

Home Health & Hospice Medicare A Newsline



Important Information from Cahaba Government Benefit Administrators®, LLC (Cahaba)

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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: www.cahabagba.com













The Inside Story

News from CMS

 	News Flash Messages from CMS.....1
 	Non-acceptance of Legacy Provider Numbers on Incoming Medicare Claims4
 	National Provider Identifier (NPI) for Secondary Providers— Revised5
 	Archiving and Retrieving of the Integrated Outpatient Code Editor (IOCE) and the Medicare Code Editor (MCE) for Processing Claims.....7
 	New 2008 Medicare Physician Fee Schedule (MPFS) Payment Rates Effective for Dates of Service July 1, 2008, through December 31, 2008.....8
 	2008 - 2009 Influenza (Flu) Season Resources for Health Care Professionals.....10
 	Influenza Pandemic Emergency -- The Medicare Program Prepares.....14
 	Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) (Attachments A, B, C)16
 	Update to Medicare Deductible, Coinsurance and Premium Rates for 200920
	Claim Adjustments to Correct Home Health Prospective Payment System (HH PPS) Payment Errors22

	2009 Annual Update to the Therapy Code List ... 25
	Home Health Prospective Payment System 2009 Update..... 26
	Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement 26
	Changes in Medicare Payment for Oxygen and Oxygen Equipment 28
	Fee Schedule Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)..... 30
	Medicare Hospice Data Collection on Claims..... 36

News from Cahaba

 	New Complex Password Policy 37
 	New Online Course for Clinicians..... 37
 	Medicare Contractor Reform Ask-the-Contractor Teleconference (ACT)..... 38
 	System Availability During the Christmas Holiday..... 38
 	Medicare Forum 39

The Inside Story Continues on the Next Page

Key for Icons:






Home Health Providers



Hospice Providers

News from Cahaba (continued)

	Top Claim Submission Error—How to Avoid Reason Code 31147 41		New Condition Code for Hospice Discharge for Cause43
	Not Responding to Widespread Home Health Edits Costs Us All 42	Cahaba Learning Corner	44

Disclaimer
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News Flash Messages from CMS for Home Health and Hospice Providers



Your Medicare Payments Could be Reduced if the Internal Revenue Service (IRS) Needs To Collect Overdue Taxes That You Owe

The Taxpayer Relief Act of 1997, Section 1024, authorizes the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of “WU” in the PLB03-1 data field. For more information, please see MLN Matters Article #MM6125 available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS Web site.





Flu Season is Here!

Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting an annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals and their staff, see http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site. To download the Medicare Part B Immunization Billing quick reference chart, go to http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS Web site. A copy of this quick reference chart can be ordered, free of charge, by going to the MLN Products Web page at <http://www.cms.hhs.gov/MLNProducts/> and clicking on "MLN Product Ordering Page" in the "Related Links Inside CMS" section of the Web page.



ICD-10-Clinical Modification/Procedure Coding System Fact Sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2008.pdf> on the CMS Web site.



The Medicare Learning Network (MLN) - The MLN Products Catalog

The MLN is the brand name for official CMS national fee-for-service (FFS) health care professional education products. The MLN is designed to promote national consistency of Medicare information developed for CMS initiatives. Most importantly, it is available to help you!

The MLN Products Catalog is now an interactive downloadable document that lists all MLN products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download", when selected, will link you to the online version of the product. The word "hard copy", when selected, will automatically link you to the MLN Product Ordering page.

The Catalog is updated quarterly and the latest version is now available for download at <http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf> on the CMS Web site.

Each quarter the MLN will send out information on the latest products available to order. Please be on the lookout for those updates!

For more information on The Medicare Learning Network, please visit <http://www.cms.hhs.gov/MLNGenInfo> on the Internet.



Stay Informed of the Educational Products from the Medicare Learning Network (MLN)

Would you like to stay informed of the educational products from the Medicare Learning Network (MLN)? If so, you can join the MLN Education Products mailing list, which will deliver the latest information about new and revised MLN products, right to your inbox. To join, visit https://list.nih.gov/cgi-bin/wa?SUBED1=mln_education_products-l&A=1; then enter your email address and full name. Click "Join the List". Follow the instructions in the confirmation email you will receive to confirm your subscription to the list. (Note that the sender of this email will appear as "NIH LISTSERV SERVER".)



Release of the 2009 HCPCS Annual Update

The Centers for Medicare and Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web site at: <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/>

All changes are effective January 1, 2009, unless otherwise indicated in the effective date column.



Non-acceptance of Legacy Provider Numbers on Incoming Medicare Claims

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0835

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Part A/B Medicare administrative contractors (A/B MACs), and/or durable medical equipment MACs (DME MACs)) services provided to Medicare beneficiaries.

Provider Action Needed

With the implementation of the National Provider Identifier (NPI) on May 23, 2008, Medicare ceased accepting legacy provider numbers, qualified by 1C and 1G within the secondary provider REF segments, on incoming Medicare American National Standards Institute (ANSI) X12N 837 4010A1 claims. Effective October 6, 2008, providers should note that, with one qualified exception, as highlighted below, Medicare will reject all incoming Medicare X12N 837 4010A1 claims that contain legacy identifiers. The following qualifiers within the secondary provider REF loops are acceptable:

- For 837 institutional claims, the Employer Identification Number (EIN)/Federal Tax ID, qualified by “EI” or “TJ,” will be accepted; and
- For 837 professional claims, the provider’s EIN/Tax ID, qualified by “EI” or “TJ,” or social security number, as qualified by “SY,” will be accepted.

The secondary provider REF loops encompass all of the following loops within the HIPAA ANSI X12N 837 4010A1 institutional or professional format: 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2330D, 2330E, 2330F, 2330G, 2330H, 2420A, 2420B, 2420C, 2420D, 2420E and 2420F.

Therefore, providers that bill Medicare should only be including the above referenced values within the indicated secondary provider REF loops as appropriate for the line of business submitted. In addition, providers should only use values qualified by “EI,” “TJ,” and “SY” when valid for the loop submitted.

EXCEPTION: Providers that bill Veterans Administration (VA) demonstration claims to TrailBlazer Health Enterprises, LLC, are permitted to include Medicare legacy provider numbers, qualified by 1C and 1G, within the secondary REF fields highlighted above. In addition, Medicare does not require NPI qualifiers and values within the NM108 and NM109 segments of the above referenced loops for incoming VA demonstration code claims (also known as the VA Medicare Remittance Advice [VA MRA] project claims).

Providers and suppliers that have questions regarding these loops and/or qualifiers should contact their software vendor for further details.

Background

The CMS implemented the NPI as the primary provider identifier to be used on Medicare claims effective May 23, 2008. Through the systematic actions that CMS is implementing on October 6, 2008, CMS will ensure that its objective of not accepting legacy provider numbers will be realized.

Additional Information

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

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National Provider Identifier (NPI) for Secondary Providers—**Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “National Provider Identifier (NPI) for Secondary Providers,” which was published in the October 1, 2008, *Home Health & Hospice Medicare A Newslines*. 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: MM6093 Revised
Related CR Release Date: October 15, 2008
Related CR Transmittal #: R270PI

Related Change Request (CR) #: 6093
Effective Date: May 23, 2008
Implementation Date: September 26, 2008 (FISS implementation date is November 3, 2008)

Note: This article was revised on October 19, 2008, to reflect changes to CR 6093, which CMS revised on October 15, 2008, to include the Fiscal Intermediary Standard System (FISS) in the business requirements. The FISS implementation date was also added. The CR release date, transmittal number, and the Web address for accessing CR 6093 were also revised. All other information remains the same.

Provider Types Affected

All Medicare providers who submit claims to Medicare carriers, Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors (DME MACs) and/or fiscal intermediaries (FIs) in which a secondary provider must be identified.

Provider Action Needed

This article is based on CR 6093 and outlines the need to use NPIs to identify secondary providers in Medicare claims beginning May 23, 2008.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers and entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS- 0045-F).

Effective May 23, 2008, paper and electronic Medicare claims must contain NPIs to identify health care providers in their role as health care providers. (NPIs do not replace Taxpayer Identification Numbers, which identify health care providers in their role as taxpayers.)

Medicare claims always identify primary providers. Primary providers are the Billing and Pay-to Providers and, for non-institutional and non-pharmacy claims, the Rendering Provider.

Some Medicare claims also need to identify one or more secondary providers. A secondary provider could be a health care provider who ordered services for a Medicare patient or who referred a Medicare patient to another health care provider (ordering/referring providers); an attending, operating, supervising, purchased service, other, or service facility provider; or a prescriber (the latter only in retail pharmacy drug claims).

Prior to May 23, 2008, health care providers who ordered/referred were identified by Unique Physician Identification Numbers (UPINs). UPINs were assigned to physicians as defined in section 1861(r) of the Social Security Act, and to nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical social workers, clinical psychologists, and certified nurse midwives—the only practitioners who are permitted by law to order/refer in the Medicare program. Medicare ceased assigning UPINs in June 2007 as part of the implementation of the NPI.

Note: CR 6093 does not alter existing requirements for capturing the name and address, when required, of secondary providers or instructions that address the specific practitioner types that must be reported in certain referral and “incident to” situations. CR 6093 instruction addresses only the reporting of the identifier for secondary providers, when required.

Key Points of CR 6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that **identifier must be an NPI**.
- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) **does not furnish** its NPI at the time of the order/, referral, purchase, prescription, or time of service, **YOU as the billing provider need to know that NPI in order to use it in your claim**.
- You may use the NPI Registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the Implementation Guides for the X12N claims transactions permit the reporting of the Social Security Number (SSN) for some secondary providers if there is no NPI, the CMS does not believe you will be successful in having secondary providers disclose their SSNs.
- If you are **unable to obtain the NPI of the entity** to be identified as the **service facility provider**, or if **that entity has not obtained an NPI**, **NO identifier is to be reported in that loop**.

- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, **you (the Billing Provider) must use YOUR NPI as the identifier for that secondary provider.**
- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional Information

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

For complete details regarding this CR please see the official instruction (CR 6093) issued to your Medicare carrier, DME MAC, MAC or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R270PI.pdf> on the CMS Web site.

Disclaimer

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Archiving and Retrieving of the Integrated Outpatient Code Editor (IOCE) and the Medicare Code Editor (MCE) for Processing 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: MM6177

Related CR Release Date: October 24, 2008

Related CR Transmittal #: R391OTN

Related Change Request (CR) #: 6177

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6177 and assures providers that Medicare contractors will have the ability to process claims and apply edits correctly. CMS requires Medicare contractors to establish a mechanism to retrieve OCE versions, effective for a date of service (DOS) prior to the most recent iteration (minus seven years), and establish a mechanism to retrieve MCE versions effective for discharges prior to the most recent iteration (minus ten years).

Background

Currently the Fiscal Intermediary Standard System (FISS) includes one copy of the IOCE software, which is supplied by 3M and replaced each quarter. However, to maintain a reasonable size for the software, there is a need to archive versions of the OCE greater than seven years (28 versions) within the Shared System so contractors can have the capability to process claims with dates of service prior to the single copy FISS currently maintains. For instance, if a contractor is required to process an Outpatient Prospective Payment System (OPPS) claim on June 1, 2009, and the claim has a DOS of April 2, 2002, the contractor should be able to process the claim without special handling. However, if the OPPS claim had a DOS of March 30, 2002, the contractor must have the capacity to retrieve the archived January 2002 version of the OCE to correctly process the claim.

This is also true for the MCE. There is a complete replacement product each year which includes all versions. Because it is not possible to use the same archiving and calling conventions used for the inpatient PRICERS, CR 6177 directs Medicare contractors to develop a new archiving and call process for FISS to use in accessing archived OCEs and MCEs.

CR6177 instructs FIs, A/B MACs and RHHIs to be able to:

- Process claims, with DOS prior to the most recent 28 versions of the OCE, with the appropriate corresponding archived version; and
- Process claims, with discharges prior to the most recent iteration of the MCE, with the appropriate corresponding archived version.

Additional Information

The official instruction (CR 6177) issued to your Medicare A/B MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/transmittals/downloads/R391OTN.pdf> on the CMS Web site.

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

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New 2008 Medicare Physician Fee Schedule (MPFS) Payment Rates Effective for Dates of Service July 1, 2008, through December 31, 2008

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: MM6212
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R389OTN

Related Change Request (CR) #: 6212
Effective Date: July 1, 2008
Implementation Date: October 24, 2008, unless otherwise noted below

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the MPFS.

Provider Action Needed STOP – Impact to You

This article is based on CR 6212, which announces the new 2008 MPFS payment rates effective for dates of service July 1, 2008, through December 31, 2008. Please note that Medicare contractors have already implemented the actions annotated in this article.

CAUTION – What You Need to Know

CMS directed Medicare contractors to revert back to the 0.5 percent payment rates that were previously in place until June 30, 2008, and to use those rates through December 31, 2008. In addition, carriers/Part B MACs are using the same rates as used for January 1 through June 30, 2008, to make payments, where appropriate, to ambulatory surgical centers (ASCs) for services rendered from July 1 through December 31, 2008. This reflects a continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services. CMS also provided revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008.

GO – What You Need to Do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. The -10.6 percent Medicare Physician Fee Schedule (MPFS) that took effect on July 1, 2008, was changed back to the January-June 2008 rates, which reflect an update of 0.5 percent. CMS directed **Medicare contractors** to revert back to the 0.5 percent payment files that were previously in place until June 30, 2008. The new MPFS rates are retroactive to July 1, 2008.

Consistent with the new legislation, **carriers/Part B MACs** are using the same fees as used for January 1 through June 30, 2008, to make payments to **ASCs** for July 1 through December 31, 2008. Those fees reflect the continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services.

Fiscal intermediaries/Part A MACs, including RHHIs, also have reverted back to the fees that were in effect from January 1, 2008, through June 30, 2008.

In addition, based on the new legislation, CMS provided Medicare contractors with new revised **fees for selected mental health codes** that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008, and Medicare contractors are currently paying the new fees.

After Medicare contractors began paying claims at the new rates, they began to identify any MPFS claims that were paid at the -10.6 percent rate for dates of service on and after July 1, 2008. Contractors were to automatically adjust those claims, and were required to complete the adjustments no later than September 30, 2008.

There may be some claims that cannot be automatically adjusted. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1 through June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount requires providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced non-participation amount also will need to request an adjustment.

Contractors are following the normal process for transmitting the adjusted claims to supplemental insurers, where appropriate. Contractors disclosed the new MPFS rates on their Web sites by July 23, 2008.

Additional Information

The official instruction, CR 6212, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R389OTN.pdf> on the CMS Web site.

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

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2008 - 2009 Influenza (Flu) Season Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0838

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this Special Edition MLN Matters article and refer to it throughout the 2008 - 2009 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

CMS reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot.

Prevention is Key to Public Health!

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff. **Protect yourself, your patients, your staff, and your family and friends. Get Your Flu Shot – Not the Flu!**

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational Products for Health Care Professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for flu vaccines and their administration.

1. MLN Matters Articles

- **MM6153:** Influenza Vaccine and the Pneumococcal Vaccine Payment Allowances Based on 95 Percent of the Average Wholesale Price (AWP) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6153.pdf> on the CMS Web site.
- **MM6121:** 2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6121.pdf> on the CMS Web site.

- **MM6079:** Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf> on the CMS Web site.
- **MM5511:** Update to *Medicare Claims Processing Manual*, (CMS Pub 100-04) Chapter 18, §10 for Part B Influenza Billing at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf> on the CMS Web site.
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf> on the CMS Web site.
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf> on the CMS Web site.

2. MLN Influenza Related Products for Health Care Professionals

- **Quick Reference Information: Medicare Part B Immunization Billing**—This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS Web site.
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition**—This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Web site.
- **Medicare Preventive Services Adult Immunizations Brochure**—This two-sided tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf on the CMS Web site.
- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course**—This WBT course contains four modules that include information about Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. To register, free of charge, to take this course go to the MLN Products web page <http://www.cms.hhs.gov/MLNProducts/> and select “Web-Based Training Modules” from Related Links Inside CMS at the bottom of the Web page.
- **Quick Reference Information: Medicare Preventive Services**—This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS Web site.

- **Medicare Preventive Services Bookmark**—This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at <http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf> on the CMS Web site.
- **MLN Preventive Services Educational Products Web Page**—This Medicare Learning Network (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** is at <http://www.cms.hhs.gov/AdultImmunizations/> on the CMS Web site.
- **CMS Frequently Asked Questions** are available at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEdhi on the CMS Web site.
- **Medicare Benefit Policy Manual (CMS Pub. 100-02) – Chapter 15, § 50.4.4.2**—Immunizations available at <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf> on the CMS Web site.
- **Medicare Claims Processing Manual (CMS Pub. 100-04) – Chapter 18, Preventive and Screening Services** available at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Web site.
- **Medicare Part B Drug Average Sales Price Payment Amounts**—Influenza and Pneumococcal Vaccines Pricing found at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp on the CMS Web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2008 – 2009 flu season:

- **Advisory Committee on Immunization Practices** are at <http://www.cdc.gov/vaccines/recs/acip/default.htm> on the Internet.
- **American Lung Association’s Influenza (Flu) Center** is at <http://www.lungusa.org> on the Internet. This Web site provides a flu clinic locator at <http://www.flucliniclocator.org> on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- **Centers for Disease Control and Prevention**—<http://www.cdc.gov/flu/>;
- **Food and Drug Administration**—<http://www.fda.gov/>;
- **Immunization Action Coalition**—<http://www.immunize.org/>;
- **Immunization: Supporting a Healthy Life Throughout the Lifespan**—<http://www.nfid.org/pdf/publications/naiaw08.pdf>;

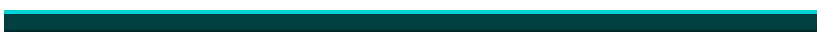
- **Indian Health Services**—<http://www.ihs.gov/>;
- **Medicare Quality Improvement Community**—[https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage](https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage;);
- **National Alliance for Hispanic Health**—<http://www.hispanichealth.org/>;
- **The National Center for Immunization and Respiratory Diseases (NCIRD)**—<http://www.cdc.gov/ncird/>;
- **National Foundation For Infectious Diseases**— <http://www.nfid.org/influenza/>;
- **National Library of Medicine and NIH Medline Plus**—<http://www.nlm.nih.gov/medlineplus/immunization.html>;
- **National Network for Immunization Information**— <http://www.immunizationinfo.org/>;
- **National Vaccine Program**—<http://www.hhs.gov/nvpo>;
- **Office of Disease Prevention and Promotion**—<http://odphp.osophs.dhhs.gov>;
- **Partnership for Prevention**—<http://www.prevent.org/>; and
- **World Health Organization**—<http://www.who.int/en/> on the Internet.

Beneficiary Information

For information to share with your Medicare patients, please visit <http://www.medicare.gov> on the Internet.

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Influenza Pandemic Emergency -- The Medicare Program Prepares

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0836 Revised

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME MACs), carriers or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Impact on Providers

This article is informational only and is alerting providers that CMS has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that may be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and
2. The Secretary of the Department of Health and Human Services declares – under §319 of the Public Health Service Act – that a public health emergency exists; and
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to §1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web Page Now Available

Providers should be aware that all relevant materials will be posted on a CMS dedicated “Pandemic Flu” Web page at http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp on the CMS Web site. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional Information

Additional CMS influenza pandemic policy documents include:

- CR 6164, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf> on the CMS Web site; and
- CR 6174, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R396OTN.pdf> on the CMS Web site.

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

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Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0837

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All fee-for-service physicians, providers, and suppliers who submit claims to fiscal intermediaries (FIs), carriers or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries. **Providers already billing Medicare Administrative Contractors (MACs) have already transitioned and need not review this article.**

Impact on Providers

This article is intended to assist all providers that will be affected by Medicare administrative contractor (MAC) implementations. CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business.

Background

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare administrative contractor authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare fee-for-service program.

When completed there will be 15 new MACs processing Part A and Part B claims. Each MAC will handle roughly the same volume of work. Because of this, the MACs will vary in geographic size but not necessarily in the amount of work they handle. This should result in greater consistency in the interpretation of Medicare policies.

NOTE: The home health and hospice workload has also been split into four jurisdictions. For additional information, refer to the [Specialty MAC Jurisdictions](#) Web page on the CMS Web page.

MAC Implementation Milestones Definitions

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action, relative to the milestones defined below:

Award – this is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover – This is the date on which carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions.

Pre-Award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare contracting reform by visiting <http://www.cms.hhs.gov/medicarecontractingreform/> on the CMS Web site.

Post-Award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

- **Pay attention to the mail** you receive from your outgoing Medicare contractor and your new MAC.-- You will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic fund transfers, etc.
- **Sign up for your new MAC’s listserv.** While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Getting on the MAC listserv distribution will ensure that you receive news as it happens concerning the implementation.
- **Access and bookmark the MAC’s Web site and visit it regularly.** The MAC will have a new Web site that will have general information, news and updates, information on the MAC’s requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.
- **Review the Frequently-Asked Questions (FAQs) on the MAC’s Web site.**
- **Participate in the MAC’s advisory groups and “Ask the Contractor” meetings.** Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!
- **Review the MAC’s local coverage determinations (LCDs)** as they may be different from the outgoing contractor LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and Web site for information regarding potential changes to the LCDs.

One Month Prior to Cutover

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and get it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. Contact your MAC with any questions concerning the agreement.
 - The CMS-588 form can be found at <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf> on the CMS Web site.
 - You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC’s Web site. Your contractor may also provide instructions on its Web site on accurately completing the form.

- Your new MAC may also request you to execute a new **Electronic Data Interchange (EDI) Trading Partner Agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at <http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf> on the CMS Web site.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their Web site for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these Submitter IDs and passwords to you in hardcopy or electronically. You **don't need to do anything to get the new IDs**; however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI Platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- **Contact your claims processing vendor and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, “Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?”; “Have you tested with the MAC?”
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware that some MACs may offer participation in an “early boarding” process for electronic claims submission and/or Electronic Remittance Advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password –watch for and document them for use after cutover to the MAC.

Cutover Weekend

- Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend. Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.
- Be aware that providers may also experience system “**dark days**” around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.
- Be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

Post-Cutover

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the “in-process” work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll free number for use.
- Be prepared that you may experience longer than normal wait times for Customer Service Representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC’s staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.

- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the CSR line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Check the MAC's outreach and education event schedule on the MAC's and outgoing Contractor's Web sites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that you may experience changes in Remittance Advice (RA) coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS Post-Cutover Monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional Assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A (see page 46) is a summary of what you need to do and information you will need;
- Attachment B (see page 48) may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation; and
- Attachment C (see page 49) may be used to assist you in tracking major MAC milestones.

Additional Information

The following MLN Matters article provides additional information about the MAC implementation process:

- MM5979: "Assignment of Providers to Medicare Administrative Contractors" located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5979.pdf> on the CMS Web site.

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

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Update to Medicare Deductible, Coinsurance and Premium Rates for 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: MM6258

Related Change Request (CR) #: 6258

Related CR Release Date: November 7, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R55GI

Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs) and carriers) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on CR 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

2009 Part A - Hospital Insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

Table 1

2009 Part A – Hospital Insurance (HI)			
Deductible	\$1,068.00		
	Hospital		Skilled Nursing Facility
	Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
Coinsurance	\$267.00	\$534.00	\$133.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	\$443.00 per month
Base Premium with 10% Surcharge	\$487.30 per month
Base premium with 45% Reduction	\$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	\$268.40 per month

2009 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2009, the standard premium for SMI services is \$96.40 a month; the deductible is \$135.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R55GI.pdf> on the CMS Web site.

Additional Information

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Claim Adjustments to Correct Home Health Prospective Payment System (HH PPS) Payment Errors

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: MM6250

Related CR Release Date: October 31, 2008

Related CR Transmittal #: R397OTN

Related Change Request (CR) #: 6250

Effective Date: Episodes beginning on or after January 1, 2008

Implementation Date: February 2, 2009

Provider Types Affected

Home health agencies (HHAs) billing regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6250 which provides the instructions and schedule for correcting payment errors that resulted from a number of software problems associated with the implementation of the Home Health Prospective Payment System (HH PPS) case-mix refinement. Be sure billing staffs are aware of these issues.

Background

Medicare implemented refinements to the HH PPS case-mix model effective for episodes beginning on or after January 1, 2008. However, Medicare systems did not correctly implement certain requirements of the HH PPS refinements initially, and errors subsequently resulted in incorrect payments to HHAs during the first two quarters of calendar year 2008. Certain errors resulted in overpayments to the HHAs, while others resulted in underpayments. These errors are further described as follows:

- 1) The January 1, 2008, version of the HH PPS Pricer software contained an error that caused the supply add-on amount to be paid on episodes that began in 2007 and spanned January 1, 2008. The supply add-on is properly only applicable for episodes beginning on or after January 1, 2008. This error resulted in overpayments of the minimum supply add-on amount of \$14.12.

Claims affected: Any HH PPS final claim with a “From” date in 2007 and a “Through” date in 2008 which was processed between January 1, 2008, and February 4, 2008.

- 2) The January 1, 2008, version of the HH PPS Pricer software contained an error that prevented appropriate upcoding of claims containing exactly 20 therapy visits, but which reported a HIPPS code projecting a lower number of therapy visits. This error resulted in underpayments due to claims being paid at a lower-weighted health insurance prospective payment system (HIPPS) code than was appropriate for the services billed.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, which reported 20 therapy visits and which was processed between January 1, 2008, and February 4, 2008.
NOTE: An HHA with claims affected by this error must request an adjustment from their RHII.

- 3) The January 1, 2008, version of the HH PPS Pricer software failed to wage adjust the low utilization payment adjustment (LUPA) add-on payment. This error resulted in overpayments for services provided to beneficiaries who reside in areas where the wage index is less than 1.0. The error resulted in underpayments for services provided to beneficiaries who reside in areas where the wage index is greater than 1.0

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, with four or fewer visits, which was the first episode in a sequence of related episodes and which was processed between January 1, 2008, and February 4, 2008. Adjustments to these claims are already scheduled as part of CR 5877. (See the related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5877.pdf> on the CMS Web site.)

- 4) The January 1, 2008, version of the HH PPS Pricer software paid the full non-routine supply add-on amount on claims for episodes subject to partial episode payment (PEP) adjustment. The supply add-on should have been prorated on a basis of days along with the remainder of Medicare’s payment for the episode. The error resulted in overpayments that varied in amount depending on the non-routine supply severity level that applied and the number of days in the PEP proration.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, which was subject to a PEP adjustment and which was processed between January 1, 2008, and February 4, 2008.

- 5) The February 4, 2008, version of the HH PPS Pricer software corrected the wage-adjustment of LUPA add-on payments but created an additional problem in which the LUPA add-on amount was paid on all HH visit lines on the claim. The LUPA add-on should properly only be paid on the earliest dated HH visit line on a claim. The error resulted in overpayments that varied in amount depending on how many visit lines were included on the claim.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, with four or fewer visits, which was the first episode in a sequence of related episodes and which was processed between February 4, 2008, and March 10, 2008. Adjustments to these claims also are already scheduled as part of CR 5877.

- 6) Medicare’s Common Working File system failed to recognize episodes that occurred in 2007 when determining episode sequences. This caused claims for later episodes to be recoded and paid as early episodes in error. This error resulted in underpayments since under the refined HH PPS later episodes have higher HIPPS code weights.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, with a HIPPS code indicating a later episode for which one of the first two episodes in the sequence of related episodes occurred in 2007 and which was processed between January 1, 2008, and July 7, 2008.

- 7) The March 10, 2008, version of the HH PPS Pricer software, as well as all previous versions, contained an incorrect per-visit rate for speech-language pathology (SLP) services. The Pricer reflected the SLP rate of \$124.54, as published in the original HH PPS final rule, rather than the corrected amount of \$124.65, as published in the correction notice to that rule. This error resulted in small underpayments in the calculation of LUPA and outlier payments.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, which was subject to LUPA or outlier payment adjustments and which was processed between January 1, 2008, and August 4, 2008.

- 8) The March 10, 2008, version of the HH PPS Pricer software, as well as all previous versions, contained an error in recoding logic that prevented the clinical domain value of the HIPPS code to be changed appropriately in certain cases. If the grouping step for the episode changed to step one during processing and the corresponding clinical severity value in the treatment authorization code was 'G' or 'N,' the clinical domain value in the HIPPS code was assigned to an incorrectly low weight. This error resulted in underpayments.

Claims affected: Any HH PPS final claim with a “From” date on or after January 1, 2008, which was recoded to a HIPPS code with '2' in the first position, which was processed between January 1, 2008, and August 4, 2008.

- 9) The August 4, 2008, version of the HH PPS Pricer software did not contain the 2008 wage index file. As a result, all HH claims processed after the version was installed paid incorrectly using the 2007 wage index. This error may have resulted in overpayments or underpayments depending on whether the wage index for a given Core Based Statistical Area (CBSA) increased or decreased between 2007 and 2008.

Claims affected: Any HH PPS final claim with a “Through” date on or after January 1, 2008, which was processed between August 4, 2008, and August 18, 2008.

CR 6250 instructs RHHIs to correct HH PPS refinement payment errors. Claims affected by these errors are those submitted on bill types 32X and 33X, excluding types 322 and 332. Your RHHI will process these corrections without any action on your part, except for item number 2, as noted above.

Additional Information

The official instruction, CR 6250, issued to your RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R397OTN.pdf> on the CMS Web site.

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

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2009 Annual Update to the Therapy 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: MM6254

Related Change Request (CR) #: 6254

Related CR Release Date: October 31, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1625CP

Implementation Date: January 5, 2009

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) or Part A/B Medicare administrative contractors (A/B MACs) for outpatient rehabilitation therapy services.

What Providers Need to Know

This article is based on CR 6254 and alerts providers to updates to Medicare's therapy code list with two "sometimes" therapy codes for CY 2009. Note that these codes always represent therapy services and require the use of a therapy modifier when performed by therapists. The two codes added are:

1. **95992** – Standard Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day.
2. **0183T** – Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.

Note: If billed by a hospital subject to Outpatient Prospective Payment System (OPPS) for an outpatient service, CPT code 0183T will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. In addition, no Medicare Physician Fee Schedule (MPFS) amount exists for this code. Since the local carrier (or A/B MAC) determines the coverage and pricing for this code, the FI or A/B MAC contacts the local contractor to obtain the appropriate fee schedule amount.

Background

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2008 and 2009 HCPCS/CPT-4.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, (CMS Pub. 100-04), Ch. 5 which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> on the CMS Web site and the *Medicare Benefit Policy Manual*, (CMS Pub 100-02), Ch. 12, which is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c12.pdf> on the CMS Web site.

Additional Information

The official instruction (CR 6254) issued to your Medicare FI, A/B MAC, carrier or RHHI, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1625CP.pdf> on the CMS Web site.

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

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Home Health Prospective Payment System 2009 Update

The Centers for Medicare & Medicaid Services (CMS) issued a notice to update the Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2009. Medicare payments to home health agencies will increase by an estimated additional \$30 million next year as a result of a 2.9 percent increase in the annual market basket calculation of the cost of goods and services included in providing services under the HH PPS. The update also accounts for a 2.75 percent reduction to the HH PPS rates (the 2nd year of a 4-year phased in reduction) to account for the changes in case-mix that are unrelated to patient's health status, and an updated 2009 wage index.

A copy of the notice (CMS-1555-N) is available on the CMS Web site at:

<http://www.cms.hhs.gov/center/hha.asp>

This information is also available on the Cahaba “[Home Health Prospective Payment System \(HH PPS\) Rates](#)” Web page by selecting “Calendar Year 2009 Rates”.



Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement

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

MLN Matters Number: MM6262

Related CR Release Date: November 7, 2008

Related CR Transmittal #: R1633CP

Related Change Request (CR) #: 6262

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed STOP – Impact to You

CMS periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

CAUTION – What You Need to Know

This article is based on CR 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm on the Internet and in the *Medicare Claims Processing Manual* (CMS Pub 100-04), Chapter 10, §20.1, available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., ‘K’ codes) throughout the calendar year.

The following HCPCS code is added to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is deleted from the home health consolidated billing supply code list, and this code is being removed because it is noncovered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf> on the CMS Web site.

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

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Changes in Medicare Payment for Oxygen and Oxygen Equipment

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) 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: SE0840

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

Providers and suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) and/or regional home health intermediaries (RHHIs) for oxygen and oxygen equipment provided to Medicare beneficiaries.

Provider Action Needed

This article alerts suppliers and providers that CMS is implementing new oxygen payment rules and supplier responsibilities as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) in the Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2009 as displayed in the Federal Register on October 30, 2008. These changes are effective for services provided on or after January 1, 2009. Be sure billing staff are aware of these changes.

Background

CMS is making these changes to comply with the new MIPPA requirements for oxygen and oxygen equipment while safeguarding beneficiaries who rely on life sustaining oxygen services. This *Special Edition* article supplements the information provided in MLN Matters 6296 and 6297 (or MM6296 and MM6297) which, when issued, outline instructions regarding repair, maintenance and servicing of oxygen equipment, and other changes resulting from implementation of section 144(b) of MIPPA. Once issued, MM6296 may be reviewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf> on the CMS Web site. Once issued, MM6297 may be reviewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6297.pdf> on the CMS Web site.

Key Points

Payment and Billing Issues

- Oxygen and oxygen equipment are paid on a fee schedule basis. The beneficiary pays coinsurance and deductibles.
- The oxygen rental payment covers the equipment, contents, maintenance, and supplies and accessories such as tubing or a mouthpiece, and other services necessary for furnishing oxygen and oxygen equipment.
- The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use after which the equipment title transferred to the beneficiary. Section 144(b) of the MIPPA repeals the transfer of ownership provision and permits suppliers to retain ownership of the oxygen equipment following the 36-month rental cap.

- Section 414.226(g)(1) of CMS regulations requires the supplier who furnished the oxygen equipment in the first month to continue furnishing the oxygen equipment for the entire 36 month period with certain exceptions such as when the beneficiary relocates outside the service area, when the beneficiary elects to obtain oxygen equipment from another supplier, or in certain cases granted by the carrier/DME MAC or CMS such as emergency situations.
- Section 414.226(g)(2) of the regulations prevent suppliers from switching oxygen equipment modalities during the 36 month period (e.g., from liquid oxygen to a concentrator). There are special exceptions to this rule in the event the physician orders different equipment based on medical necessity or where the beneficiary chooses newer technology and signs an Advance Beneficiary Notice (ABN) acknowledging potential financial liability for the newer technology.
- Section 414.226(g)(1) also requires the supplier to disclose its intentions for accepting assignment of claims during the 36 month rental period.
- **Be aware that after the 36 month cap the following requirements apply:**
 - The supplier is required to continue furnishing the equipment, supplies and accessories for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.
 - The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid oxygen equipment. Suppliers should continue to use HCPCS codes **E0441** through **E0444** in order to bill and receive payment for furnishing oxygen contents. Medicare can pay for a general maintenance-and-servicing visit for concentrators or transfilling equipment in 2009, which must take place 6 months after the end of the 36-month rental period.
 - Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.
 - The supplier is responsible for furnishing all of the same items **and services** after the 36-month rental period as they furnished during the 36-month rental period. With the exception of oxygen contents and the general maintenance and servicing visit in 2009, the supplier must furnish these items and services without charging Medicare or the beneficiary.
 - Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Beneficiary Relocation Issues

- If the beneficiary relocates before the end of the 36-month rental period, he/she should work with his or her supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at his or her new place of residence.
- If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore, must make arrangements for the beneficiary to continue receiving oxygen services at his or her new place of residence.

Take Note: Suppliers that are found to be out of compliance with existing regulations and these new requirements are subject to significant administrative remedies, including removal of billing privileges.

Beneficiary Issues of Importance to Providers

- Beneficiaries are entitled to change suppliers at any time during their period of medical need. A word of caution, finding new suppliers after the 36 month cap may be difficult because the new supplier would receive no monthly payments except for maybe the maintenance and servicing visit.
- If beneficiaries choose to purchase their own oxygen equipment instead of renting, they need to understand that Medicare does not pay a lump-sum purchase for oxygen equipment. Medicare pays on a rental basis up to a 36-month rental period.

Additional Information

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

Questions and answers regarding changes in payment for oxygen and oxygen equipment are posted at http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_alp.php?p_sid=AUyrW7ij&p_lva=&p_li=&p_accessibility=0&p_redirect=&p_page=1&p_cv=1.33&p_pv=&p_prods=&p_cats=33&p_hidden_prods=&cat_lvl1=33 on the Internet.

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Fee Schedule Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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: MM6270

Related CR Release Date: November 7, 2008

Related CR Transmittal #: R1630CP

Related Change Request (CR) #: 6270

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6270 and alerts providers that CMS has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background

The update process for the DMEPOS fee schedule is contained in §60, Chapter 23 of the *Medicare Claims Processing Manual*, (CMS Pub 100-04), which is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS Web site. The key points of CR 6270 are as follows:

- The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993	L5994	L5995	L7611	L7612	L7613
L7614	L7621	L7622			

- For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition
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- The fee schedule amounts for HCPCS code **K0672** (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.
- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008 will not be adjusted.

2009 Fee Schedule Updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)

- MIPPA of 2008 mandates a fee schedule covered item **update of -9.5 percent for 2009 for items included in round 1 of the DMEPOS Competitive Bidding Program**. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a **-9.5 percent** update for 2009 with the **exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444**. These 6 oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0 percent update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5 percent, even though they are competitive bid items.
- Non-competitive bid items will receive a 5.0% covered item update for 2009.

New KE Modifier and the KL Modifier

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment). To accommodate the fee schedule updates required per the MIPPA, CMS is adding the KE modifier to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 Wheelchair Accessory, Seat Upholstery, Replacement Only, Each can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the KE modifier will receive a 5 percent covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5 percent reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without the KE modifier. If such claims are submitted with the KE modifier, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the KE modifier, but with the KC modifier when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the KC modifier, but with the KE modifier.

For the aforementioned reasons, CMS is also adding the KE modifier to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the KE modifier. Suppliers should bill codes A4636 and A4637 with the KE modifier when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the KE modifier when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the BA modifier, but without the KE modifier. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the BA modifier, but with the KE modifier.

Further instruction on the use of the KE modifier with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Web site.

Note: Suppliers should not use the KE modifier on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in MLN Matters article MM5641 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>), suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the KL modifier has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the KL modifier on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

Note: Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Competitive Bidding Items from 2008 Impacted by 2009 Pricing

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the - 9.5 percent covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in **Attachment A** of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Web site.

Product Category 1—Oxygen, Supplies and Equipment (for the detailed product description of each HCPCS code see *Attachment A*)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of \$175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of \$175.79 includes the 9.5 percent covered item reduction ascribed to items selected for competitive bidding in 2008. The previously announced payment amount for 2009 of \$193.21 did not include the 9.5 percent reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

Product Category 2—Standard Power Wheelchairs, Scooters, and Related Accessories (for the detailed product description of each HCPCS code see *Attachment A*)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

Product Category 3—Complex Rehabilitative Power Wheelchairs and Related Accessories (for the detailed product description of each HCPCS code see *Attachment A*)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	K0851
K0852	K0853	K0854	K0855	K0856	K0857	K0858	K0859
K0860	K0861	K0862	K0863	K0864			

Product Category 4—Mail-Order Diabetic Supplies (for the detailed product description of each HCPCS code see *Attachment A*)

A4233 KL	A4234 KL	A4235 KL	A4236 KL	A4253 KL	A4256 KL	A4258 KL	A4259 KL
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Product Category 5— Enteral Nutrients, Equipment, and Supplies (for the detailed product description of each HCPCS code see *Attachment A*)

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088
B4149	B4150	B4152	B4153	B4154	B4155	B9000	B9002
E0776							

Product Category 6— Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories (for the detailed product description of each HCPCS code see *Attachment A*)

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

Product Category 7—Hospital Beds and Related Supplies (for the detailed product description of each HCPCS code see *Attachment A*)

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304
E0305	E0310	E0316	E0910	E0911	E0912	E0940	

Product Category 8—Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories (for the detailed product description of each HCPCS code see *Attachment A*)

A6550	A7000	E2402
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Product Category 9—Walkers and Related Supplies (for the detailed product description of each HCPCS code see *Attachment A*)

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

Product Category 10—Support Surfaces (for the detailed product description of each HCPCS code see *Attachment A*)

E0193	E0277	E0371	E0372	E0373
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Billing Instructions for Power Wheelchair Harness (HCPCS code E2313)

The April Quarterly Update for the 2007 DMEPOS Fee Schedule included instructions for suppliers to submit claims for the electronics necessary to **upgrade from a non-expandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure** until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power Wheelchair Accessory, Harness For Upgrade to Expandable Controller, Including all Fasteners, Connectors and Mounting Hardware, Each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.
- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual Obligation denials.

Additional Information

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

For complete details regarding this CR please see the official instruction (CR 6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

News from CMS for Hospice Providers



Medicare Hospice Data Collection on Claims

The Centers for Medicare & Medicaid services (CMS) began collecting visit data on hospice claims as of July 1, 2008. Various hospice industry representatives have communicated to CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care. Of particular concern was the fact that CMS was not requiring reporting of the visit intensity. As a result of these concerns, CMS committed to working with the industry to expand the data collection requirements. Please visit the Spotlight section of CMS’ Hospice Center Web page (<http://www.cms.hhs.gov/center/hospice.asp>) for a link to a document containing CMS’ suggestions for the next phase of data collection and a sample claim.



New Complex Password Policy

In our ongoing efforts to comply with the Centers for Medicare & Medicaid Services (CMS) security requirements, Cahaba is implementing a complex password policy effective January 1, 2009. Currently, your Cahaba RACF password, which is entered on the “Entry Validation” screen to access to the Fiscal Intermediary Standard System (FISS) mainframe system for Direct Data Entry (DDE) contains 8 characters consisting of letters and numbers. To comply with the new complex password policy, your password must meet the following specifications:

- Eight characters long
- Include at least one number
- Include at least one upper case letter
- Include at least one lower case letter
- Include one of the following special characters: @, #, or \$

For example, if your current password is Q2WER5TY, the new one could be Q@wer5ty. When prompted to change your password on or after January 1, please choose a password that complies with the complex password security policy.

```
KLGLGONI                               Entry Validation
Date: 11/07/08                           System: SY1
Time: 11:02:56                           Device: TCP00979

Identification:
  Userid.....
  Password..... Q@wer5ty  Change Password ?  N (Y or N)

Additional Information:
  Group.....
  Acct.....
  Proc.....
```

If you have any questions, please contact our EDI Services Department at 866 839-2441.



New Online Course for Clinicians

In an effort to help providers understand Medicare’s medical review processes, Cahaba has developed the new online course “Medical Review (Getting a View of)”. The information provided in this online course will help you understand the medical review process, and how it affects you. In addition, it explains the Progressive Corrective Action (PCA) process, identifies the standards used in medical review, and discusses the importance of documentation.

Keep in mind, online courses allow you to learn from the convenience of your own desk! All courses are free and available at any time. To access this course and additional online courses, access the '[Online Courses](#)' link from the HH+H (Home Health and Hospice) '[Educational Materials](#)' Web page.



Medicare Contractor Reform Ask-the-Contractor Teleconference (ACT)

The Medicare Modernization Act (MMA) of 2003 mandated a change in the way Medicare contracting is administered. As a result of this change, current Medicare contractors, and companies wanting to become a Medicare contractor, must submit bids to the Centers for Medicare & Medicaid Services (CMS) for geographic jurisdictions. These new contractors are called Medicare Administrative Contractors (MACs).

It is important for all Medicare providers to understand the potential change that could result due to contractor reform. To better educate our providers on Medicare Contracting Reform, Cahaba is hosting an Ask-the-Contractor Teleconference (ACT) titled: "Coming Soon to a Contractor Near You: Medicare Contracting Reform". The teleconference will be held on December 10, 2008, from 1:00 – 2:00 p.m. (Central Time). Providers interested in attending this event must register via our [Calendar of Events](#) Web page. Registration deadline is December 5. Due to the format of the call, providers are encouraged to submit their questions prior to the event.

Providers can also access additional information, including recent contract announcements, via CMS's [Medicare Contracting Reform](#) Web page. In addition, please see the Medicare Learning Network Matters article, "Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC)" which begins on page 16 of this *Newsline*.



System Availability During the Christmas Holiday

While we celebrate the Christmas holiday with our families, our office will be closed on Wednesday and Thursday, December 24 and 25, 2008. Our data center has informed us that FISS will not be available December 25, 2008. In addition, FISS will not cycle December 24 and 25, 2008, which means that claims will not be sent to the Common Working File (CWF) either night. Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on December 24 and 25, 2008. However, the **Interactive Voice Response (IVR) unit will be available to providers to check beneficiary eligibility or the status of claims.**



Medicare Forum

Do you have a Medicare question or topic that you would like addressed in the *Home Health & Hospice Medicare A Newsline*? If so, fax it to the Provider Outreach and Education (POE) department at 515-471-7584, or e-mail it to ianewsline@cahabagba.com. Please include your facility's name and provider number, your name and telephone number. Responses to the inquiries received in this e-mail box will be provided only through the *Medicare Forum* article, if appropriate. If you need an immediate response to a question, please contact a Provider Contact Center for assistance. Refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call a Customer Service Representative (CSR). We also welcome your comments or suggestions on this publication and other Cahaba customer service activities.

Q1. Where do I find the descriptions of the ADR reason codes?

- A2. When an Additional Development Request (ADR) is requested, the claim is moved to status/location S B6001. To determine what information is being requested, you need to access the claim through the Inquiry Menu screen (Option "12"). Select the claim that you wish to view the ADR information. ADR information is electronically attached to the end of the claim, as pages 07 and 08. Therefore, you can access the ADR information, by typing "07" in the CLAIM PAGE field and press the enter key. From the Additional Development Request screen, press F8 to display the reason code narrative.

REPORT: 001	MEDICARE PART A 00011	PVDR NO : XXXXXX
DATE : 11/07/2008	ADDITIONAL DEVELOPMENT REQUEST	BILL TYPE: 813
ABC/123 HOSPICE AGENCY		
123 MAIN ST USA		
DES MOINES		IA 12345 6789
<p>WE HAVE REVIEWED THIS CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED. TO ASSIST YOU IN PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE AFFECTED CLAIM RECORD (SEE BELOW) FOR YOUR REVIEW. PLEASE REFER TO THE ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODES. WE MUST RECEIVE THE REQUESTED INFORMATION BEFORE THE DUE DATE LISTED BELOW, OR THE CLAIM WILL BE DENIED LACK OF RESPONSE. SEND YOUR RESPONSE TO THE ATTENTION OF:</p>		
CAHABA GBA - RHHI		
400 E COURT AVE		
DES MOINES		IA 50309 2017
PATIENT CNTRL NBR: XXXXXX	DUE DATE: 12/20/2008	
MEDICAL REC NO: XXXXXX	DCN: XXXXXXXXXXXXXXXX	
HIC: 123456789A	PATIENT NAME: JOHN	SMITH
FROM DATE: 10/01/2008 THRU DATE: 10/31/2007 OPR/MED ANALYST:		
TOTAL CHARGES: 1000.00	ORIG REQ DT: 11/05/2008	CLM RCPT DT: 11/04/2008
PRESS PF3-EXIT	PF5-SCROLL BKWD	PF6-SCROLL FWD
	PF8-NEXT	PF9-UPDT

REASONS: 59BX9

REASON CODE NARRATIVES FOR HIC/DCN: 123456789A XXXXXXXXXXXXXXX

59BX9 MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 30TH DAY. THIS ALLOWS FOR MAIL TIME AND FOR US TO MOVE THE CLAIM INTO THE MEDICAL REVIEW STATUS/LOCATION SM50MR BY DAY 45 OR IT WILL BE DENIED WITH REASON CODE 56900 ON THE 46TH DAY. SEND THE FOLLOWING CHECK-LIST OF INFORMATION TO SUPPORT THE TERMINAL ILLNESS AND SERVICES BILLED:

- *INITIAL ASSESSMENT, ALL VISIT NOTES
- *PLAN OF CARE/CHANGES AND INTERDISCIPLINARY GROUP NOTES,
- *PHYSICIAN ORDERS AND VISIT NOTES
- *HOSPITAL DISCHARGE AND/OR PHYSICIAN SUMMARIES
- *HISTORY AND PHYSICAL EXAM, LAB, X-RAY, AND/OR SURGICAL REPORTS
- *SIGNED/DATED: CERTIFICATION, TRANSFER, REVOCATIONS
- *ANY PERTINENT INFORMATION PRIOR TO/AFTER THIS BILLING PERIOD
- *DATES AND TIMES OF SERVICE CHANGES, WHEN BILLING MULTIPLE LEVELS OF CARE
- *THE BENEFICIARY SIGNED AND DATED HOSPICE ELECTION STATEMENT.

THIS EDIT SELECTS CLAIMS DUE TO PREVIOUS DENIALS FOR THIS BENEFICIARY.
OMB CONTROL #: XXXX-XXXX

In addition, information about checking for and responding to ADRs can be found in the “[Inquiry Menu](#)” section of the *Fiscal Intermediary Standard System (FISS) Reference Guide*.

Q2. Within the last three years, our agency has had several patients go to a physician appointment, obtain a prescription for a service to be done at a hospital, and go to the hospital to have that service rendered. We are not notified because the patient does not relate the doctor's directions to the homecare benefit. The hospital in turn receives a denial because the patient is under a home health episode of care. They then expect to receive payment from our agency. I told the hospital the required procedure is to have a prior "providing care under arrangement" agreement in place for services we cannot do in the home. I cannot find anywhere in the regulations where it is our responsibility. Please clarify this issue.

A2. It is the intent of consolidated billing for home health episodes of care to include all services and supplies needed to carry out the plan of care (POC). Therefore, if the following conditions are met, the HHA would not be liable for payment:

- The service or supply is not on POC or [Consolidated Billing Master Supply List](#).
- The HHA does not have an existing arrangement with supplier/provider.
- The HHA is unaware that the beneficiary received home health related services/supplies from another provider.

The [Medicare Claims Processing Manual \(Pub. 100-04, Ch. 10 § 20.1.1\)](#) states that HHAs “would not be responsible for payment to another provider in the situation in which they have no prior knowledge (e.g., they are unaware of physicians orders) of the services provided by that provider during an episode to a patient who is under their home health plan of care.”

However, it is the HHA’s responsibility to “fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by his/her primary HHA.” This would include advising the beneficiary to contact the HHA when needing medical care or supplies while under the

home health agency's care. In addition, HHAs must also advise "the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient. Information regarding patient liability for payment must be provided by the HHA both orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA."

If the beneficiary is properly notified, the beneficiary may be held liable for payment. However, CMS further states that "In order to protect the beneficiary from unexpected liability in these cases, and in order to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a home health patient notify the beneficiary of the possibility that they will be responsible for payment."

The [*Medicare Claims Processing Manual \(Pub. 100-04, Ch. 10*](#), § 20.1.2) outlines the responsibilities of providers and suppliers of services subject to home health consolidated billing, including their responsibility to "determine whether or not a home health episode of care exists" for a beneficiary before providing services to them.

News from Cahaba for Home Health Providers



Top Claim Submission Error—How to Avoid Reason Code 31147

Cahaba sent an email message October 6, 2008, notifying home health providers about reason code 31147, which became effective for home health claims received on or after October 1, 2008. Claims with a "FROM" date of January 1, 2008, and after will be sent to your Return to Provider (RTP) file with reason code 31147 if the fifth position of the HIPPS code billed contains the letters S, T, U, V, W, or X and supply revenue codes 027X or 0623 are not present on the claim.

For the month of October, reason code 31147 constituted twenty (20) percent of all claims that went to RTP. Please review the following information to help avoid delays in receiving timely Medicare payments due to reason code 31147.

Did your home health agency (HHA) provide non-routine supplies to the beneficiary during the episode?

- Yes—your claim must include the supply revenue code(s), units, charges and a date of service that falls within the "FROM" and "TO" date of the home health claim.
- No—the 5th position of the HIPPS code must be changed to the corresponding numeric value of 1, 2, 3, 4, 5, or 6. For example, if the HIPPS code for the episode was 2BFKV, it will need to be changed to 2BFK4 if non-routine supplies were not provided to the beneficiary.

Please note that the fifth position of the HIPPS code does not need to match between the final claim and the request for anticipated payment (RAP) when the "FROM" date of the claim is on or after January 1, 2008.

More information is available on the Cahaba Web site at:

https://www.cahabagba.com/rhhi/claims/home_health/supplies_changes.htm and
https://www.cahabagba.com/rhhi/claims/home_health/supplies_nr.htm

Additional instructions regarding this billing requirement are available in Medicare Learning Network (MLN) article MM5776 available at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5776.pdf>



Not Responding to Widespread Home Health Edits Costs Us All

Cahaba's goal is to pay your claims correctly. To do this, our Medical Review department reviews claims that are found to be at the highest risk for errors. One way of doing this is through the use of widespread edits. These edits are based on data analysis of issues that are found across the provider community. Four of the current widespread edits over the last quarter have seen a substantial percentage of denials for "56900." This denial reason code indicates the providers did not submit documentation to support the services billed in response to an Additional Development Request (ADR). Providers have 30 days from the date of the ADR request to submit the requested information to Cahaba. If Cahaba does not receive the documentation timely, the claim will be automatically denied on the 46th day with denial reason code 56900. When an ADR is requested, the claim is moved to status/location S B6001. Providers are encouraged to monitor the S B6001 status/location at least weekly to identify when an ADR has been requested.

Not responding to an ADR adversely impacts a home health agency in several ways:

- Negatively impacts cash flow
- Creates the need to request appeals, which can be costly and time consuming, in order to receive Medicare payment.
- ADR denials are incorporated into overall denial statistics
- Claims are automatically denied on day 46
- Potential for continued medical review of your claims

The "[Additional Development Request \(ADR\) Quick Reference Tool](#)" has been developed to assist you with the process of monitoring and responding to ADRs. This tool and additional quick reference tools can be found at https://www.cahabagba.com/rhhi/education/materials/quick_hha.htm on our Web site.

Please refer to the [Medicare Program Integrity Manual, \(CMS Pub. 100-08\) Ch. 3](#), §3.4.1.2 for additional information. In addition, information about checking for and responding to ADRs can be found in the "[Inquiry Menu](#)" section of the *Fiscal Intermediary Standard System (FISS) Reference Guide*.



New Condition Code for Hospice Discharge for Cause

Change Request (CR) 6115 requires hospice providers to use a new condition code, H2, when a beneficiary is discharged by the hospice for cause. The new code is effective for claims with dates of service January 1, 2009. Examples of a discharge for cause could include issues where patient safety or hospice staff safety is compromised.

As a reminder, the new condition code H2 results only in a discharge from the hospice provider's care. The code itself does not indicate a beneficiary discharge from the Medicare hospice benefit.

If the hospice discharging the beneficiary for cause **and discharging the beneficiary from the hospice benefit**, the condition code H2 should be used, as well as the occurrence code 42 (to indicate the discharge from the hospice benefit).

If the hospice is discharging the beneficiary for cause **and transferring the beneficiary to another hospice**, the condition code H2 should be used. An occurrence code 42 should not be used on the claim.

The Medicare Learning Network (MLN) Matters Article for this CR, entitled, "Hospice Discharge for Cause" was published in the [September 1, 2008, Home Health & Hospice Medicare A Newslines](#).

If you have any questions regarding this CR, please contact the Hospice Provider Contact Center at 1-866-539-5592.

December 2008 Education Events

To register for educational events, go to the “[Calendar of Educational Events](#)” page on our Web site. Select the event title for registration instructions.

➤ **“Medicare Contracting Reform” Ask-The-Contractor Teleconference (ACT)**

Date: December 10, 2008

Time: 1:00—2:00 Central Time

Registration Deadline: December 5, 2008

Intended Audience: Home health and hospice agency staff, including administrators, billers, and clinicians.

Description: This teleconference will inform providers about Medicare contracting reform, including the legislation that mandated it, the timeline established for this major change, the benefits of the changes, the jurisdiction your agency is in, and how these changes will affect your home health and/or hospice agency.

➤ **“Navigating the Medicare Resources Sea” Webinar**

Date: December 16, 2008

Time: 12:00—2:00 Central Time

Registration Deadline: December 11, 2008

Intended Audience: Although any home health or hospice provider will benefit from this event, the intended audience is home health and hospice providers who have 25 or fewer full-time employees, or have recently received Medicare certification or who have staff new to Medicare.

Description: This Webinar explores critical Medicare resources found on the Cahaba and the Centers for Medicare & Medicaid Service (CMS) Web sites, including the self-service technologies available.

Cahaba GBA Learning Corner

- **“[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.
Advanced Hospice Billing	Learn about advanced hospice billing topics.
Appeals Process	Learn about the Medicare appeals process.
Basics of ICD-9-CM Coding for Home Health Clinicians	Learn the basics ICD-9-CM coding.
Beginner Hospice Billing	Learn the basics of hospice billing.
Beginner Home Health Billing	Learn the basics of home health billing.
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.
Medicare Coding (Insight into)	Learn the basics about Medicare coding.
Medicare Cost Report (Introduction to)	Learn the basics about the Medicare Cost Report
Medical Review (Getting a view of)	Learn the basics of the Medical review process.
NEW	
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.
Verifying Beneficiary Eligibility	Learn how to identify various eligibility information by using ELGA and ELGH.

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

- Didn't find what you were looking for? [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated. In addition, subscribe to the Cahaba [E-mail Notification Service](#) to receive the most current home health and hospice Medicare information.

Attachment A

TIMELINE AND CHECKLIST FOR PREPARING FOR MAC IMPLEMENTATION

Scheduled Award Date:

Actual Award Date:

MAC Scheduled Dark Days

MAC Contractor:

MAC Website:

MAC Contractor Number:

MAC Contact Center Number: 1-800-

MAC Mailing Address:

MAC EDI Mailing Address:

90 DAYS BEFORE CUTOVER

1. Visit MAC website and bookmark for future use
2. Join the MAC Listserv
3. **Monitor:**
 - LCDs Published by the new MAC; compare current LCD's that affect your practice's services.
4. **Review:**
 - Provider enrollment status for all providers, update as needed.
 - Pay-to address information for practice/providers, update as needed.
5. **Contact:**
 - Your Practice Management/Billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.
 - Claims Clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.

75 DAYS BEFORE CUTOVER

1. Continue to check the MAC's website and/or Listserv for outreach programs, educational and informational events, and conference calls.
2. Check your state's Medical Society or local provider organization website for MAC transition information, MAC Coordinators.

60 DAYS BEFORE CUTOVER

1. If needed, submit CMS Form 588 – EDI form(s) to the new MAC
2. Consider registering for Electronic Remittance Advice (ERA) enrollment, if you are not already enrolled.

3. Download or request a sample Remittance Advice (RA). RA codes are standard but use of codes may vary across contractors.

45 DAYS BEFORE CUTOVER

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of e-mail from the MAC Listserv.

15 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational.
3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Place test calls and become familiar with the MAC IVR query system.
5. Continue daily monitoring of the MAC Listserv.

10 DAYS BEFORE CUTOVER

1. Address any existing open items.
2. Continue daily monitoring of the MAC Listserv.

5-10 DAYS AFTER CUTOVER

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of the MAC listserv.
3. Monitor and follow up on the MAC Open Item list.

30 DAYS AFTER CUTOVER

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

Attachment B

SCHEDULE OF MAC CONTRACTOR TRAINING CLASSES

Scheduled Date	Title of Class	Attendee

SCHEDULE OF MAC CONFERENCES

Scheduled Date	Conference Subject	Attendee

Attachment C

Important MAC Implementation Dates

MAC Dark Days	
Cutoff Date for Claims Submission	
Last date Outgoing Contractor will make Payment	
Last date Outgoing Contractor will have Telephone/Customer Service	
Last date Outgoing Contractor will send file to Bank	
Date MAC will Accept Electronic Claims	
Date MAC will Accept Paper Claims	
Date Bill/Claim Cycle Begins	
First Anticipated MAC Payment Date	
Date MAC Begins Customer Service	

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