were revised. The Web address for accessing CR 6395 was also revised. All other information remains the same.

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/R1782CP.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 OPPTS)), 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.





The Use of the CR Modifier and the DR Condition Code on Disaster/Emergency-Related Claims

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: MM6451	Related Change Request (CR) #: 6451
Related CR Release Date: July 31, 2009	Effective Date: August 31, 2009
Related CR Transmittal #: R1784CP	Implementation Date: August 31, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on CR 6451, which updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the *Medicare Claims Processing Manual* dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

Background

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the “DR” condition code and the “CR” modifier to facilitate the processing of claims affected by that emergency. **The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies.** Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the “CR” modifier and “DR” condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

Key Points of CR 6451

The DR Condition Code: The title of the DR condition code is “disaster related” and its definition requires it to be “used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.” The DR condition code is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier’s discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a “formal waiver.”

The CR Modifier: Both the short and long descriptors of the CR modifier are “catastrophe/disaster related.” The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by “physicians and other suppliers”, are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier’s discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a “formal waiver.”

Formal Waivers: A “formal waiver” is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not “waivable” under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the “3-day qualifying hospital stay” requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

Further Instructions in the Event of a Disaster or Emergency: In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary’s declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Additional Information

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.pdf> on the CMS website.

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





Billing of Routine Foot Care When Payment Ceases for Loss of Protective Sensation Evaluation and Management

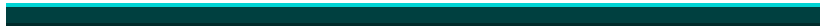
Background

The Center for Medicare & Medicaid Services (CMS) is clarifying the requirement for podiatric treatment in Pub. 100-04, Chapter 32, §80.8. This clarification is necessary to support podiatric coverage requirements found in Pub. 100-02, Chapter 15, §290. Coverage policy found in Pub. 100-02, Chapter 15, §290 allows contractors to cover podiatric treatment based on additional case findings not included in Class A, Class B or Class C finding as determined by the contractor's medical staff and developed as necessary.

Additional Information

The official instruction, CR 6456, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1742CP.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-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2010- **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: MM6461 Revised	Related Change Request (CR) #: 6461
Related CR Release Date: July 24, 2009	Effective Date: July 1, 2009
Related CR Transmittal #: R1780CP	Implementation Date: July 6, 2009

Note: This article was revised on **July 27, 2009**, to reflect changes made to CR 6461. The CR was revised to show a corrected labor-related share of 75.889 percent and a corrected non-labor-related share of 24.111 percent. The CR release date, transmittal number, and the Web address for accessing CR 6461 were also changed. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS).

Impact on Providers

Change Request (CR) 6461, from which this article is taken, identifies changes required as part of the annual Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) update for rate year (RY) 2010. These changes are effective July 1, 2009, and are applicable to IPF discharges occurring during the RY beginning on July 1, 2009, through June 30, 2010. This is the fourth RY update to the IPF PPS. The applicable previous year update is detailed in MLN Matters® article MM6077 and may be reviewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6077.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Make sure that your billing staffs are aware of these IPF PPS changes.

Background

Under the IPF PPS, payments to inpatient psychiatric facilities are based on a Federal Per Diem base rate that:

- Includes both inpatient operating and capital-related costs (including routine and ancillary services); but
- Excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

CMS is required to update this IPF PPS annually. The RY update is effective July 1 - June 30 of each year and the Medicare Severity (MS) DRGs and ICD-9-CM codes are updated on October 1 of each year.

Key Points

Market Basket Update

CMS uses the Rehabilitation/Psychiatric/Long-Term Care (RPL) market basket to update the IPF PPS portion of the blended payment rate (that is the Federal per diem base rate).

PRICER Updates

For the IPF PPS RY 2010, (July 1, 2009 – June 30, 2010) the following are effective for discharges on July 1, 2009 through June 30, 2010:

- The Federal per diem base rate is \$651.76;
- The fixed dollar loss threshold amount is \$6,565.00;
- The IPF PPS will use the FY 2009 unadjusted pre-floor, pre-reclassified hospital wage index;
- The labor-related share is 75.889%;
- The non-labor related share is 24.111%; and
- The electroconvulsive therapy (ECT) rate is \$280.60.

Cost to Charge Ratios

The National Urban and Rural Cost to Charge Ratios (CCR) for the IPF PPS RY 2010 are displayed in the following table:

Cost to Charge Ratio	Median	Ceiling
Urban	0.5300	1.7647
Rural	0.6515	1.7381

CMS is applying the national median CCRs to the following situations:

- For new IPFs that have not yet submitted their first Medicare cost report, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG Update

The code set and adjustment factors are unchanged for RY 2010.

Note: For the FY 2009 pre-floor, pre-reclassified hospital wage index CMS is using the updated wage index and the wage index budget neutrality factor of 1.0009.

Additional Information

To see the official instruction (CR6461) issued to your Medicare FI or A/B MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1780CP.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.



Point of Origin Codes Update to the UB-04 (CMS-1450) Manual Code List

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: MM6478	Related Change Request (CR) #: 6478
Related CR Release Date: July 24, 2009	Effective Date: October 1, 2007
Related CR Transmittal #: R1775CP	Implementation Date: January 4, 2010

Provider Types Affected

All hospitals and other providers who submit UB-04s or their electronic equivalent to Medicare Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries.

Provider Action Needed

This article explains the addition of two new valid Point of Origin codes to the valid list of acceptable UB-04 codes. The new codes are E, Transfer from Ambulatory Surgical Center; and F, Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program. These codes must be used to complete Form CMS-1450 Data Set, described in the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the Form CMS-1450 Data Set). Providers should inform their claims staff of the new codes.

Background

The following point of origin (formerly source of admission) codes, created by the National Uniform Billing Committee (NUBC), should be used, when appropriate in FL 15 of the UB-04 and its electronic equivalent and these codes will be accepted by Medicare’s claims processing systems as of January 4, 2010:

E – Transfer from Ambulatory Surgical Center:

- **Inpatient:** This patient was admitted to this facility as a transfer from an ambulatory surgery center.
- **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.

F – Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program:

- **Inpatient:** The patient was admitted to this facility as a transfer from hospice.
- **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

Additional Information

The official instruction, CR 6478, issued to your Medicare FI and/or MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1775CP.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.



Telehealth Services in Indian Health Service (IHS) or Tribal Providers

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: MM6493	Related Change Request (CR) #: 6493
Related CR Release Date: July 24, 2009	Effective Date: January 1, 2009
Related CR Transmittal #: R1776CP	Implementation Date: January 4, 2010

Provider Types Affected

Indian Health Service (IHS) and tribal providers who bill Medicare carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MAC) for providing telehealth services to Medicare Beneficiaries.

What You Need To Know

CR 6493, from which this article is taken, expands the instructions for telehealth services (effective January 1, 2009) to include Indian Health Service (IHS) and tribal providers as eligible to receive the telehealth originating site facility fee. The CR also clarifies the payment basis to the distant site physician or practitioner. You should make sure that your billing staffs are aware of this new information.

Background

The following point of origin (formerly source of admission) codes, created by the CR 6493, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is expanding the instructions for telehealth services to include Indian Health Service (IHS) and tribal providers.

Effective January 1, 2009, IHS and tribal providers are included in the telehealth service polices (presented below) and eligible to receive:

- The originating site facility fee (generated from an originating site facility service in which the beneficiary is presented to the distant site practitioner); and
- The payment to the distant site physician or practitioner (usually a professional consultation).

Telehealth Policies

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended Section 1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services. With this amendment, effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous “store and forward” technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. In addition, BIPA does not require that a practitioner present the patient for interactive telehealth services.

Originating Site Facility and Distant Site Practitioner Services

The originating site facility fee is equal to \$23.72 for the period January 1, 2009 through December 31, 2009. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI). For CY 2009, the payment amount is 80 percent of the lesser of the actual charge or \$23.72. (No clinic visit is to be billed if this is the only service received.)

The following facility types are authorized by law to be eligible for payment of the telehealth originating site facility fee when a beneficiary is presented to a distant site practitioner:

- The office of a physician or practitioner;
- A hospital (inpatient or outpatient);
- A critical access hospital (CAH);
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

NOTE: Except for the Federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSA).

IHS/Tribal facilities should submit claims for the originating site facility fee on Types of Bills (TOB) 12x, 13x, 71x, 73x, or 85x, using HCPCS code Q3014 and revenue code 0780.

Distant site practitioners include only physicians and selected medical practitioners, specifically Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Certified Nurse-Midwives (CNM), Clinical Social Workers (CSW), Clinical Psychologists (CP), or Registered Dietician or Nutrition professionals.

Distant site practitioners services are payable as if they were provided face-to-face, using the Medicare Physician Fee Schedule (MPFS); and are based on 80% of the Medicare Physician Fee Schedule (MPFS) payment amount for a physician, and the appropriate step down percentages for other practitioners. The usual Part B coinsurance and deductible apply, but are waived for IHS/Tribal facilities.

Billing providers should use the following Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes on claims for distant site practitioner services:

- Consultations (CPT codes 99241 - 99255)
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801);

- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803);
- Neurobehavioral status exam (CPT code 96116); and
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408).

You must include either the GT modifier (for interactive telecommunications) on your claims, or the GQ modifier (for the store and forward communication) if used in the Federal Telemedicine Demonstration in Alaska or Hawaii.

Additional Information

Your Medicare contractor will not search their files to find and adjust claims with dates of service on or after January 1, 2009 that were processed prior to the January 4, 2010 implementation date of CR 6493. However, they will adjust such claims that you bring to their attention.

You can find more information about the provision of telehealth services by IHS or tribal providers by going to CR 6493, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1776CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Claims Processing Manual*, Chapter 19 (Indian Health Services), Sections 100.16 (Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.1 (FI--Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.2 (FI – Telehealth Originating Site Facility Fee – Medicare Part B – Payment Policy) and (FI – Telehealth Originating Site Facility Fee – Medicare Part B – Claims Processing) as an attachment to that CR.

You might also want to review *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 190 (Medicare Payment for Telehealth Services); and *Medicare Benefit Policy Manual* Chapter 15 (Covered Medical and Other Health Services), Section 270 (Telehealth Services) for more information on telehealth services. This manual is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> 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.





Diabetes Self-Management Training (DSMT) Certified Diabetic Educator

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: MM6510	Related Change Request (CR) #: 6510
Related CR Release Date: August 7, 2009	Effective Date: March 30, 2009
Related CR Transmittal #: R109CP	Implementation Date: September 8, 2009

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 DSMT services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6510 which recognizes the American Association of Diabetes Educators (AADE) as an approved Diabetes Self-Management Training (DSMT) national accreditation organization. CR 6510 also implements the following exception for DSMT in rural areas: an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by the Centers for Medicare & Medicaid Services (CMS) may furnish training and is deemed to meet the multidisciplinary team requirement.

Background

The Centers for Medicare & Medicaid Services (CMS) announced in their Final Notice published in the Federal Register (Volume 74, February 27, 2009) that the American Association of Diabetes Educators (AADE) is approved as a national accreditation organization to furnish DSMT and is recognized as a national accrediting organization for accrediting entities to furnish outpatient DSMT to Medicare beneficiaries. See the Federal Register (V74, February 27, 2009) at <http://edocket.access.gpo.gov/2009/pdf/E9-3287.pdf> on the Internet.

Providers and suppliers of DSMT services may submit requests for accreditation through the AADE, and Medicare contractors shall recognize the AADE as an approving entity for the DSMT program billable through Medicare.

In addition, if providers/suppliers had a valid AADE certificate disapproved by their Medicare contractor, they may ask their contractor to reprocess that application.

CR 6510 also amended the *Medicare Benefit Policy Manual* (Chapter 15 (Covered Medical and Other Health Services)) to clarify that there is an exception for who can provide DSMT in a rural area as follows:

“...Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. ***There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement.***”

See the Code of Federal Regulations (CFR), Title 42, Chapter IV, Section 410.144(a)(4)(C)(ii) which describes the exception for DSMT in rural areas at http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.144.pdf on the Internet.

Additional Information

The official instruction, CR 6510, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R109BP.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.





Revised Processing of Osteoporosis Drugs under the Home Health Benefit

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: MM6512	Related Change Request (CR) #: 6512
Related CR Release Date: July 24, 2009	Effective Date: January 1, 2010
Related CR Transmittal #: R1773CP	Implementation Date: January 4, 2010

Provider Types Affected

Home Health Agencies (HHA) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHI), Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC)) for injectable osteoporosis drugs provided to Medicare beneficiaries are affected.

Provider Action Needed

HHAs are reminded that the current criteria for coverage of injectable osteoporosis drugs must be met when submitting claims for these drugs. There is no change in these criteria. However, this article explains that the date of service on claims submitted for covered osteoporosis drugs must fall within the start and end dates of an existing home health prospective payment system (PPS) episode. Please inform your billing staffs of this requirement.

Background

Medicare covers injectable osteoporosis drugs if certain criteria are met. These criteria include:

- Eligibility for coverage of home health services;
- Physician certification that the individual sustained a bone fracture related to post-menopausal osteoporosis; and
- Physician certification that the female patient is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Currently, the second and third criteria are enforced to the extent possible through Medicare systems by edits that require that the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present. However, the first criterion that the beneficiary must be covered under the home health benefit is only partially enforced. If an osteoporosis claim is received and a home health episode of care is on file, Medicare requires that the provider number of the HHA submitting the osteoporosis claim must be the same as the provider number on the episode record. CR 6512 revises the Medicare systems to fully enforce this criterion by requiring that the date of service for an injectable osteoporosis drug on a home health claim falls within the start and end dates of an existing home health episode if the claim contains:

- Type of bill 34x;
- Healthcare Common Procedure Coding Systems (HCPCS) codes J0630, J3110 or J3490; and
- Covered charges corresponding to these HCPCS codes.

Claims not meeting the criteria for coverage will be rejected with the following messages: MSN message 6.5, "Medicare cannot pay for this injection because one or more requirements for coverage were not met;" and claim adjustment reason code 177, "Patient has not met the required eligibility requirements."

Additional Information

The official instruction, CR 6512, issued to your Medicare RHHI, FI, and/or MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1773CP.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.





Appropriate Use of Modifier 50 and Add-On Current Procedural Terminology Codes (CPT) for Facet Joint Injection Services- 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: MM6518- Revised	Related Change Request (CR) #: 6518
Related CR Release Date: July 31, 2009	Effective Date: August 31, 2009
Related CR Transmittal #: R526OTN	Implementation Date: August 31, 2009

Note: This article was revised on **August 10, 2009**, to reflect a revision made to CR 6518. The transmittal number and the Web address for accessing CR 6518 have been changed. All other information remains the same.

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC)) for facet joint injections performed on Medicare beneficiaries.

Provider Action Needed

This article clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services. Physicians who perform facet joint injections on both the right and left sides of one level of the spine must use modifier 50 with the appropriate CPT codes when submitting claims. Physicians who perform facet joint injections on multiple levels on the same side of the spine must use the CPT add-on codes to represent these additional levels injected, instead of using modifier 50. Physicians should ensure that billing staffs are aware of this clarification.

Background

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. The CPT codes used for facet joint injections are:

Table: Facet Joint Injection CPT Codes and Descriptions

CPT Code	Description
64470	Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical/thoracic; single level
64472 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; cervical/thoracic; each additional level
64475	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; single level
64476 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; each additional level

The primary codes, 64470 and 64475, are used for a **single** injection in the cervical/thoracic or lumbar/sacral area of the spine, respectively. Each primary code has an associated **add-on code for use when injections**

are provided at multiple spinal levels. The add-on codes are 64472 (cervical/thoracic) and 64476 (lumbar/sacral).

Bilateral injections are performed on the right and left sides of one joint level. The Centers for Medicare & Medicaid Services (CMS) requires physicians **to indicate a bilateral injection by using billing modifier 50 and the appropriate CPT code.** If a physician performs multiple bilateral injections, modifier 50 should accompany each facet joint injection CPT code.

The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and released a final report, entitled, “Medicare Payments for Facet Joint Injection Services,” OEI-05-07-00200. **The OIG found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.** This report is viewable at <http://www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf> on the Internet.

To summarize, when facet joint injections are performed on both the right and left sides of a level of the spine, physicians must use modifier 50 and the appropriate primary CPT code. When facet joint injections are performed at more than one level, physicians must use add-on codes 64472 or 64476 to represent additional levels of the spine injected.

Additional Information

The official instruction issued to your Medicare carrier, FI and/or MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R526OTN.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.





Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

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: MM6520	Related Change Request (CR) #: 6520
Related CR Release Date: July 10, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R1770CP	Implementation Date: October 5, 2009

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors, and Fiscal Intermediaries (FIs) including regional home health intermediaries).

Provider Action Needed

This article is based on Change Request (CR) 6520 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

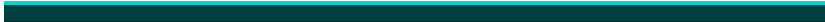
CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

The official instruction (CR 6520) issued to your Medicare MAC and/or FI/carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf> on the CMS website.

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





Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)

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

MLN Matters Number: MM6526	Related Change Request (CR) #: 6526
Related CR Release Date: July 24, 2009	Effective Date: January 1, 2008
Related CR Transmittal #: R1777CP	Implementation Date: January 4, 2010

Provider Types Affected

Method II Critical Access Hospitals (CAH) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for bilateral procedure services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6526 which implements payment for bilateral procedures performed in Method II Critical Access Hospitals (CAHs), in cases where the physician reassigns billing rights to the Method II CAH.

What You Need to Know

Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on the lesser of the actual charges or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. Modifier 50 is used for bilateral procedures and this article provides information on claims submission for these procedures. CR 6526 implements the 150 percent payment adjustment for bilateral procedures.

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

Background

The Social Security Act (Section 1834(g)(2)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) states that professional services included within outpatient Critical Access Hospital (CAH) services, will be paid 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services. The Centers for Medicare & Medicaid Services (CMS) establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. See 42 CFR 414.40 at http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr414.42.pdf on the Internet, This includes the use of the 50 modifier (bilateral procedure).

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on lesser of the actual charges or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. CR 6526 implements the 150 percent payment adjustment for bilateral procedures. Medicare contractors use payment policy indicators associated with certain procedures in the MPFS in processing claims and determining payment.

Bilateral procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized as a bilateral procedure and is billed on TOB 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure). Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral or bilateral, the 50 modifier is not reported.

If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure should be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one.

Modifiers LT (left side) and RT (right side) are not to be reported when the 50 modifier applies. Claims with the LT and RT modifiers will be returned to the provider (RTP) when modifier 50 applies. See the Medicare Claims Processing Manual, Chapter 4, section 20.6 at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf> on the CMS website for more information on the use of the 50, LT and RT modifiers.

If a procedure can be billed as bilateral but is not authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 3), the procedure is to be reported on a single line item with the 50 modifier and one service unit. Payment is made based on the lesser of the actual charges or 100% of the MPFS amount for each side of the body.

The January 2010 Integrated Outpatient Code Editor (IOCE) specifications will include a change to edit 74 (units greater than one for bilateral procedures billed with modifier 50). At that time, claims submitted on TOB 85X with revenue code (RC) 96X, 97X or 98X, a Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code with a bilateral indicator of '1' or '3', modifier 50 and more than one service unit on the same line will be returned to the provider.

Medicare uses the bilateral surgery payment policy indicators on the MPFS to determine if the 150 percent payment adjustment is payable for a specific HCPCS/CPT code. The MPFS database is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the CMS website. Medicare contractors have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in their claims processing systems.

In summary, Medicare contractors will:

- Return to Provider (RTP) bilateral procedures submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 50 modifier, has a payment policy indicator of '0', '2', or '9'.
 - **Payment Policy Indicator 0** – 150 percent payment adjustment for bilateral procedures **does not apply**. The bilateral procedure is inappropriate for codes in this category because of

physiology or anatomy or the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

- **Payment Policy Indicator 2** - 150 percent payment adjustment for bilateral procedures **does not apply**. The relative value units (RVUs) are based on a bilateral procedure because the code descriptor states that the procedure is bilateral, the codes descriptor states that the procedure may be performed either unilaterally or bilaterally, or the procedure is usually performed as a bilateral procedure.
- **Payment Policy Indicator 9** - concept **does not apply**.
- RTP bilateral procedures submitted on TOB 85X with RC 96X, 97X or 98X when the bilateral procedure code is billed with the RT and LT modifiers and the payment policy indicator is '1' or '3'. This includes claims with a bilateral procedure and modifiers LT and RT on the same claim line or claims with the same bilateral procedure on two claim lines with the same line item date of service (LIDOS), one claim line with modifier RT and another claim line with modifier LT.
 - **Payment Policy Indicator 1** – 150 percent payment adjustment for bilateral procedures **does apply**.
 - **Payment Policy Indicator 3** - 150 percent payment adjustment for bilateral procedures **does not apply**. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.
- Pay for bilateral procedures on TOB 85X with RC 96X, 97X or 98X, one service unit and modifier 50 when the HCPCS/CPT code has a payment policy indicator of '1' based on the lesser of the actual charges or the 150 percent payment adjustment for bilateral procedures as follows: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) minus (deductible and coinsurance)) times 115 percent.
- Pay for bilateral procedures on TOB 85X with RC 96X, 97X or 98X and modifier 50 and one service unit when the HCPCS/CPT code has a payment policy indicator of '3' based on the lesser of the actual charges or 200 percent of the MPFS amount as follows: (facility specific MPFS amount times 200 percent (100 percent for each side) minus (deductible and coinsurance)) times 115 percent.

NOTE: Although the 150 percent payment adjustment does not apply to payment policy indicator '3', modifier 50 may be billed with these procedures. When billed with the 50 modifier, payment is based on the lower of the actual charges or 200 percent of the MPFS amount.

- Calculate payment using all payment modifiers associated with the line item.

Example 1:

Modifiers 50, AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) and 80 (assistant surgeon) are submitted on the line. The line item HCPCS/CPT code is authorized for both bilateral surgery and assistant at surgery. Payment would be made based on the lesser of the actual charges or the following calculation: (facility specific MPFS amount times bilateral procedure adjustment

(150 percent) times assistant at surgery reduction (16 percent) times non-physician practitioner adjustment (85 percent) minus (deductible and coinsurance)) times 115 percent.

Example 2:

Modifiers 50 and 62 (two surgeons) are submitted on the line. The line item HCPCS/CPT code is authorized for both bilateral surgery and co-surgery. Payment would be made based on the lesser of the actual charges or the following calculation: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) times co-surgery reduction (62.5 percent) minus (deductible and coinsurance)) times 115 percent.

Note: Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date of CR 6526, but will adjust claims brought to their attention.

Additional Information

The official instruction, CR 6526, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1777CP.pdf> 0.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.





Compliance Standards for Consignment Closets and Stock and Bill Arrangements

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: MM6528	Related Change Request (CR) #: 6528
Related CR Release Date: August 7, 2009	Effective Date: September 8, 2009
Related CR Transmittal #: R297PI	Implementation Date: September 8, 2009

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution and which submit claims to the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) are affected. In addition, physicians and non-physician practitioners who maintain DMEPOS inventory at the physician or non-physician practitioner’s practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider Action Needed

DMEPOS suppliers, physicians and non-physician practitioners who maintain consignment closets and stock and bill arrangements for DMEPOS must comply with current standards, which may be verified by the NSC-MAC. Providers should assure that their billing staff are advised of these billing and compliance standards.

Background

This article is based on CR 6528, which defines and prohibits certain arrangements where an enrolled DMEPOS supplier maintains inventory at a practice location that is not owned by the enrolled DMEPOS supplier, but rather, owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution, commonly referred to as a consignment closet and/or stock and bill arrangement. A common practice example is that of an enrolled physician practice that allows DMEPOS owned by a separately enrolled DMEPOS supplier to be kept at the physician’s practice location.

CR 6528 instructs the NSC-MAC that use of consignment closets and/or stock and bill arrangements, as defined in the background above, must be in compliance with current standards. In addition, the CR defines additional specific compliance standards for NSC-MAC validation for consignment closets and stock and bill arrangements added to the *Medicare Program Integrity Manual* (PIM), chapter 10, section 21.8, and viewable as an attachment to CR 6528 at <http://www.cms.hhs.gov/Transmittals/downloads/R297PI.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare allows Medicare enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

- The title to the DMEPOS shall be transferred to the enrolled physician or non-physician practitioner’s practice at the time the DMEPOS is furnished to the beneficiary.

- The physician or non-physician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, not by any other DMEPOS supplier.
- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or non-physician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or non-physician practitioner's practice.

The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. (Note: This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location.) A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or non-physician practitioner.

Additional Information

The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R297PI.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.





The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2007 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)

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: MM6530	Related Change Request (CR) #: 6530
Related CR Release Date: July 24, 2009	Effective Date: August 7, 2009
Related CR Transmittal #: R1774CP	Implementation Date: August 7, 2009

Provider Types Affected

Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and 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.

Provider Action Needed

This article is based on Change Request (CR) 6530 which 1) provides updated Supplemental Security Income (SSI)/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low income patients and 2) furnishes links to the electronic files containing the data used for interim payments and for cost settlement purposes.

Background

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA; Section 9105) provides additional payment amounts for Inpatient Prospective Payment System (IPPS) hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate. See http://www.cms.hhs.gov/acuteinpatientpps/05_dsh.asp and http://www.cms.hhs.gov/COBRAContinuationofCov/01_Overview.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Under the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS), IRFs receive additional payment amounts to account for the cost of furnishing care to low-income patients. See 42 CFR Section 412.624(e)(2) at http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr412.624.pdf on the Internet.

Under the Long Term Care Hospital (LTCH) PPS, the payment adjustment for short-stay outlier (SSO) cases is based on the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., the “IPPS comparable amount.”). See 42 CFR Section 412.529 at http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr412.529.pdf on the Internet. The calculation of the “IPPS comparable amount” in the LTCH PPS SSO payment adjustment includes an IPPS comparable adjustment for the costs of serving a disproportionate share of low-income patients, where applicable, which utilizes SSI data (see 42 CFR Section 412.529(d)(4)).

Change Request (CR) 6530 provides links to the electronic files containing updated SSI Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients. The SSI/Medicare beneficiary data for hospitals contains the name of the hospital,

provider number, SSI days, total Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during Fiscal Year (FY) 2007 (cost reporting periods beginning on or after October 1, 2006 and before October 1, 2007).

The files are located at the following addresses:

- The IPPS data is available at http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopofPage on the CMS website;
- The IRF PPS data is at http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopofPage on the CMS website;
- The LtCH PPS data is at http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopofPage on the CMS website.

Additional Information

The official instruction, CR 6530, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1774CP.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.





Sleep Testing for Obstructive Sleep Apnea (OSA)

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: MM6534	Related Change Request (CR) #: 6534
Related CR Release Date: July 10, 2009	Effective Date: March 3, 2009
Related CR Transmittal #: R103NCD	Implementation Date: August 10, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6534 which announces that Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of Obstructive Sleep Apnea (OSA) as contained in section 240.4.1 of the National Coverage Determination (NCD) Manual. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has addressed the coverage of continuous positive airway pressure (CPAP) in three separate decisions in October 2001, April 2005, and March 2008. In each of those decisions, CMS limited coverage of CPAP in patients with OSA to those patients whose diagnosis was based on specific testing modalities. Initially, it limited coverage to OSA diagnosed with polysomnography (PSG). In the latest decision, it expanded coverage to OSA diagnosed with several types of home sleep tests. However, CMS has not, at a national level, specifically addressed coverage of the tests themselves. In other words, CPAP is nationally covered for beneficiaries with OSA if diagnosed with these specific tests; yet, coverage of the specific tests has previously been left to local contractor discretion.

After careful consideration, Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the NCD Manual.

Effective for claims with dates of service on and after March 3, 2009, Medicare will allow for coverage of the following:

1. Type I PSG when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing device when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing device measuring three or more channels, one of which is airflow, when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

4. Sleep testing device measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Nationally Non-Covered Indications:

Effective for claims with dates of services on and after March 3, 2009, other diagnostic sleep tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP and are not covered.

NOTE: All current claims processing and associated coding remain unchanged. Consult CR 6048, dated October 15, 2008, for detailed claims processing information. The MLN Matters® Article related to CR 6048 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf> on the CMS website.

Additional Information

Note that Medicare contractors will not search their files to adjust claims processed prior to the implementation date of CR 6534. However, they will adjust such claims that you bring to their attention.

The official instruction (CR 6534) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103NCD.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.





2009 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations

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: MM6539	Related Change Request (CR) #: 6539
Related CR Release Date: July 10, 2009	Effective Date: August 10, 2009
Related CR Transmittal #: R515OTN	Implementation Date: August 10, 2009

Provider Types Affected

This article has information for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for influenza and pneumococcal vaccinations provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6539 to remind the Medicare physician community of the requirements to correctly enroll in order to conduct Mass Immunization Roster Billing and Centralized Billing for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for Mass Immunizer Roster Billers.

Providers Take Note: A vaccine is being developed for the H1N1 virus and the development of the H1N1 vaccine could result in beneficiaries being eligible to receive more than one influenza vaccine during the upcoming influenza season. CMS will release more information regarding the development of the H1N1 vaccine and any coding updates in future CRs as necessary.

Background

CMS is issuing CR 6539 as a reminder for Mass Immunization Roster Billing and Centralized Billing for Influenza and Pneumococcal vaccinations. Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza and/or pneumococcal vaccinations to a large number of individuals, and they must be properly licensed in the States in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors or A/B MACs processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

All providers, except Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, already enrolled in the Medicare program may render and bill for providing influenza and/or pneumococcal vaccinations. DMEPOS suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Providers/suppliers who will only render influenza and/or pneumococcal vaccination services must enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a Centralized Biller.

They must:

- Accept assignment on both the vaccine and its administration;
- Bill only for influenza and/or pneumococcal vaccinations; and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS 855 provider enrollment form. Information on provider enrollment forms can be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp on the CMS website. Refer to the *Medicare Claims Processing Manual* Chapter 18, Sections 10-10.5 for more information on billing requirements. This manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS website.

CMS offers a number of free educational products on its Medicare Learning Network (MLN). These products are available on the MLN Preventive Services Educational Products web page located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year;
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration; and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease; and
- Have not received a pneumococcal vaccine within the last five years; or
- Are revaccinated because they are unsure of their vaccination status.

Additional Information

CMS offers a number of free educational products on its Medicare Learning Network (MLN). These products are available on the MLN Preventive Services Educational Products web page located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.

The official instruction, CR 6539, issued to your Medicare FI, carrier or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R515OTN.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.





Interest Payment on Clean Non- PIP Claims Not Paid Timely

Background

This Change Request revises Pub.100-04, Chapter 1, section 80.2.2 “Interest Payment on Clean Non-PIP Claims Not Paid Timely” to replace the internet web URL with the latest URL for accessing the Department of Treasury for current and past Prompt Payment Act interest rates payable when clean non-PIP Medicare claims are not paid in a timely manner by Medicare contractors. This CR also clarifies the section’s language regarding notifying providers of changes in the Prompt Payment Act interest rate. Finally, the dates have been updated in the illustrative example for the calculation of the payable interest to give more recent dates. The interest rate shown is unchanged and correct for the new dates shown.

Additional Information

The official instruction, CR 6542, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1771CP.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.





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

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

MLN Matters Number: MM6548	Related Change Request (CR) #: 6548
Related CR Release Date: July 10, 2009	Effective Date: October 1, 2009
Related CR Transmittal #: R1766CP	Implementation Date: October 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6548 which announces the changes that will be included in the October 2009 release of Medicare’s edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2009. Be sure billing staff are aware of the changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001.

Nationally uniform software was developed and incorporated in Medicare’s systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

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

CR 6548 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2009. These changes become effective for services furnished on or after October 1, 2009. The changes that are effective for dates of service on and after October 1, 2009 are as follows:

For the Urine Culture, Bacterial:

- Add ICD-9-CM codes 670.10, 670.12, 670.14, 670.20, 670.22, 670.24, 670.30, 670.32, 670.34, 670.80, 670.82, 670.84, and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.

For Blood Counts:

- Add ICD-9-CM codes V26.42, V26.82, V53.50-V53.51, V53.59, V61.07-V61.08, V61.23-V61.25, V61.42, V72.60-V72.63, and V72.69 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes V53.5 and V72.6 from that list.

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM codes 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PTT (190.16) NCD.
- Delete ICD-9-CM code 453.8 from that list.

For Prothrombin Time (PT):

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PT (190.17) NCD.
- Delete ICD-9-CM code 453.8 from that list.
- Replace the duplicate ICD-9-CM code 868.19 with 868.09 within that list.

For Serum Iron Studies:

- Add ICD-9-CM codes 209.31-209.36, 209.70-209.75, 209.79, 239.81, 239.89, 285.3, 453.50-453.52 and 569.87 to the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM code 239.8 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.

For Thyroid Testing:

- Add ICD-9-CM codes 279.41, 279.49, 784.42-784.44, 784.51, 784.59, 799.21-799.25, 799.29, and V10.91 to the list of ICD-9-CM codes that are covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes 279.4, 784.5, and 799.2 from that list.

For Lipids Testing:

- Add ICD-9-CM codes 438.13-438.14 to the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD.
-

For Digoxin Therapeutic Drug Assay:

- Add ICD-9-CM codes 787.04, 799.21-799.25, 799.29 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.
- Delete ICD-9-CM code 799.2 from that list.

For Alphafetoprotein:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the Alpha-fetoprotein (190.25) NCD.

For Carcinoembryonic Antigen:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 569.87, 969.00-969.05, 969.09, 969.70-969.73 and 969.79 to the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM codes 453.8, 969.0 and 969.7 from that list.

For the Hepatitis Panel/Acute Hepatitis Panel:

- Add ICD-9-CM codes 787.04 and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

For Fecal Occult Blood Test:

- Add ICD-9-CM codes 209.70-209.75, 209.79, 285.3, 569.87, 787.04, 789.7 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Delete CPT® code G0394 from the list of CPT® codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.

For all 23 Lab NCDs:

- ICD-9-CM codes V20.31-V20.32, V60.81, V60.89, V80.01, and V80.09 will be denied for all 23 NCDs.
- ICD-9-CM codes V60.8 and V80.0 will be deleted from the non-covered by Medicare lists for all 23 NCDs.

Additional Information

The official instruction (CR 6548) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1766CP.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.



2010 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

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

MLN Matters Number: MM6581	Related Change Request (CR) #: 6581
Related CR Release Date: August 7, 2009	Effective Date: January 1, 2010
Related CR Transmittal #: R1789CP	Implementation Date: January 4, 2010

Provider Types Affected

Physicians and other providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries in HPSAs.

What You Need To Know

Change Request (CR) 6581, from which this article is taken, alerts providers that the 2010 file will be posted to the Centers for Medicare & Medicaid Services (CMS) website.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS will create a new automated HPSA bonus payment file for claims with dates of service on or after January 1, 2010, through December 31, 2010 and post it to the website in early December of 2009.

You will find the annual HPSA bonus payment file and other important HPSA information at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/> on the CMS website. You should also review the CMS website to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf> on the CMS website and following the instructions on the page.

Additional Information

The official instruction (CR 6581) issued to your MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1789CP.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.





Healthcare Provider Taxonomy Codes (HPTC) Update October 2009

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

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

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

Additional Information

The official instruction (CR 6598) issued to your MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/transmittals/downloads/R1794CP.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.





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