MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *http://medicare.fcso.com/*.

Routing Suggestions:

[ ] Medicare Manager
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The *Medicare A Bulletin* is published monthly by First Coast Service Options Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers.

Questions concerning this publication or its contents may be faxed to:

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About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications are posted to the FCSO Medicare provider education Web site *http://medicare.fcso.com*.

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy. Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the *Educational Resources* section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

We use the same mailing address for *all* correspondence, and we cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. **Please remember that address changes must be done using CMS-855A.**

What is in the *Bulletin*?

The *Bulletin* is divided into sections addressing general and coverage guidelines, and facility-specific information:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publication.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- The *Local Coverage Determination* (LCD) section contains notification of new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin represents formal notice of coverage policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the QPU by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Items or services furnished to Medicare beneficiaries in state or local custody under a penal authority

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B MACs) for services provided to individuals or groups of individuals who are in "custody" under a penal statute or rule.

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6544 which describes special conditions that must be met in order for Medicare to make payment for services provided to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute or rule.

CAUTION – what you need to know

CR 6544 instructs Medicare contractors that "payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and the state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

GO – what you need to do

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

Background

Under the Social Security Act (Section 1862(a)(2); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet), the Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

In addition, under the Social Security Act (Section 1862(a)(3)), if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

In the fiscal year (FY) 2008 inpatient prospective payment system (IPPS) final rule published in the *Federal Register*, Volume 72, Number 162 (72 FR 47409 and 47410 – August 22, 2007; see *http://edocket.access.gpo.gov/2007/07-3820.htm* on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified the regulations at 42 CFR Section 411.4(b) (See *http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.4.htm* on the Internet) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest
- Incarcerated
- Imprisoned
- Escaped from confinement
- Under supervised release
- On medical furlough
- Required to reside in mental health facilities
- Required to reside in halfway houses
- Required to live under home detention, or
- Confined completely or partially in any way under a penal statute or rule.

The *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody as follows:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Providers and suppliers are reminded that if they render services or items to a prisoner or patient in a jurisdiction that meets these conditions of 42 CFR 411.4(b), they are to include **modifier QJ** on claims submitted to carriers, A/B MACs, or DME MACs or use **condition code 63** on institutional claims sent to Medicare FIs or A/B MACs.

CR 6544 also amends the *Medicare Benefit Policy Manual* (Chapter 16, section 50.3.3) and the *Medicare*

Items or services furnished to Medicare beneficiaries in state or local custody under a penal authority (continued)

Claims Processing Manual (Chapter 1, Section 10.4) in order to be consistent with 42 CFR Section 411.4(b). These revisions are included as attachments to CR 6544.

Additional information

There are two transmittals associated with the official instruction, CR 6544, issued to your carrier, [DME MAC], FI, and A/B MAC regarding this change. The first transmittal amends the *Medicare Claims Processing Manual* and it may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1812CP.pdf*.

The second transmittal amends the *Medicare Benefit Policy Manual* and it may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R110BP.pdf*.

If you have any questions, please contact your carrier, DME MAC, FI, or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6544
Related Change Request (CR) #: 6544
Related CR Release Date: September 4, 2009
Effective Date: December 7, 2009
Related CR Transmittal #: R1812CP and R110BP
Implementation Date: December 7, 2009

Source: CMS Pub. 100-04, Transmittal 1812, CR 6544

October 2009 quarterly HCPCS update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article explains updates, effective for dates of service on or after October 1, 2009 (unless otherwise specified), to the Healthcare Common Procedure Coding System (HCPCS) codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis. This article describes updates for specific HCPCS codes and the October 2009 update has only one new code payable for Medicare. Effective for claims with dates of service on or after October 1, 2009, the following HCPCS code will be payable for Medicare:

- HCPCS code Q2024 with short description of bevacizumab injection and long description of injection, bevacizumab, 0.25 mg, a type of service code 1 or P and a Medicare physician fee schedule database status indicator of E.

There are no deletions of HCPCS codes effective for October 1, 2009.

Additional information

The official instruction, CR 6594, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1805CP.pdf*.

If you have questions, please contact your Medicare carrier, FI, DME MAC and/or MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6594
Related Change Request (CR) Number: 6594
Related CR Release Date: August 28, 2009
Related CR Transmittal Number: R1805CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1805, CR 6594

October update to the 2009 Medicare physician fee schedule database

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6617 which amends payment files that were issued to contractors based upon the 2009 MPFS final rule. Billing staff should be aware of these updates.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

The key change in CR 6617 is the assignment of H1N1 vaccine and administration Level II Healthcare Common Procedure Coding System (HCPCS) codes. In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, the Centers for Medicare & Medicaid Services (CMS) is creating two new Level II HCPCS codes that are effective September 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family). More information on the H1N1 flu and the associated vaccine can be found at the Centers for Disease Control and Prevention Web site at *http://www.cdc.gov/h1n1flu/*.

Under the MPFS, HCPCS codes G9141 and G9142 will be assigned status indicator "X," indicating these codes represent an item or service that is not within the statutory definition of "physicians' services" for MPFS payment purposes. CMS anticipates the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Payment for the administration of the H1N1 vaccine is the same as the payment established for G0008 and G0009, codes used for reporting the administration of the influenza or pneumococcal vaccine. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine. Beneficiary copayment and deductible do not apply to HCPCS code G9141.

CR 6617 also clarifies Transmittal 1691, CR 6397, dated March 4, 2009 and Transmittal 1748, Change Request 6484, dated May 29, 2009, which included PE RVUs for *CPT* code *93351 (26)*. Transmittal 1748 noted that this service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the PE RVUs noted were informational only. CMS is clarifying that *CPT* code *93351 (26)* is payable when performed by a physician in a facility setting.

Specific changes included in the October Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6617. That CR is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1810CP.pdf*.

Key changes, however, are summarized as follows:

The following changes are effective for dates of service on and after January 1, 2009:

CPT	Action
38999	Assistant at surgery indicator: 0
55899	Assistant at surgery indicator: 0
69200	Bilateral indicator: 1
93503	Transitional facility PE RVU: 0.75 Fully implemented facility PE RVU: 0.77

The following change is effective for dates of service on and after October 1, 2009:

Q2024 Long descriptor: Injection, Bevacizumab, 0.25 MG
Short descriptor: Bevacizumab injection
Procedure status: E

Additional information

The official instruction, CR 6617, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1810CP.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6617
Related Change Request (CR) Number: 6617
Related CR Release Date: September 1, 2009
Related CR Transmittal Number: R1810CP
Effective Date: January 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1810, CR 6617

Medicare Part A and B coverage and prior authorization

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare administrative contractors [MACs], fiscal intermediaries [FIs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on the Social Security Act and other laws which describe covered and noncovered items and services and their payment under Part A and Part B. Originally, the Social Security Act did not authorize any form of "prior authorization" for Medicare services. The law was subsequently changed to allow prior authorization of limited items of durable medical equipment and physicians' services. Currently, Medicare does not pre-authorize coverage of any item or service that will receive payment under Part A or B, **except for custom wheelchairs.** Please advise all staff and inform your Medicare patients, as appropriate, that Medicare does not currently pre-authorize coverage for any item or service other than custom wheelchairs.

Background

The overall scope of allowable benefits under the Medicare program is prescribed by law. When Medicare was established, Congress included certain provisions on the broad categories of items and services that may be covered under the Medicare program as well as provisions on certain items and services that were to be excluded from coverage. Congress also included in Section 1862(a)(1)(A) of the Social Security Act the following provision:

"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,…"

This clause has become known as the "reasonable and necessary" provision. Medicare coverage and payment for items and services is therefore contingent upon a determination that an item and service:

- Falls within a benefit category,
- Is not specifically excluded from coverage, AND
- The item or service is "reasonable and necessary" unless specifically excluded from meeting this provision.

Also, as prescribed by law, the Centers for Medicare & Medicaid Services (CMS) develops national coverage determinations (NCDs), which are national policy statements granting, limiting, or excluding Medicare coverage for a particular item or service. NCDs may be found in the *Medicare National Coverage Determinations Manual* (Publication 100-03) on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

For those items or services whose coverage is not determined in law, regulation or NCD, the local Medicare contractors are authorized to develop local coverage determinations (LCDs) to further determine coverage of items and services covered by Medicare. LCDs specify under what conditions an item or service is considered to be "reasonable and necessary". Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, including comments from the provider community. LCDs may be found on the CMS coverage Web site and your local contractor's Web site.

If a provider believes that a Medicare NCD or LCD needs to be revised, they should request CMS or its contractors to reconsider the existing NCD or LCD. What factors CMS considers when deciding to open or reopen an NCD may be found on the CMS Web site at *https://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6*.

To request a new LCD or an LCD reconsideration, the provider should contact the local Medicare contractor.

In regard to prior authorization under fee-for-service Medicare, providers should be aware that Section 1834(a)(15)(c) of the Social Security Act allows for an advance determination of Medicare coverage (ADMC) for certain items of durable medical equipment (DME). The only items of DME currently subject to this provision are custom wheelchairs. Also, Section 938 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173) required the Secretary to establish a "Prior Determination" process for a limited number of physicians' services under Medicare. Implementation of this provision is pending. It should also be noted that Medicare Part C and Part D programs are authorized to have and may require prior authorizations for services billed to them.

Additional information

The Social Security Act Amendments of 1965, Section 1862 (a)(1)(A) may be viewed on the Social Security Web site at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*.

If you have any questions, please contact your carrier, FI, MAC, or RHHI at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE0916
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE0916

2009 Medicare contractor provider satisfaction survey results available

The results of the 2009 Medicare contractor provider satisfaction survey (MCPSS) are now available. The MCPSS enables the Centers for Medicare & Medicaid Services (CMS) to gauge provider satisfaction with key services performed by the Medicare fee for-service (FFS) contractors that process and pay the more than $300 billion in Medicare claims each year. Respondents rated their FFS contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The 2009 MCPSS marked the fourth annual administration of the survey.

The national average has remained relatively stable through each MCPSS administration. The 2009 national average was 4.54, compared to last year's national average of 4.51. The MCPSS was sent early this year to more than 32,000 randomly selected providers, including physicians, suppliers, health-care practitioners and institutional facilities that serve Medicare beneficiaries across the country.

As in 2008, provider inquiry measure was cited as the top indicator of satisfaction. For the fourth consecutive year this business function was cited as one of the key predictors of provider satisfaction. Claim processing remained a strong predictor of provider satisfaction as in the past three years.

The public reporting of the results over the last four years has increased awareness about the MCPSS. CMS has used the MCPSS to establish a uniform measure of provider satisfaction with FFS contractor performance.

Each FFS contractor receives an individual report of findings specific to their organization, which can be used to implement process improvement initiatives.

The results of the 2009 survey are available through the CMS and MCPSS Web pages at *http://www.cms.hhs.gov/MCPSS/* and *https://www.mcpsstudy.org/*. ❖

Source: CMS PERL 200909-23

Information on value-driven health care initiative on ambulatory surgery center

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007 and 2008 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare Web site where it may be viewed along with hospital quality information. The *Hospital Compare* Web site may be found at *http://www.medicare.gov*.

On August 28, 2009, Medicare posted an update to the ASC data. Hospital outpatient department and physician payment data will be updated later this year. The information is being displayed in the same format as in previous years, updated with calendar year 2008 data. The posting updates may be found at *http://www.cms.hhs.gov/HealthCareConInit/*. ❖

Source: CMS PERL 200908-42

October 2009 average sale price files are now available

The Centers for Medicare & Medicaid Services (CMS) has posted the October 2009 average sale price (ASP) files and crosswalks, which are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp*. ❖

Source: CMS PERL 200909-24

Medicare fee-for-service emergency preparedness questions and answers

The Centers for Medicare & Medicaid Services (CMS) has updated the Medicare fee-for-service emergency preparedness questions and answers (Qs & As). The emergency Qs & As are posted in a document at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp*.

These Qs & As include a section applicable to the H1N1 flu virus.

The document is dated to reflect the posting date. As additions and changes are made to the document, the download name will change to reflect the date. Please take note that these Qs & As do not address the waiver situation requirements addressed in Title XVIII of the Social Security Act, Section 1135. ❖

Source: CMS PERL 200908-35

Influenza pandemic emergency—the Medicare program prepares

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

The Centers for Medicare & Medicaid Services (CMS) has rescinded the special edition *MLN Matters*® article SE0836. The *MLN Matters*® article SE0836 was published in the June 2009 *Medicare A Bulletin* (page 10).

MLN Matters® Number: SE0836 – Rescinded
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE0836

Fact sheet for the introduction to ICD-10-CM/PCS now available

The revised publication titled ICD-10-CM/PCS: An Introduction fact sheet (August 2009), which was previously titled ICD-10-Clinical Modification/Procedure Coding System fact sheet, 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-10factsheet2009.pdf*.

This fact sheet 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. ❖

Source: CMS PERL 200908-33

Revised ICD-10-CM/PCS bookmark

The revised ICD-10-CM/PCS bookmark (August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system may be found, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200908-40

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

Compliance standards for consignment closets and stock and bill arrangements

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6528 to reflect changes made to change request (CR) 6528. The CR release date, transmittal number, implementation date, and the Web address for accessing CR 6528 have been changed. All other information remains the same. The *MLN Matters*® article MM6528 was published in the August 2009 *Medicare A Bulletin* (pages 18-19).

Provider types affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that maintain inventory at a practice location owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution and which submit claims to the national supplier clearinghouse Medicare administrative contractor (NSC-MAC) are affected. In addition, physicians and nonphysician practitioners who maintain DMEPOS inventory at the physician or nonphysician practitioner's practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider action needed

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

Background

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

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

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

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

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

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

Additional information

The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed on the CMS Web site a *http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf*.

If you have questions, please contact the Medicare NSC-MAC at their toll-free number which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6528 – Revised
Related Change Request (CR) Number: 6528
Related CR Release Date: September 1, 2009
Related CR Transmittal Number: R300PI
Effective Date: September 8, 2009
Implementation Date: March 1, 2010

Source: CMS Pub. 100-08, Transmittal 300, CR 6528

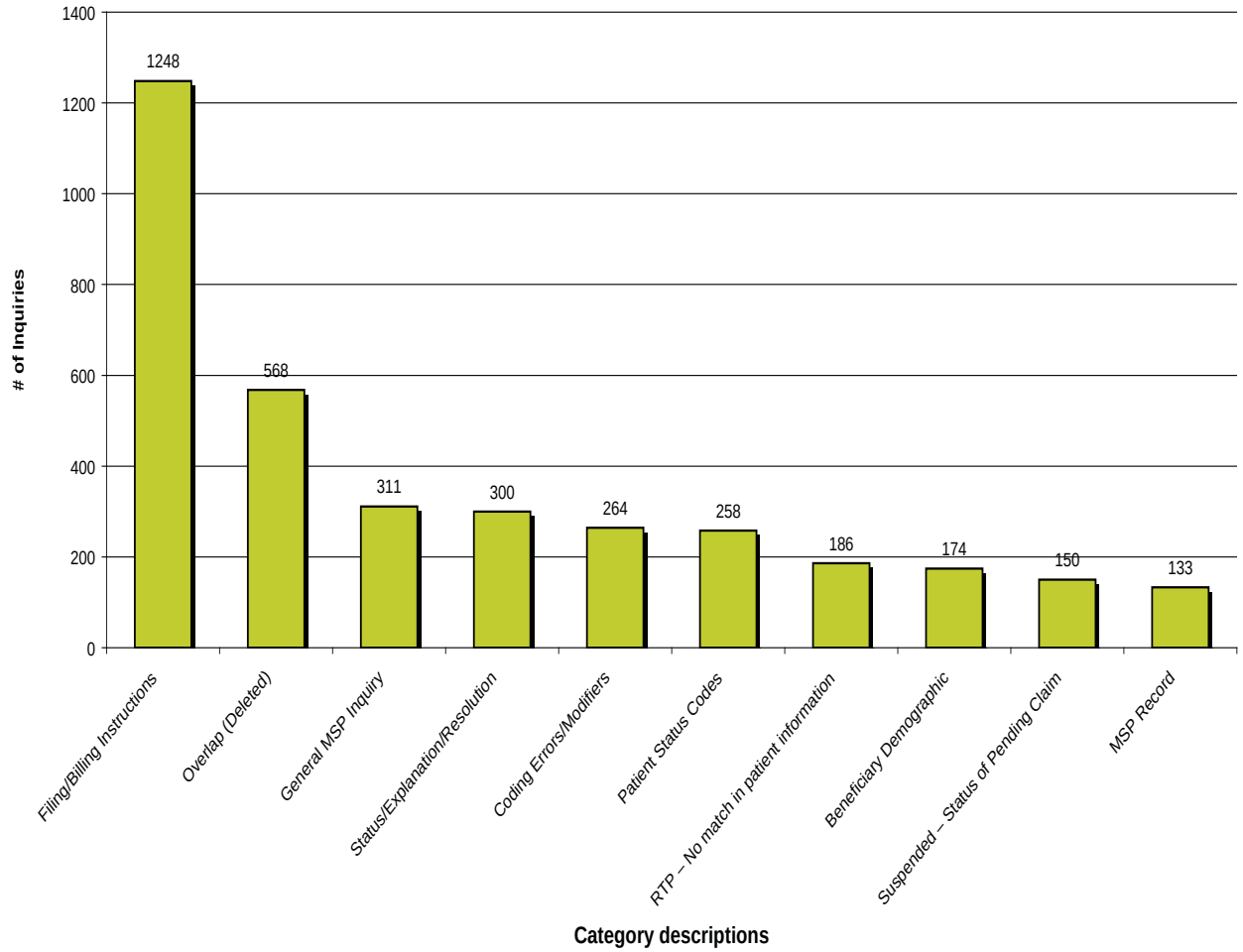
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for August 2009

The following charts demonstrate the available top number of inquiries, the top reason codes for return to providers (RTPs), and reject claims submitted to First Coast Service Options Inc. (FCSO), by Florida, and U.S. Virgin Islands providers during August 2009.

For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for August 2009



Create an account to receive your personalized provider data summary report

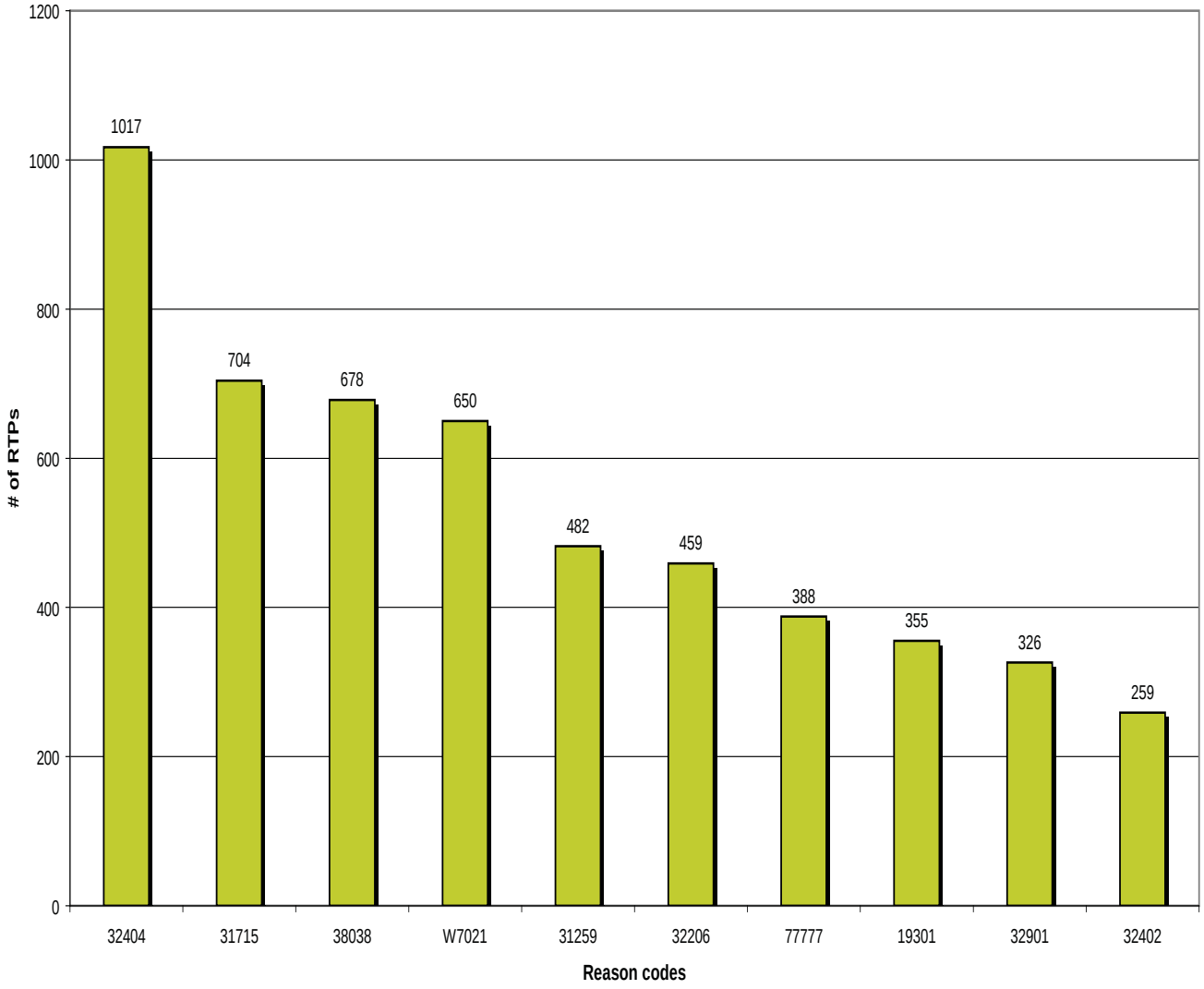
The provider data summary (PDS) is a comprehensive billing report designed to be utilized along with Medicare remittance notices (MRNs) and other provider-accessible billing resources to help identify potential Medicare billing issues through a detailed analysis of your personal billing patterns in comparison with those of similar providers. Use the PDS portal to request this useful report and enhance the accuracy and efficiency of your Medicare billing process.

To obtain your personalized PDS report, visit our provider Web site at *http://medicare.fcso.com*.

Once on the Web site, navigate to the "Home" link in your applicable line of business (e.g., Part A or Part B). Select "More" within the Provider Data Summary section. It is here you will find all PDS resources, including a guide, helpful FAQs, and the PDS Portal. Select the link titled "PDS Portal." From there, you will be given the option to log in, get help with a misplaced password, or create an account.

Top inquiries, return to provider, and reject claims for August 2009 (continued)

Florida Part A top RTPs for August 2009



Frequently asked question related to reason code 38038

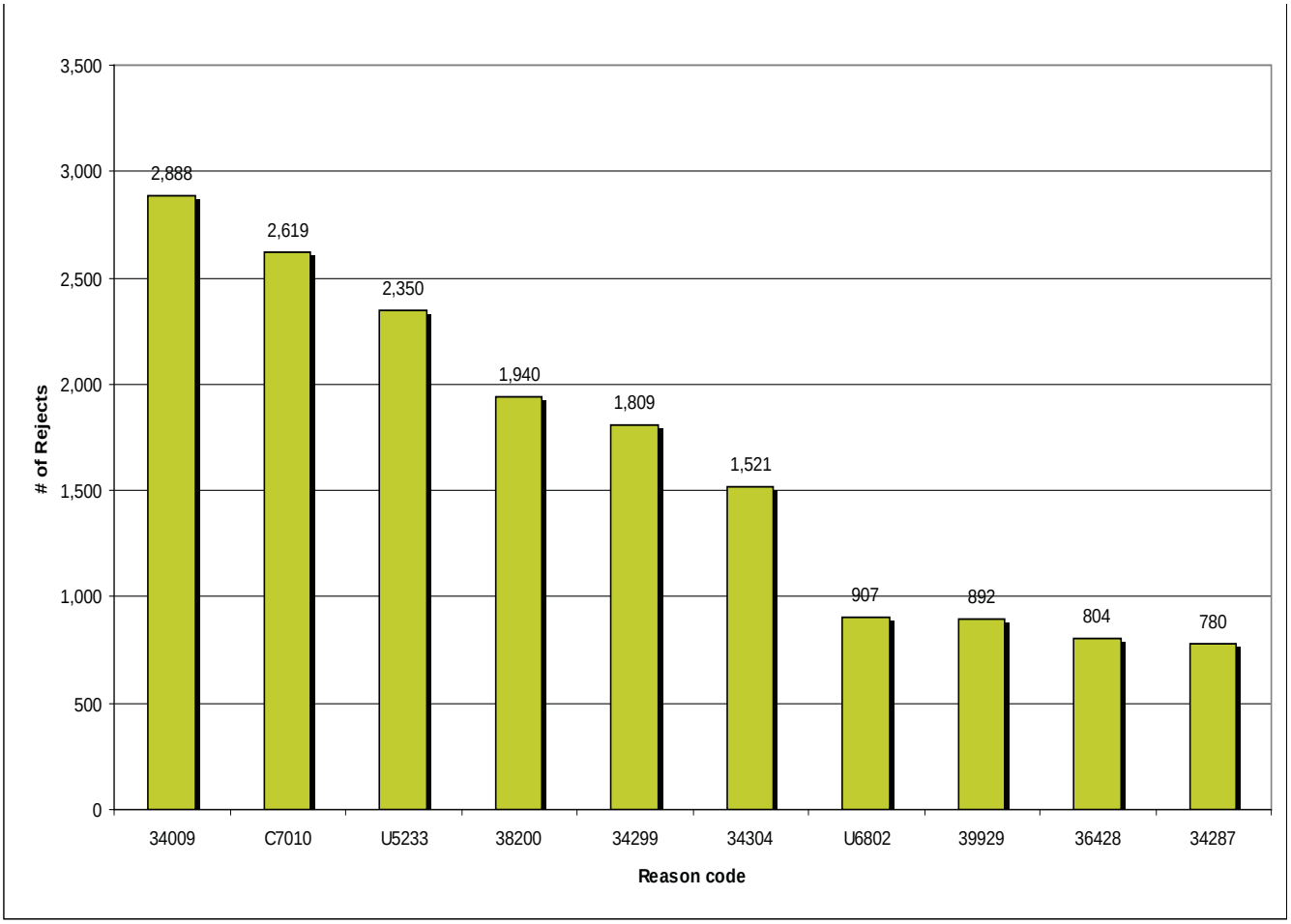
Q: Are there codes we can add to a claim to keep it from duplicating against another claim and receiving a returned to provider (RTP) reason code 38038?

A: Yes, there are several steps you can take prior to submitting the claim:

- Conduct a direct data entry (DDE) claim inquiry to pull the beneficiary health insurance claim (HIC) number and see a history of the claims.
- Contact the Part A interactive voice response (IVR) unit by calling 1-877-602-8816 for claim statuses, including those which are pending and RTP.
- Review your weekly 201 report, which may be obtained from DDE. You may receive this report hard copy in the mail.
- Review your remittance advice after you receive it.
- Do not continuously submit your claims through the EDI gateway from your claim software. Once you submit the claims electronically, the EDI gateway will send a confirmation on the batch of claims received. It is important to wait for this confirmation prior to resubmitting your batch of claims. ❖

Top inquiries, return to provider, and reject claims for August 2009 (continued)

Florida Part A top rejects for August 2009



Frequently asked question related to reason code C7010

Q: Will the common working file (CWF) system provide information on a beneficiary's hospice election to help us avoid receiving reject code C7010 on our claims?

A: Yes. There are several ways you can verify this information:

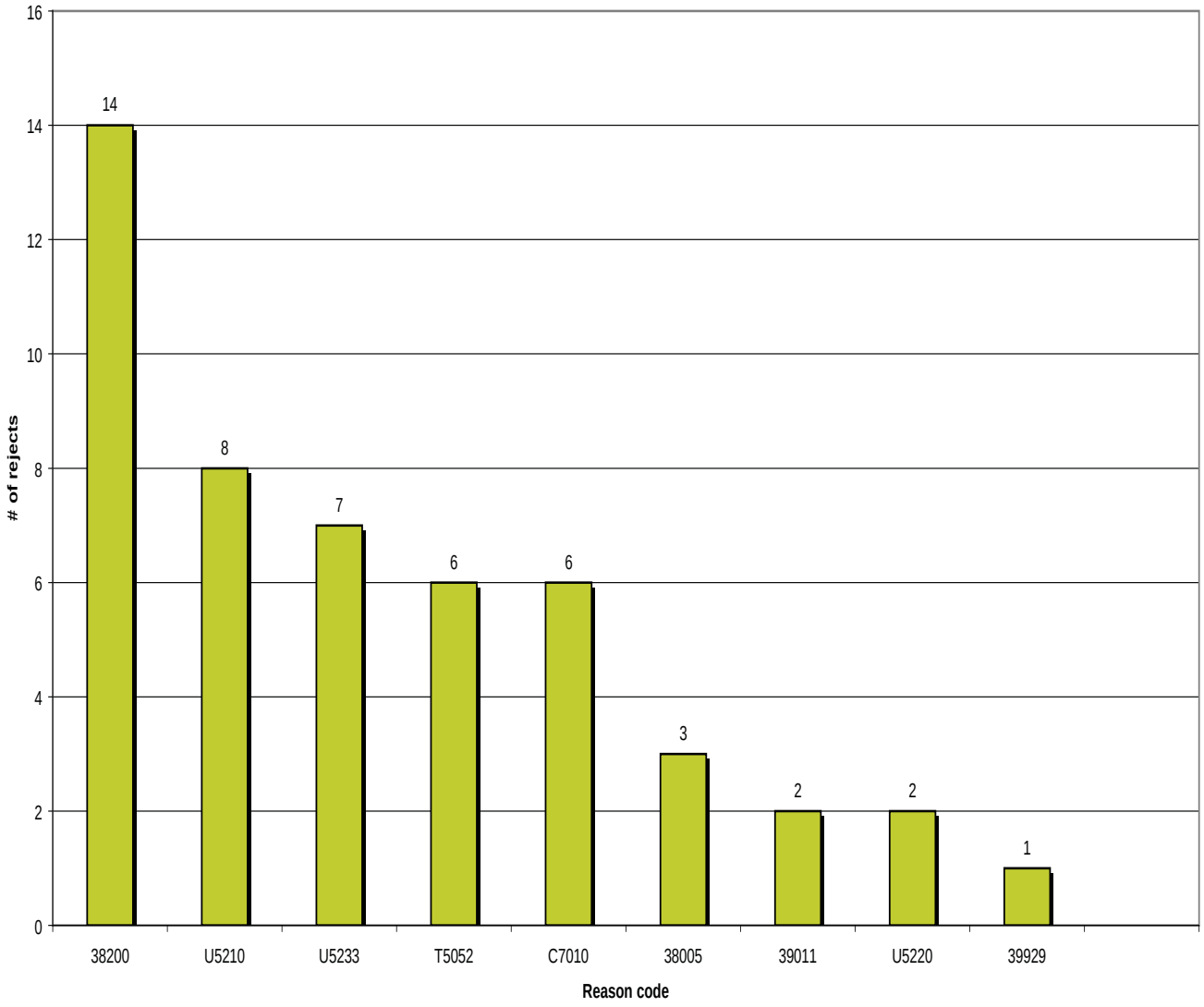
- Direct data entry (DDE) users can verify patient's eligibility information by using the eligibility inquiry access (ELGA)
- You can contact the interactive voice response (IVR) unit by calling 1-877-602-8816. For instructions, refer to the Part A IVR operating guide. ❖

Find your favorites fast – use Quick Find

Looking for the fastest way to find your favorite sections of our Web site? It's easy – just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site – with just one click. You'll find links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast – use Quick Find.

Top inquiries, return to provider, and reject claims for August 2009 (continued)

U.S. Virgin Islands Part A top rejects for August 2009



Frequently asked question related to reason code U5233

Q: On some claims we submit, we are receiving reject reason code U5233, indicating the admission date falls within a risk group health organization (GHO) paid period. What steps should we take to determine if a beneficiary is in a GHO?

A: To avoid this reject reason code, verify the beneficiary eligibility prior to submitting the claims. There are two ways to obtain this information:

1. Access the direct data entry (DDE) system, or
2. Contact the interactive voice response (IVR) unit by calling 1-877-602-8816. For instructions, refer to the Part A IVR operating guide.

If the GHO has paid on the claim, you **must** submit the appropriate code and/or condition code "69" on the claim.

Condition code 69 – IME/DGME/N&A payment only

Code indicates a request for a supplemental payment for IME/DGME/N&AH (indirect medical education/graduate medical education/nursing and allied health). ❖

GENERAL COVERAGE

Screening computed tomography colonography for colorectal cancer

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for colorectal cancer screening services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6578 which instructs that the Centers for Medicare & Medicaid Services (CMS) has determined that current evidence is inadequate to conclude that computed tomography colonography (CTC) is an appropriate colorectal cancer screening test under Section 1861(pp)(1) of the Social Security Act (the Act). Therefore, effective May 12, 2009, CTC for colorectal cancer screening, also known as virtual colonoscopy, remains nationally noncovered by Medicare. Medicare contractors will continue to process claims for CTC for colorectal cancer screening without change.

Background

Medicare covers colorectal cancer screening for average-risk individuals age 50 and older using:

- Fecal occult blood testing
- Sigmoidoscopy
- Colonoscopy
- Barium enema.

On March 5, 2008, the American Cancer Society, the U.S. Multi Society Task Force on Colorectal Cancer, and the American College of Radiology issued new cancer screening guidelines, including a recommendation that CTC be considered an acceptable option for colorectal cancer screening for such individuals. CTC (also referred to as virtual colonoscopy) uses computed tomography (CT) to acquire images and advanced 2-dimensional (2D) or 3-dimensional (3D) image display techniques for interpretation.

Neither Medicare law nor regulations identify the CTC test as a possible coverage option under the colorectal cancer screening benefit. However, under 42 CFR 410.37(a)(1) [see *http://www.gpoaccess.gov/CFR/retrieve.html*], CMS is allowed to use the national coverage determination (NCD) process to determine coverage of other types of colorectal cancer screening tests that are not specifically identified in law or regulations as it determines to be appropriate, in consultation with appropriate organizations.

Following a thorough review of the evidence, meetings with medical professional organizations, and conducting a Medicare Evidence Development and Coverage Advisory Committee Meeting, **CMS has determined that the current evidence is inadequate to conclude that CTC is an appropriate colorectal cancer screening test** under the Act (section 1861(pp)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet).

Additional information

The official instruction, CR 6578, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R105NCD.pdf*.

Providers may also be interested in the *Medicare Learning Network* brochure on cancer screenings that is available for download on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6578
Related Change Request (CR) Number: 6578
Related CR Release Date: August 7, 2009
Related CR Transmittal Number: R105NCD
Effective Date: May 12, 2009
Implementation Date: September 8, 2009

Source: CMS Pub. 100-03, Transmittal 105, CR 6578

Did you know?

If you are enrolled in Medicare but have not submitted a CMS-855 since 2003, you are required to submit a complete application. Providers and suppliers should follow the instructions for completing an initial enrollment application.

Correct billing for facet joint injection services

The Centers for Medicare & Medicaid Services (CMS) recently released *MLN Matters*® article MM6518, which provides information concerning the appropriate use of modifier 50 and add-on *Current Procedural Terminology Codes (CPT)* for facet joint injection services. The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.

It has come to our attention that confusion remains regarding correct physician billing for these services. The examples below illustrate incorrect and correct billing for bilateral facet joint injections at the C7, T1, and T2 vertebrae. Note that both the initial and add-on codes should be billed with modifier 50.

Correct example

CPT code	Modifier
64470	*50*
64472	*50*
64472	*50*

Incorrect example

CPT code	Modifier
64470	*50*
64472	
64472	
64472	
64472	

Billing using the method shown in the incorrect example above will result in an overpayment to the physician. Billing in this manner intentionally may be considered fraudulent billing.

Note: This information applies only to physician billing; it does not apply to facility billing.

Source: CMS Pub. 100-20, Transmittal 526, CR 6518

Billing correctly for the professional component with modifier 26

First Coast Service Options Inc. (FCSO) has noticed an excessive amount of providers billing incorrectly for the professional component by submitting modifier PC with the *CPT*/HCPCS code in question versus using correct modifier 26. The definitions of these modifiers are as follows:

Modifier 26 *Professional component*
Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier PC Wrong surgery on patient
Modifier PC is used by hospital outpatient departments, ambulatory surgical centers and other practitioners and it must be appended to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009. In addition, all claims identified with modifier PC with date of services on or after January 15, 2009 will be denied. Furthermore, Medicare will also not cover hospitalizations and other services related to the noncovered surgery as defined in the *Medicare Benefit Policy Manual.*

For more information on modifier PC as it relates to wrong surgery on a patient, refer to the MLN Matters® article MM6405 included in the July 2009 *Medicare A Bulletin* (pages 21-23), or the July 2009 *Medicare B Update!* (pages 28-30).

Action required by providers

- Providers must ensure that when billing for the professional component of a procedure, the service must be properly identified **by adding modifier 26** to the appropriate *CPT*/HCPCS code. This action will eliminate unnecessary delays and/or denial of the professional component procedure and claims for related services.
- Providers whose claim(s) were billed in error with modifier PC and have been denied for wrong surgery must request an appeal. Your appeal request will also alert Medicare to remove edit logic that was installed for the beneficiary and date of service of the wrong surgery (based on the initial claim).

Do not correct and resubmit the claim. Until Medicare has removed the edit logic, all claims for the beneficiary with a date of service of the wrong surgery will continue to deny. ❖

Source: CMS Pub. 100-04, Transmittal 1819, CR 6405

Coverage and reimbursement rules for the H1N1 vaccine and seasonal flu

A new special edition *MLN Matters*® article regarding billing for the administration of the influenza A (H1N1) vaccine is now available. This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine and also addresses seasonal flu coverage and reimbursement.

Note that Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. The Centers for Medicare & Medicaid Services understands that such preparations are critical for the upcoming flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e., the number of doses of a vaccine, and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claim processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims, and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A (H1N1) vaccination, then Medicare will pay for both.

Please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine administration (not for the vaccine itself).

All providers administering flu vaccine should review this article and be sure that their billing staffs are aware of this information. For more information, please read the article located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200909-03

Medicare fee-for-services billing for the administration of the influenza A (H1N1) virus vaccine

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Physicians, providers, and suppliers administering the H1N1 vaccine to Medicare patients are affected by this article.

Provider Action Needed

This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine. All providers administering this vaccine should review this article and be sure that their billing staffs are aware of this information.

Background

Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the **administration** of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

G9142 Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available **at no cost to providers,** Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (HIN1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied.

Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number
- Date of service
- Control number for Medicare contractor
- Patient's health insurance claim number
- Patient's name
- Patient's address
- Date of birth
- Patient's sex
- Beneficiary's signature or stamped "signature on file."

Medicare fee-for-services billing for the administration of the influenza A (H1N1) virus vaccine (continued)

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a Form CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself.

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A [H1N1] vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A [H1N1] vaccination, then Medicare will pay for both. However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

Additional Information

You may want to review the following *MLN Matters*® articles:

- MM6626 (October 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6626.pdf*
- MM6617 (October Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)) on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6617.pdf*.

If you have any questions, please contact your FI, Medicare carrier, or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE0920
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE0920

Surgery for diabetes national coverage determination

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6419 to show the correct group code of "CO" (contractual obligation). All other information remains the same. The *MLN Matters*® article MM6419 was published in the April 2009 *Medicare A Bulletin* (page 15).

Provider types affected

All hospitals and physicians who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs) for bariatric surgery procedures.

Provider action needed

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

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

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

Background

CMS has a specific NCD at Section 100.1 (attached to CR 6419), Bariatric Surgery for Treatment of Morbid Obesity, effective February 21. 2006. That NCD covers open and laparoscopic RYGBP, open and laparoscopic BPD/

Surgery for diabetes national coverage determination (continued)

DS, and LAGB for persons with a BMI ≥35 having one or more comorbidities associated with obesity, and have been previously unsuccessful with medical treatments for obesity. The only change to this NCD is the clarification that effective February 12, 2009, T2DM is considered a comorbidity for purposes of bariatric surgery for the treatment of morbid obesity.

Note: This NCD does not change related NCDs in the *National Coverage Determinations NCD Manual* at Sections 40.5 (Obesity), 100.8 (Intestinal Bypass Surgery), or 100.11 (Gastric Balloon for Treatment of Obesity). In addition, treatments for obesity alone remain noncovered, as does use of the open or laparoscopic sleeve gastrectomy, open adjustable gastric banding, and open and laparoscopic vertical banded gastroplasty procedures, regardless of the patient's BMI or comorbidity status.

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

The remittance advice for claims for bariatric surgery that are denied or rejected by Medicare because the patient's BMI was <35 will contain a claim adjustment reason code of 167 (This (these) diagnosis(es) is (are) not covered.), a remittance advice remark code of N372 (Only reasonable and necessary maintenance/service charges are covered.), **and a group code of CO (Contractual obligation)**.

Additional information

The official instruction, CR 6419, issued to your carrier, FI, or MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1728CP.pdf*.

The second transmittal modifies the *National Coverage Determinations NCD Manual* and it is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R100NCD.pdf*.

If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6419 – Revised
Related Change Request (CR) Number: 6419
Related CR Release Date: May 4, 2009
Related CR Transmittal Number: R100 NCD and R1728CP
Effective Date: February 12, 2009
Implementation Date: May 18 2009

Source: CMS Pub. 100-04, Transmittal 1728, CR 6419

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site *http://medicare.fcso.com* through the CMS Medicare Coverage Database.

Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

This section of the *Medicare A Bulletin* features summaries of new and revised LCDs developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the provider education Web site is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our educational Web site *http://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

More information

If you do not have Internet access, contact the Medical Policy and Procedures department at:

Medical Policy and Procedures – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

Table of contents

Additions/revisions to existing LCDs

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our provider education Web site at *http://medicare.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

A87181: Susceptibility studies – revision to the LCD

LCD ID Number: L28989 (Florida)
LCD ID Number: L29021 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was effective for services provided on or after February 16, 2009, for Florida and March 2, 2009, for Puerto Rico, and the U.S. Virgin Islands. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) laboratory national coverage determination (NCD) edit software for October 2008, transmittal 1606, change request 6213 dated October 2, 2008, business requirement 6213.1 for urine culture (section 190.12), a revision was made to update the access instructions for the online list of covered ICD-9-CM codes in the NCD. In addition, the "CMS National Coverage Policy" section of the LCD was updated, and under the "Other Comments" section of the coding guidelines, the ICD-9-CM codes were removed and CMS language was added regarding editing.

Effective date

This LCD revision is effective for claims processed **on or after September 24, 2009** for services provided **on or after October 1, 2008,** for Florida and services provided **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

AG0108: Diabetes outpatient self-management training – revision to the LCD

LCD ID Number: L28821 (Florida)
LCD ID Number: L28854 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diabetes outpatient self-management training (DSMT) was effective for services provided on or after February 16, 2009, for Florida, and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 6510, transmittal 109, dated August 7, 2009, to notify contractors that the American Association of Diabetes Educators (AADE) is a recognized national accreditation organization for accrediting entities to furnish outpatient diabetes self-management training (DSMT). Therefore, the LCD was updated to include the AADE as a recognized national accreditation body for accrediting entities to furnish DSMT.

Effective date

This LCD revision is effective for services provided **on or after March 30, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

2010 ICD-9-CM changes

The 2010 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2009. Providers are required to use the 2010-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2009.**

Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing.

First Coast Service Options Inc. (FCSO) has revised the local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2010 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2010 ICD-9-CM update.

LCD title	2010 ICD-9-CM changes
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Added diagnosis codes 569.71-569.79, 569.87, 784.42, 784.43, and 784.44 for procedure codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*. • Changed descriptor for diagnosis codes 784.49, 793.4, and 793.6 for procedure codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*.
A44388 – Diagnostic Colonoscopy	• Added diagnosis code range 569.71-569.79 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*. • Changed descriptor for diagnosis code 793.4 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*.
A70540 – Magnetic Resonance Imaging of the Orbit, Face, and/or Neck	• Changed descriptor for diagnosis range 784.40-784.49 and 793.0 for procedure codes *70540*, *70542*, and *70543*. • Removed diagnosis 784.5 for procedure codes *70540*, *70542*, and *70543*. • Added diagnosis code range 784.51-784.59 for procedure codes *70540*, *70542*, and *70543*.
A70544 – Magnetic Resonance Angiography (MRA)	• Added diagnosis code 416.2 for procedure codes *71555*, C8909, C8910, and C8911.
A73218 – Magnetic Resonance Imaging of Upper Extremity	• Changed descriptor for diagnosis codes 793.7 and 996.43 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*. • Removed diagnosis code 274.0 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*. • Added diagnosis codes 274.00-274.03 and 359.71 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*.
A77055 – Screening and Diagnostic Mammography	• Add diagnosis 793.82 for procedure codes *77055*, *77056*, G0204 and G0206. • Changed descriptor for diagnosis code 793.89 for procedure codes *77055*, *77056*, G0204 and G0206.
A78460 – Myocardial Perfusion Imaging	• Added diagnosis 995.24 for procedure codes *78460*, *78461*, *78464*, *78465*, *78478*, and *78480*.
A82310 – Total Calcium	• Added diagnosis codes 209.31-209.36 and 787.04 for procedure code *82310*. • Changed descriptor for diagnosis code range 584.5-584.9 for procedure code *82310*.
A82330 – Ionized Calcium	• Added diagnosis code 787.04 for procedure code *82330*.

2010 ICD-9-CM changes (continued)

LCD title	2010 ICD-9-CM changes
A83735 – Magnesium	• Added diagnosis codes 569.87 and 787.04 for procedure code *83735*. • Changed descriptor for diagnosis code range 584.5-584.9 for procedure code *83735*.
A83970 – Parathormone (Parathyroid Hormone)	• Added diagnosis code 787.04 for procedure code *83970*.
A84100 – Serum Phosphorus	• Changed descriptor for diagnosis codes 584.5-584.9, 793.0, and 793.7 for procedure code *84100*. • Removed diagnosis code 799.2 for procedure code *84100*. • Added diagnosis codes 799.21 and 799.22 for procedure code *84100*.
A85651 – Sedimentation Rate, Erythrocyte	• Removed diagnosis code 279.4 for procedure code *85651* and *85652*. • Added diagnosis code range 279.41-279.49 for procedure code *85651* and *85652*.
A93312 – Transesophageal Echocardiogram	• Changed descriptor for diagnosis code 453.2 for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, *93318*, C8925, C8926, and C8927.
A93965 – Non-invasive Evaluation of Extremity Veins	• Changed descriptor for diagnosis code range 453.40-453.42 for procedure codes *93965*, *93970*, and *93971*. • Removed diagnosis code 453.8 for procedure codes *93965*, *93970*, and *93971*. • Added diagnosis codes 453.50-453.52, 453.6, 453.71, 453.72, 453.73, 453.74, 453.81, 453.82, 453.83, and 453.84 for procedure codes *93965*, *93970*, and *93971*.
A93975 – Duplex Scanning	• Changed descriptor for diagnosis code 793.6 for procedure codes *93975*, *93976*, *93978*, and *93979*. • Changed descriptor for diagnosis codes 453.2 and 784.49 for procedure codes *93978* and *93979*. • Removed diagnosis code 784.5 for procedure codes *93978* and *93979*. • Added diagnosis codes 784.42, 784.43, 784.44, and 784.51-784.59 for procedure codes *93978* and *93979*.
A94640 – Diagnostic Aerosol or Vapor Inhalation	• Changed descriptor for diagnosis code 793.1 for procedure code *94640*.
AJ0881 – Erythropoiesis Stimulating Agents	• Added diagnosis codes 285.3, 209.31-209.36, and 209.70-209.79 for procedure code J0881 and J0885 with **modifier EA**. This will require a dual diagnosis (285.3 and one of the malignancy codes listed in List 2 must be billed together).
APULMDIAGSVCS – Pulmonary Diagnostic Services	• Changed descriptor for diagnosis code 793.1 for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94150*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*.

Source: CMS Pub. 100-04, Transmittal 1770, CR 6520

HOSPITAL SERVICES

Inpatient rehabilitation facility annual update: prospective payment system PRICER changes for fiscal year 2010

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for inpatient rehabilitation facilities (IRFs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6607 which provides updated rates used to correctly pay IRF prospective payment system (PPS) claims for fiscal year (FY) 2010. Be sure billing staff are aware of these changes.

Background

The FY 2010 IRF PPS final rule, published on August 7, 2009, sets forth the prospective payment rates applicable for IRFs for FY 2010. A new IRF PRICER software package will be released prior to October 1, 2009, that will contain the updated rates that are effective for claims with discharge dates that fall within October 1, 2009, through September 30, 2010, inclusive.

PRICER updates for IRF PPS FY 2010 (October 1, 2009-September 30, 2010)

- The standard federal rate is: $13,661
- The fixed loss amount is: $10,652
- The labor-related share is: 75.779 percent
- The non-labor related share is: 24.221 percent
- Urban national average cost-to-charge ratio (CCR) is: 0.494
- Rural national average CCR is: 0.622
- The low income patient (LIP) Adjustment is: 0.4613
- The teaching adjustment is: 0.6876
- The rural adjustment is: 1.1840

Additional information

The *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), Section 140 (Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)) is available for review on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

The official instruction, CR 6607, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1808CP.pdf*.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6607
Related Change Request (CR) Number: 6607
Related CR Release Date: August 28, 2009
Related CR Transmittal Number: R1808CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1808, CR 6607

Inpatient rehabilitation facility prospective payment system fact sheet

The revised *Inpatient Rehabilitation Facility Prospective Payment System* fact sheet (August 2009), which provides information about inpatient rehabilitation facility prospective payment system rates, classification criterion, and reasonable and necessary criteria, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/InpatRehabPaymtfctsht09-508.pdf*.

Note: If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200909-12

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6634 which outlines changes for inpatient prospective payment system (IPPS) and long-term care hospitals (LTCHs) for fiscal year (FY) 2010. The policy changes for FY 2010 appeared in the *Federal Register* on August 27, 2009. All items covered in CR 6634 are effective for hospital discharges occurring on or after October 1, 2009, unless otherwise noted. CR 6634 also addresses changes to Medicare severity-diagnosis related groups (MS-DRGs) and ICD-9-CM coding that affects the inpatient psychiatric facility (IPF) PPS. The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment, effective October 1, 2009. The IPF PPS rate changes occurred on July 1, 2009 and are discussed in *MLN Matters*® article MM6461 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6461.pdf*.

Be sure your billing personnel are aware of these changes.

Background

The key changes conveyed in CR 6634 are as follows:

ICD-9-CM changes

The ICD-9-CM coding changes are effective October 1, 2009. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 27, 2009, *Federal Register*. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 27, 2009, *Federal Register* notice is available on the Internet at *http://www.access.gpo.gov/su_docs/fedreg/frcont09.html*.

The GROUPER contractor, 3M-HIS, introduced a new MS-DRG GROUPER, Version 27.0, software package effective for discharges on or after October 1, 2009. The GROUPER 27.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare code editor (MCE) 26.0 which is also developed by 3M-HIS, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2009.

The inpatient prospective payment system FY 2010 update

The FY 2010 IPPS PRICER is for discharges occurring on or after October 1, 2009. It includes all pricing files for FY 2005 through FY 2010 to process bills with discharge dates on or after October 1, 2004.

FY 2009 inpatient prospective payment system rates

Standardized amount update factor	1.021 1.001 (for hospitals that do not submit quality data)
Hospital specific update factor	1.021 1.001 (for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	$23,140.00
Federal capital rate	$429.26
Puerto Rico capital rate	$203.56
Outlier offset-operating national	0.948994
Outlier offset-operating Puerto Rico	0.957524
IME formula (no change for FY 2010)	1.35 x [(1 + resident to bed ratio).405 – 1]
MDH/SCH budget neutrality factor	0.997941

Operating rates with FULL market basket

	Wage index > 1		Wage index ≤ than 1	
	Labor share	Non-labor share	Labor share	Non-labor share
National	$3,953.52	$1,629.62	$3,238.35	$1,984.79
Puerto Rico national	$3,953.52	$1,629.62	$3,238.35	$1,984.79
Puerto Rico specific	$1,542.72	$941.52	$1,540.23	$944.01

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Rates with REDUCED Market Basket

	Wage index > 1		Wage index ≤ than 1	
	Labor share	Non-labor share	Labor share	Non-labor share
National	$3,523.13	$1,597.70	$3,174.91	$1,945.92
Puerto Rico national	$3,953.13	$1,597.70	$3,174.91	$1,945.92
Puerto Rico specific	$1,542.72	$941.52	$1,540.23	$944.01

Cost-of-living adjustment (COLA) factors: Alaska and Hawaii hospitals

Area	COLA factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change for FY 2010)

Note: There are no COLA changes for Hawaii in FY 2010.

Postacute transfer policy

See Table 5 of the IPPS final rule for a listing of all postacute and special postacute MS-DRGs.

New technology add-on payments

The following items are eligible for new-technology add-on payments in FY 2010:

- **Total artificial heart (TAH-t)** – Effective in FY 2009 and through FY 2010, the new technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial). The maximum add-on payment is $53,000 per case.
- **Spiration IBV** – Effective for FY 2010, cases involving the Spiration® IBV® that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 163, 164 and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49. The maximum add on payment for the Spiration® IBV® is $3,437.50 per case.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount will be paid that is equal to the lesser of 50 percent of the costs of the new medical service/technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

State rural floor budget neutrality adjustment factors

The FY 2009 IPPS PRICER included a new PRICER table, "State Rural Floor Budget Neutrality Adjustment Factors", due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570). "Specifically, CMS must make an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) and the imputed floor under Section 412.64(h)(4) are made in a manner that ensures that aggregate payments to hospitals are not affected. Beginning October 1, 2008, such payments will transition from a nationwide adjustment, with a statewide adjustment fully in place by October 1, 2011."

The table in Attachment A of CR 6634 lists the blended overall rural floor budget neutral factors, for FY 2010, that are to be applied onto the wage index (based on the providers' geographic state location). CR 6634 is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1815CP.pdf*.

The wage table loaded for the FY 2010 PRICER contains wage index values **prior** to the application of the blended overall rural floor budget neutrality factors. The PRICER software is applying the budget neutrality factors from Attachment A to the wage index within the PRICER payment logic. The wage index tables printed in the FY 2010 *Federal Register* final rule notice already have the blended overall rural floor budget neutrality factors applied. To confirm the wage index PRICER used in calculating payments with the wage index printed in the *Federal Register*, you must take the wage index from PRICER and multiply it by the appropriate factor from Attachment A. Attachment A of CR 6634 is also duplicated at the end of this article.

Expiration of Section 508 reclassifications

Section 508 of the 2003 Medicare Modernization Act will expire on October 1, 2009. The provider specific file (PSF) will be adjusted accordingly for hospitals previously designated as a Section 508 hospital.

Section 505 hospital (out-commuting adjustment)

Attachment B of CR 6634 shows the IPPS providers that will be receiving a "special" wage index for FY 2010 (i.e., receives an out-commuting adjustment under section 505 of the MMA). For any provider with a special wage index from FY 2009, FIs and A/B MACs shall remove that special wage index, by entering zeros in the field unless they receive a new special wage index as listed in Attachment B.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Low volume hospitals

Hospitals considered low volume shall receive a 25 percent bonus to the operating final payment. To be considered "low volume" the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify their FI or A/B MAC if they believe they are a low volume hospital. The low volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at on the Internet *http://www.qualitynet.org/pqri*.

This Web site is expected to be updated in September 2010. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the Web site. Hospitals not receiving the 2.0 percent RHQDAPU annual payment update for FY 2010 s are listed in Attachment C of this CR.

For new hospitals, FIs and A/B MACs will provide information to the quality improvement organization (QIO) as soon as possible so that the QIO can enter the provider information into the program resource system and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the hospital quality initiative.

Capital inpatient prospective payment system adjustment for indirect medical education (IME)

In the FY 2008 IPPS final rule, the CMS adopted a policy to phase-out the capital IPPS teaching adjustment. For FY 2009, hospitals would receive 50 percent of the IME adjustment provided under the current formula. Section 4301(b) of the American Recovery and Reinvestment Act (ARRA) removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009, (per CR 6444 issued on March 27, 2009).

The capital teaching adjustment is no longer being eliminated for FY 2010. Therefore, the full capital IME teaching adjustment is restored for FY 2010 and will be determined under Section 412.322(b).

Capital PPS payment for providers redesignated under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(II)(D)(3) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the federal payment amount for the urban area to which they are redesignated. To ensure these "Lugar hospitals" are paid correctly under the capital PPS, FIs and A/B MACs must enter the urban core based statistical area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF.

Note: This may be different from the urban CBSA in the wage index CBSA field on the PSF for "Lugar hospitals" that are reclassified for wage-index purposes. However, if a "Lugar hospital" declines its redesignation as urban in order to retain its rural status, FIs and A/B MACs must enter the rural CBSA (2-digit state code) in the standardized amount CBSA field on the PSF rather than the urban CBSA from the chart to ensure correct payment under the capital PPS.

Treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103 for purposes of capital PPS payments

Hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)). Similarly, the geographic adjustment factor (GAF) for hospitals reclassified as rural under Section 412.103 is determined from the applicable statewide rural wage index.

Medicare-dependent hospitals (MDHs): Budget neutrality adjustment factors for FY 2002-based hospital-specific (HSP) rate

Effective FY 2010, CMS is correcting the MDH FY 2002 HSP rate calculation to include the cumulative budget neutrality adjustment factor for FYs 1993 through 2002 in addition to the budget neutrality adjustment factors for FYs 2003 forward. Section 5003(b) of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) allows MDHs to rebase their HSP rates using data from their FY 2002 cost report if this results in a payment increase.

To implement this provision, CMS issued Transmittal 1067 (Change Request 5276 dated September 25, 2006) with instructions to FIs to determine and update the FY 2002 HSP rate for qualifying MDHs. To calculate an MDH's FY 2002 HSP rate and update it to FY 2007, the instructions directed FIs to apply cumulative budget neutrality adjustment factors for FYs 2003 through 2007. However, the instructions did not include the cumulative budget neutrality adjustment factor to account for changes in the DRGs from FYs 1993 through 2002.

To correct for this, FIs and A/B MACs must adjust any FY 2002 HSP rates of MDHs currently in the PSF by applying a factor of 0.982557, which is calculated as the product of the following budget neutrality adjustment factors from FYs 1993 through 2002:

0.999851 for FY 1993

0.999003 for FY 1994

0.998050 for FY 1995

0.999306 for FY 1996

0.998703 for FY 1997

0.997731 for FY 1998

0.998978 for FY 1999

0.997808 for FY 2000

0.997174 for FY 2001

0.995821 for FY 2002.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

The inflation update from FYs 2002 through 2007 and the cumulative budget neutrality adjustment factors for FYs 2003 through 2007 should have already been applied as specified in Transmittal 1067 (change request 5276 dated September 25, 2006).

Section 1886(d)(5)(G) of the Act provides that the HSP rate for MDHs is based on FY 1982, FY 1987 or FY 2002 costs per discharge, whichever of these HSP rates is the highest.

After the FY 2002 HSP rates are adjusted as described above, FIs and A/B MACS should verify that the FY 2002 HSP rate is still the highest of the applicable based years (that is, FY 1982, FY 1987 or FY 2002). In those cases where a MDH's FY 2002 HSP rate is no longer higher than its FY 1982 or FY 1987 HSP rate, the applicable HSP rate (FY 1982 or FY 1987) updated to FY 2007 dollars shall be entered in to the PSF effective October 1, 2009.

For FY 1982 or FY 1987 HSP rates that had previously been updated to FY 2000 dollars (that is, a MDH's HSP rate prior to the implementation of the rebasing to FY 2002 provided for by section 5003(b) of the DRA) before entering it in the PSF with an effective date of October 1, 2009, the FY 1982 or FY 1987 HSP shall be updated from FY 2000 dollars to FY 2007 dollars by applying an update factor of 1.233973509, which is computed as the product of the FY 2001 update factor of 1.034, the FY 2001 budget neutrality factor of 0.997174, the FY 2002 update factor of 1.0275, the FY 2002 budget neutrality factor of 0.995821 and the update and inflation factors for FYs 2003 through 2007 listed above.

As directed above, FIs and A/B MACs shall adjust the FY 2002 HSP rates of MDHs currently in the PSF and enter it that amount in the PSF with an effective date of October 1, 2009. This adjustment to the FY 2002 HSP rates of MDHs is not to be applied in determining payments for discharges occurring prior to October 1, 2009. For purposes of the settlement of MDH cost reports that include discharges that occurred from October 1, 2006, through September 30, 2009, FIs and A/B MACs shall use the originally computed, that is, the FY 2002 HSP rates of MDHs that is currently in the PSF.

The long-term care hospital PPS rate year 2010 update

RY 2010 LTCH PPS rates

Federal rate	$39,896.65
High cost outlier fixed-loss amount	$18,425.00
Labor share	75.779 percent
Non-labor share	24.221 percent

MS-LTC-DRG update

The LTCH PPS PRICER has been updated with the Version 27.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2009, and on or before September 30, 2010.

Cost-of-living adjustment (COLA) update for LTCH PPS

LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. See the table below for the updated COLAs implemented as part of the RY 2010 LTCH PPS Final Rule, which are effective for discharges occurring on or after October 1, 2009.

Area	COLA factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25 (no change from RY 2009)
Hawaii:	
City and County of Honolulu	1.25 (no change from RY 2009)
County of Hawaii	1.18
County of Kauai	1.25 (no change from RY 2009)
County of Maui and County of Kalawao	1.25 (no change from RY 2009)

Core-based statistical area (CBSA)-based labor market definition changes

There are several revisions to the core-based statistical area (CBSA)-based labor market definitions used under the LTCH PPS, which are the basis of the wage index adjustment, effective October 1, 2009. The following changes affect the CBSA codes used for the wage index assignment under the LTCH PPS:

- For any LTCHs currently located in CBSA 42260, the CBSA code on the PSF will need to be changed to 14660 (from 42260) effective October 1, 2009, due to a title change for that CBSA.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

- For any LTCHs currently located in Bollinger County or Cape Girardeau County, Missouri, the CBSA code on the PSF will need to be changed to 16020 (from the rural two-digit state code 26) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Alexander County, Illinois, the CBSA code on the PSF will need to be changed to 16020 (from the rural two-digit state code 14) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Geary County, Pottawatomie County or Riley County, Kansas, the CBSA code on the PSF will need to be changed to 31740 (from the rural two-digit state code 17) effective October 1, 2009, due to the creation of a new urban CBSA.
- For any LTCHs currently located in Blue Earth County or Nicollet County, Minnesota, the CBSA code on the PSF will need to be changed to 31860 (from the rural two-digit state code 24) effective October 1, 2009, due to the creation of a new urban CBSA.

Changes to LTCH PPS payment policy made by the American Recovery and Reinvestment Act (ARRA) of 2009

The February 17, 2009, enactment of the ARRA, made changes to two provisions of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007, the three-year moratoria on the establishment of new LTCHs and LTCH satellites and on the increase in beds in existing LTCHs and LTCH satellites and revisions to the percentage threshold payment adjustment for LTCHs and LTCH satellites. (These MMSEA changes, which were finalized in the RY 2010 LTCH PPS final rule, were addressed, respectively, in CR 6172, issued on December 19, 2008, and CR 5955, issued on March 7, 2008.) The ARRA added an additional exception to the moratorium on the increase in beds in existing LTCHs or LTCH satellites if an existing LTCH located in a state that required a certificate of need (CON), had obtained a CON for a bed increase that was issued on or after April 1, 2005, and before December 29, 2007.

Additionally, the ARRA amended the MMSEA provision regarding the percentage threshold payment adjustment. (These ARRA changes were implemented in an interim final rule with comment period which was published with the RY 2010 LTCH PPS final rule.) Specifically, an additional category of LTCH satellites, "grandfathered" satellites (described at 42 CFR Section 412.22(h)(3)(i)) was added to those LTCH HwHs and satellites identified by the MMSEA as "applicable" for the three-year percentage threshold increase. The ARRA also changed the effective date of all of MMSEA changes from the effective date of MMSEA (December 29, 2009) to July 1, 2007 or October 1, 2007, based upon the particular provision.

The inpatient psychiatric facility (IPF) PPS update

DRG adjustment update

The IPF PPS has DRG specific adjustments for MS-DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS's identified psychiatric DRGs, the IPF will still receive the federal per diem base rate and all other applicable adjustments.

The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2010 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. This table is only a listing of FY 2010 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating MS-DRG adjustment.

Diagnosis code	MS-DRG descriptions	MS-DRG
438.13	Late effects of cerebrovascular disease, dysarthria	056, 057
438.14	Late effects of cerebrovascular disease, fluency disorder	056, 057
799.21	Nervousness	880
799.22	Irritability	880
799.23	Impulsiveness	882
799.24	Emotional lability	883
799.25	Demoralization and apathy	880
799.29	Other signs and symptoms involving emotional state	880

The following table lists the FY 2010 **invalid** ICD-9-CM diagnosis code that is no longer applicable for the DRG adjustment.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Diagnosis code	MS-DRG description	MS-DRG
799.2	Nervousness	880

Since CMS does not plan to update the regression analysis until the IPF PPS data is analyzed, the MS-DRG adjustment factors, shown in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 3, Section 190.5.1 are effective October 1, 2009, and will continue to be paid for RY 2010.

Comorbidity adjustment update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to eight additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

The IPF PPS utilizes the MS-severity DRG coding system, in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is currently using the FY 2010 GROUPER, version 27.0 which is effective for discharges occurring on or after October 1, 2009.

The following three tables below list the FY 2010 new, revised and invalid ICD-9-CM diagnosis codes, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2010 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

The table below lists the FY 2010 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table lists only the FY 2010 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2010 IPF PRICER will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis code	Description	Comorbidity category
209.31	Merkel cell carcinoma of the face	Oncology treatment
209.32	Merkel cell carcinoma of the scalp and neck	Oncology treatment
209.33	Merkel cell carcinoma of the upper limb	Oncology treatment
209.34	Merkel cell carcinoma of the lower limb	Oncology treatment
209.35	Merkel cell carcinoma of the trunk	Oncology treatment
209.36	Merkel cell carcinoma of other sites	Oncology treatment
209.70	Secondary neuroendocrine tumor, unspecified site	Oncology treatment
209.71	Secondary neuroendocrine tumor of distant lymph nodes	Oncology treatment
209.72	Secondary neuroendocrine tumor of liver	Oncology treatment
209.73	Secondary neuroendocrine tumor of bone	Oncology treatment
209.74	Secondary neuroendocrine tumor of peritoneum	Oncology treatment
209.75	Secondary Merkel cell carcinoma	Oncology treatment
209.79	Secondary neuroendocrine tumor of other sites	Oncology treatment
239.81	Neoplasms of unspecified nature, retina and choroid	Oncology treatment
239.89	Neoplasms of unspecified nature, other specified sites	Oncology treatment
969.00	Poisoning by antidepressant, unspecified	Poisoning
969.01	Poisoning by monoamine oxidase inhibitors	Poisoning
969.02	Poisoning by selective serotonin and norepinephrine reuptake inhibitors	Poisoning
969.03	Poisoning by selective serotonin reuptake inhibitors	Poisoning
969.04	Poisoning by tetracyclic antidepressants	Poisoning
969.05	Poisoning by tricyclic antidepressants	Poisoning

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Diagnosis code	Description	Comorbidity category
969.09	Poisoning by other antidepressants	Poisoning
969.70	Poisoning by psychostimulant, unspecified	Poisoning
969.71	Poisoning by caffeine	Poisoning
969.72	Poisoning by amphetamines	Poisoning
969.73	Poisoning by methylphenidate	Poisoning
969.79	Poisoning by other psychostimulants	Poisoning

The table below lists the FY 2010 **revised** ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2010 revised codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment.

Diagnosis code	Description	Comborbidity category
584.5	Acute kidney failure with lesion of tubular necrosis	Renal failure, acute
584.6	Acute kidney failure with lesion of renal cortical necrosis	Renal failure, acute
584.7	Acute kidney failure with lesion of renal medullary [papillary] necrosis	Renal failure, acute
584.8	Acute kidney failure with other specified pathological lesion in kidney	Renal failure, acute
584.9	Acute kidney failure, unspecified	Renal failure, acute
639.3	Kidney failure following abortion and ectopic and molar pregnancies	Renal failure, acute
669.32	Acute kidney failure following labor and delivery, delivered, with mention of postpartum complication	Renal failure, acute
669.34	Acute kidney failure following labor and delivery, postpartum condition or complication	Renal failure, acute

The table below lists the **invalid** ICD-9-CM codes no longer applicable for the comorbidity adjustment. The RY 2010 IPF PRICER will be updated to remove these codes in the comorbidity tables, effective for discharges on or after October 1, 2009.

Diagnosis code	Description	Comorbidity category
239.8	Neoplasm of unspecified nature of other specified sites	Oncology treatment
969.0	Poisoning by antidepressants	Poisoning
969.7	Poisoning by psychostimulants	Poisoning

The seventeen comorbidity categories for which CMS is providing an adjustment, their respective codes, including the new FY 2010 ICD codes, and their respective adjustment factors, are listed below in the following table.

Description of comorbidity	ICD-9-CM code	Adjustment factor
Developmental disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation factor deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal failure, acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal failure, chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V4511, V4512, V560, V561, and V562	1.11
Oncology treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled diabetes-mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Description of comorbidity	ICD-9-CM code	Adjustment factor
Severe protein calorie malnutrition	260 through 262	1.13
Eating and conduct disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or alcohol induced mental disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic obstructive pulmonary disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial openings – digestive and urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe musculoskeletal and connective tissue diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Billing wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedures performed on the wrong body part, and surgical or other invasive procedures performed on the wrong patient (related CR 6405)

Effective date: Discharges on or after October 1, 2009

CMS internally generated a request for a national coverage analysis (NCA) to establish national coverage determinations (NCDs) addressing Medicare coverage of wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedures performed on the wrong body part, and surgical or other invasive procedures performed on the wrong patient. Information regarding these NCDs may be found in Publication (Pub.) 100-03, Chapter 1, Sections 140.6, 140.7, and 140.8, respectively.

The CMS previously issued CR 6405 to provide instruction to hospitals on how to bill erroneous surgeries. It explained that, for inpatient claims, hospitals are required to submit a no-pay claim (type of bill 110) when the erroneous surgery related to the NCD is reported. However, if there are also covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim.

Additionally, CR 6405 instructed hospitals to report surgical error indicators in the remarks field of the noncovered TOB 110. However, effective for discharges on or after October 1, 2009, hospitals are not to report the surgical error indicator as was previously instructed. Instead, the noncovered TOB 110 must have one of the following ICD-9-CM diagnosis code reported in diagnosis position 2-9:

E876.5 Performance of wrong operation (procedure) on correct patient (existing code)

E876.6 Performance of operation (procedure) on patient not scheduled for surgery

E876.7 Performance of correct operation (procedure) on wrong side/body part

Note: The above codes shall not be reported in the external cause of injury (E-code) field.

Additional Information

For a one-stop resource Web page focused on the informational needs and interests of Medicare fee-for-service (FFS) hospitals, go to the Hospital Center on the CMS Web site at *http://www.cms.hhs.gov/Center/Hospital.asp*.

The LTCH PPS regulations and notices are available on the CMS Web site at *http://www.cms.hhs.gov/longtermcarehospitalpps/*.

The IPF PPS regulations and notices are available on the CMS Web site at *http://www.cms.hhs.gov/inpatientPsychFacilPPS/*.

The official instruction, CR 6634, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1816CP.pdf*.

Fiscal year 2010 inpatient PPS, long-term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6634
Related Change Request (CR) Number: 6634
Related CR Release Date: September 17, 2009
Effective Date: Discharges on or after October 1, 2009
Related CR Transmittal Number: R1816CP
Implementation Date: October 5, 2009
Source: CMS Pub. 100-04, Transmittal 1816, CR 6634

Rural floor budget neutrality factors for acute care hospitals – Fiscal year 2010

Attachment A of change request 6634

The rural floor budget neutrality adjustment factor in this table reflects a blend of the state factor (weighted at 50 percent) and the nationwide factor (50 percent).

State	Rural floor budget neutrality adjustment factor
Alabama	0.99835
Alaska	0.99835
Arizona	0.99835
Arkansas	0.99835
California	0.99415
Colorado	0.99413
Connecticut	0.97887
Delaware	0.99835
Washington, D.C.	0.99835
Florida	0.99755
Georgia	0.99835
Hawaii	0.99835
Idaho	0.99835
Illinois	0.99835
Indiana	0.99813
Iowa	0.99767
Kansas	0.99829
Kentucky	0.99835
Louisiana	0.99835
Maine	0.99835
Maryland *	------
Massachusetts	0.99835
Michigan	0.99835
Minnesota	0.99835
Mississippi	0.99835
Missouri	0.99835

State	Rural floor budget neutrality adjustment factor
Montana	0.99835
Nebraska	0.99835
Nevada	0.99835
New Hampshire	0.99698
New Jersey **	0.98437
New Mexico	0.99576
New York	0.99836
North Carolina	0.99833
North Dakota	0.99668
Ohio	0.99783
Oklahoma	0.99835
Oregon	0.99705
Pennsylvania	0.99812
Puerto Rico	0.99835
Rhode Island	0.99835
South Carolina	0.99778
South Dakota	0.99835
Tennessee	0.99691
Texas	0.99835
Utah	0.99835
Vermont	0.99835
Virginia	0.99835
Washington	0.99792
West Virginia	0.99714
Wisconsin	0.99816
Wyoming	0.99835

* Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS rate setting. Therefore, the rural floor budget neutrality adjustment does not apply.
** The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see Table 4B).

Section 505 adjustment: Provider numbers and corresponding special wage indexes

Attachment B

010008	0.7563
010015	0.7435
010021	0.7441
010027	0.7415
010032	0.7714
010038	0.7650
010040	0.8411
010045	0.7611
010046	0.8411
010047	0.7516
010049	0.7415
010078	0.7650
010091	0.7435
010109	0.7794
010110	0.7604
010125	0.7865
010128	0.7435
010129	0.7523
010138	0.7455
010146	0.7650
010150	0.7516
030067	0.9099
040047	0.7676
040067	0.7566
040081	0.7916
040149	0.7758
050007	1.5600
050070	1.5600
050090	1.5541
050113	1.5600
050118	1.2377
050122	1.2377
050136	1.5541
050167	1.2377
050174	1.5541
050289	1.5600
050291	1.5541
050298	1.1756
050313	1.2377
050325	1.1778

050336	1.2377
050366	1.1760
050385	1.5541
050444	1.2086
050547	1.5541
050690	1.5541
050748	1.2377
050754	1.5600
080001	1.0786
080003	1.0786
090001	1.0733
090003	1.0733
090005	1.0733
090006	1.0733
090008	1.0733
100290	0.8932
110100	0.8609
110101	0.7886
110142	0.8004
110190	0.8060
110205	0.8326
130024	0.8318
130066	0.9380
140001	0.8691
140026	0.8637
140116	1.0399
140176	1.0399
140234	0.8637
150022	0.8671
150072	0.8618
160013	0.8743
160030	0.9546
160032	0.8799
170150	0.8349
180064	0.8275
180070	0.8201
180079	0.8220
190034	0.8013
190044	0.8085
190050	0.7868

190053	0.7925
190054	0.7909
190078	0.8011
190099	0.8013
190116	0.7909
190133	0.7926
190140	0.7859
190145	0.7914
190246	0.7899
200032	0.8922
230005	0.9270
230015	0.9092
230041	0.9498
230047	0.9879
230075	1.0121
230093	0.8855
230099	1.0193
230204	0.9879
230217	1.0121
230227	0.9879
230257	0.9879
230264	0.9879
230301	0.9883
240018	1.0071
240044	0.9891
240117	0.9793
240211	1.0078
250128	0.8163
250162	0.8737
260059	0.8241
260097	0.8464
260160	0.8308
260163	0.8251
320011	0.9301
320018	0.8988
320085	0.8988
320088	0.8988
330010	0.8541
330033	0.8697
330047	0.8541

330103	0.8605
330106	1.2841
330132	0.8605
330135	1.1908
330144	0.8530
330151	0.8530
330175	0.8734
330205	1.1908
330264	1.1908
330276	0.8510
340020	0.8749
340024	0.8770
340037	0.8755
340038	0.8846
340068	0.8680
340070	0.9042
340104	0.8755
340133	0.8853
340151	0.8645
360002	0.8656
360040	0.8902
360044	0.8642
360070	0.8666
360071	0.8550
360084	0.8666
360096	0.8586
360107	0.8634
360131	0.8666
360151	0.8666
360156	0.8634
360161	0.8673
370023	0.7897
370065	0.7903
370072	0.8065
370083	0.7858
370100	0.7907
370156	0.7928
370169	0.7970
370172	1.4682
370214	0.7928

Section 505 adjustment: Provider numbers and corresponding special wage indexes (continued)

390008	0.8423
390039	0.8400
390052	0.8410
390056	0.8399
390112	0.8400
390117	0.8365
390122	0.8416
390125	0.8385
390146	0.8385
390150	0.8394
390173	0.8400
390201	0.9533
390236	0.8366
390316	0.9403
420002	0.9316
420019	0.8547
420043	0.8546
420053	0.8424
420054	0.8391
420082	0.9442
430008	0.8895
430048	0.8489
430094	0.8489

440007	0.8109
440008	0.8339
440012	0.8120
440016	0.8034
440017	0.8120
440031	0.7909
440033	0.7917
440047	0.8228
440050	0.7899
440051	0.7972
440057	0.7911
440060	0.8228
440063	0.7923
440070	0.7999
440081	0.7942
440084	0.7915
440105	0.7923
440109	0.7960
440115	0.8228
440137	0.8628
440176	0.8120
440180	0.7917
440181	0.8255

440182	0.8034
440184	0.7923
450052	0.7944
450059	0.8988
450090	0.8594
450163	0.7998
450192	0.8215
450194	0.8157
450210	0.8095
450236	0.8333
450270	0.8215
450395	0.8385
450451	0.8480
450460	0.7997
450497	0.8319
450539	0.8011
450573	0.8070
450615	0.7977
450641	0.8319
450698	0.8071
450755	0.8220
450813	0.8070
450838	0.8070

450884	0.8288
450888	0.9458
460001	0.9444
460013	0.9444
460017	0.8825
460023	0.9444
460043	0.9444
460052	0.9444
490002	0.8104
490038	0.8104
490084	0.8288
490105	0.8104
490110	0.8534
500019	1.0250
510012	0.7594
520035	0.9334
520044	0.9334
520045	0.9248
520048	0.9248
520057	0.9419
520198	0.9248

Hospital quality initiative

Attachment C

State	HSP ID	Hospital name
AL	010015	SOUTHWEST ALABAMA MEDICAL CENTER
AL	010052	LAKE MARTIN COMMUNITY HOSPITAL
AZ	030074	SELLS INDIAN HEALTH SERVICE HOSPITAL
AZ	030113	WHITERIVER PHS INDIAN HOSPITAL
CA	050091	COMMUNITY AND MISSION HOSPITAL OF HUNTINGTON PARK
CA	050110	LOMPOC VALLEY MEDICAL CENTER
CA	050193	SOUTH COAST MEDICAL CENTER
CA	050205	EAST VALLEY HOSPITAL MEDICAL CENTER
CA	050301	UKIAH VALLEY MEDICAL CENTER/HOSPITAL D
CA	050325	TUOLUMNE GENERAL MEDICAL FACILITY
CA	050342	PIONEERS MEMORIAL HEALTHCARE DISTRICT
CA	050378	PACIFICA HOSPITAL OF THE VALLEY
CA	050385	PALM DRIVE HOSPITAL
CA	050423	PALO VERDE HOSPITAL
CA	050433	INDIAN VALLEY HOSPITAL

Hospital quality initiative (continued)

State	HSP ID	Hospital name
CA	050545	LANTERMAN DEVELOPMENTAL CENTER
CA	050546	PORTERVILLE DEVELOPMENTAL CENTER
CA	050548	FAIRVIEW DEVELOPMENTAL CENTER
CA	050662	AGNEWS STATE HOSPITAL
CA	050667	N M HOLDERMAN MEMORIAL HOSPITAL
CA	050682	KINGSBURG MEDICAL CENTER
CA	050698	SAN DIEGO HOSPICE & THE INSTITUTE FOR PALLIATIVE MEDICINE
CA	050740	MARINA DEL REY HOSPITAL
CA	050751	MIRACLE MILE MEDICAL CENTER
CA	050760	KAISER FOUNDATION HOSPITAL – ANTIOCH
CO	060049	YAMPA VALLEY MEDICAL CENTER
CT	070038	CONNECTICUT HOSPICE INC.
FL	100105	INDIAN RIVER MEMORIAL HOSPITAL INC
FL	100134	ED FRASER MEMORIAL HOSPITAL
FL	100139	NATURE COAST REGIONAL HOSPITAL
FL	100298	FLORIDA STATE HOSPITAL UNIT 31 MED
HI	120004	WAHIAWA GENERAL HOSPITAL
ID	130062	IDAHO FALLS RECOVERY CENTER
IL	140033	VISTA MEDICAL CENTER WEST
IL	140082	VHS ACQUISTION DBA LOUIS A WEISS MEMORIAL HOSPITAL
IL	140151	SACRED HEART HOSPITAL
IL	140205	SWEDISH AMERICAN MEDICAL CENTER BELVIDERE
IN	150166	PINNACLE HOSPITAL
KS	170180	MEADOWBROOK REHABILITATION HOSPITAL
LA	190037	SOUTH CAMERON MEMORIAL HOSPITAL
LA	190118	DESOTO REGIONAL HEALTH SYSTEM
LA	190161	W O MOSS REGIONAL MEDICAL CENTER
LA	190208	EAST CARROLL PARISH HOSPITAL
LA	190245	MONROE SURGICAL HOSPITAL
[LA]	[190258]	[BOSSIER SPECIALTY HOSPITAL]
LA	190297	DOCTORS HOSPITAL AT DEER CREEK LLC
MA	220153	SOLDIERS HOME OF HOLYOKE
MA	220154	CHELSEA SOLDIERS HOME
MA	220172	UNIVERSITY HEALTH SERVICES
MA	220177	NANTUCKET COTTAGE HOSPITAL
MI	230135	HENRY FORD COTTAGE HOSPITAL
MI	230144	FOREST HEALTH MEDICAL CENTER
MN	240196	PHILLIPS EYE INSTITUTE
MS	250018	JASPER GENERAL HOSPITAL
MS	250060	JEFFERSON COUNTY HOSPITAL
MS	250079	SHARKEY ISSAQUENA COMMUNITY HOSPITAL

Hospital quality initiative (continued)

State	HSP ID	Hospital name
MS	250127	CHOCTAW HEALTH CENTER
MS	250149	NEWTON REGIONAL HOSPITAL
MS	250151	ALLIANCE HEALTH CENTER
MS	250152	MISSISSIPPI METHODIST REHAB CTR
MO	260104	SSM DEPAUL HEALTH CENTER
NE	280119	P H S INDIAN HOSPITAL
NV	290002	SOUTH LYON MEDICAL CENTER
NV	290020	NYE REGIONAL MEDICAL CENTER
NV	290027	GROVER C DILS MEDICAL CENTER
NV	290042	HARMON MEDICAL AND REHABILITATION HOSPITAL
NM	320057	SANTA FE PHS INDIAN HOSPITAL
NY	330010	AMSTERDAM MEMORIAL HEALTH CARE SYSTEM
NY	330407	EDDY COHOES REHABILITATION CENTER
NY	330408	TRI-TOWN REGIONAL HEALTHCARE
NC	340104	CRAWLEY MEMORIAL HOSPITAL
NC	340138	CENTRAL REGIONAL HOSPITAL
NC	340168	WILMINGTON TREATMENT CENTER
OH	360046	MCCULLOUGH-HYDE MEMORIAL HOSPITAL
OH	360241	EDWIN SHAW REHAB, LLC
OH	360247	WOODS AT PARKSIDE,THE
OH	360258	BARIX CLINICS OF OHIO, LLC
OH	360349	ADVANCED SPECIALTY HOSPITAL OF TOLEDO
OK	370011	PARKVIEW HOSPITAL
OK	370214	LINDSAY MUNICIPAL HOSPITAL
OK	370220	ORTHOPEDIC HOSPITAL
PA	390104	KANE COMMUNITY HOSPITAL
PA	390302	BARIX CLINICS OF PENNSYLVANIA
SD	430060	HOLY INFANT HOSPITAL
SD	430081	PINE RIDGE IHS HOSPITAL
SD	430083	PHS INDIAN HOSPITAL AT EAGLE BUTTE
SD	430084	ROSEBUD IHS HOSPITAL
SD	430093	SAME DAY SURGERY CENTER LLC
SD	430096	LEWIS AND CLARK SPECIALTY HOSPITAL
TN	440007	UNITED REGIONAL MEDICAL CENTER
TN	440026	ROLLING HILLS NASHVILLE REHAB HOSPITAL
TN	440147	BAPTIST REHABILITATION GERMANTOWN
TN	440162	HEALTHSOUTH CHATTANOOGA REHAB HOSPITAL
TN	440181	BOLIVAR GENERAL HOSPITAL
TN	440218	THE CENTER FOR SPINAL SURGERY
TX	450044	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL - ST. PAUL
TX	450253	BELLVILLE GENERAL HOSPITAL

Hospital quality initiative (continued)

State	HSP ID	Hospital name
TX	450283	COZBY-GERMANY HOSPITAL
TX	450446	RIVERSIDE GENERAL HOSPITAL
TX	450460	TYLER COUNTY HOSPITAL
TX	450683	RENAISSANCE HOSPITAL TERRELL
TX	450749	EAST TEXAS MEDICAL CENTER TRINITY
TX	450766	U.T. SOUTHWESTERN UNIVERSITY HOSPITAL – ZALE LIPSHY
TX	450770	CENTRAL TEXAS HOSPITAL
TX	450796	NORTHWEST TEXAS SURGERY CENTER
TX	450813	COMMUNITY GENERAL HOSPITAL
TX	450831	SURGERY SPECIALTY HOSPITALS OF AMERICA
TX	450839	SHELBY REGIONAL MEDICAL CENTER
TX	450845	EL PASO SPECIALTY HOSPITAL
UT	460018	KANE COUNTY HOSPITAL
UT	460035	BEAVER VALLEY HOSPITAL
VA	490002	RUSSELL COUNTY MEDICAL CENTER
VA	490104	HIRAM W DAVIS MEDICAL CENTER
VA	490105	SOUTHWESTERN VIRGINIA MENTAL HEALTH INSTITUTE
VA	490108	CENTRAL VIRGINIA TRAINING CENTER
VA	490129	CAPITAL HOSPICE - HALQUIST MEMORIAL INPATIENT CENTER
VA	490134	PIEDMONT GERIATRIC HOSPITAL
VA	490135	CATAWBA HOSPITAL
WY	530017	SOUTH LINCOLN MEDICAL CENTER
TX	670007	BEAUMONT BONE & JOINT INSTITUTE
TX	670008	HOUSTON PHYSICIANS' HOSPITAL
TX	670010	DENTON REHABILITATION HOSPITAL L.P.
TX	670021	INNOVA HOSPITAL SAN ANTONIO
TX	670027	ACUITY HOSPITAL OF HOUSTON
TX	670029	FIRST STREET HOSPITAL LP
TX	670040	ATRIUM MEDICAL CENTER
TX	670045	COOK CHILDRENS NORTHEAST HOSPITAL, L.L.C.
TX	670050	TRUSTPOINT HOSPITAL

Wage-index changes

Attachment D

Wage-index values have changed for the following areas per the FY 2010 correction notice.

Note: These wage index values do not have the state specific blended rural floor budget neutrality factors applied. The state specific rural floor budget neutrality factors are published in Attachment A for this CR.

Area reclass				
Record	**CBSA**	**WIX**	**WIX**	**CBSA Name**
New	05	**1.1901**	**1.1901**	CALIFORNIA
Old	05	**1.1814**	**1.1814**	CALIFORNIA
New	10900	1.1521	**0.9829**	Allentown-Bethlehem-Easton, PA-NJ
Old	10900	1.1521	**0.9654**	Allentown-Bethlehem-Easton, PA-NJ
New	12540	**1.1901**	0	Bakersfield, CA
Old	12540	**1.1814**	0	Bakersfield, CA
New	15380	**0.9825**	**0.9825**	Buffalo-Niagara Falls, NY
Old	15380	**0.9816**	**0.9816**	Buffalo-Niagara Falls, NY
New	17020	**1.1901**	0	Chico, CA
Old	17020	**1.1814**	0	Chico, CA
New	19804	**0.9793**	**0**	Detroit-Livonia-Dearborn, MI
Old	19804	**0.9804**	**0.9804**	Detroit-Livonia-Dearborn, MI
New	20940	**1.1901**	0	El Centro, CA
Old	20940	**1.1814**	0	El Centro, CA
New	23420	**1.1901**	0	Fresno, CA
Old	23420	**1.1814**	0	Fresno, CA
New	23844	**0.9185**	**0.9185**	Gary, IN
Old	23844	**0.9213**	**0.9213**	Gary, IN
New	25260	**1.1901**	0	Hanford-Corcoran, CA
Old	25260	**1.1814**	0	Hanford-Corcoran, CA
New	31084	1.196	**1.1901**	Los Angeles-Long Beach-Santa Ana, CA
Old	31084	1.196	**1.1835**	Los Angeles-Long Beach-Santa Ana, CA
New	31460	**1.1901**	0	Madera-Chowchilla, CA
Old	31460	**1.1814**	0	Madera-Chowchilla, CA
New	33700	1.241	**1.2274**	Modesto, CA
Old	33700	1.241	**1.241**	Modesto, CA
New	40140	**1.1901**	1.1165	Riverside-San Bernardino-Ontario, CA
Old	40140	**1.1814**	1.1165	Riverside-San Bernardino-Ontario, CA

Wage-index changes continued)

Area reclass				
Record	**CBSA**	**WIX**	**WIX**	**CBSA Name**
New	1740	**1.1901**	0	San Diego-Carlsbad-San Marcos, CA
Old	41740	**1.1814**	0	San Diego-Carlsbad-San Marcos, CA
New	42044	**1.1901**	**1.1901**	Santa Ana-Anaheim-Irvine, CA
Old	42044	**1.1814**	**1.1814**	Santa Ana-Anaheim-Irvine, CA
New	47300	**1.1901**	0	Visalia-Porteville, CA
Old	47300	**1.1814**	0	Visalia-Porteville, CA
New	49700	**1.1901**	0	Yuba City, CA
Old	49700	**1.1814**	0	Yuba City, CA

Revised acute care hospital inpatient prospective payment system fact sheet

The revised *Acute Care Hospital Inpatient Prospective Payment System* fact sheet (September 2009), which provides general information about the acute care hospital inpatient prospective payment system (IPPS) including information about the basis for IPPS payment, IPPS payment rates, and how IPPS payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf*." ❖

Source: CMS PERL 200909-18

Timely claim filing guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. The time parameters are:

Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011

ESRD Services

CMS proposes new prospective payment system for renal dialysis facilities

Program would reward efficient, high quality care for people with end-stage renal disease

The Centers for Medicare & Medicaid Services (CMS) proposed a new prospective payment system (PPS) for facilities that provide dialysis services to Medicare beneficiaries who have end-stage renal disease (ESRD).

The proposed PPS would provide a single bundled payment to dialysis facilities that would cover the items and services used in providing outpatient such services, including the dialysis treatment, prescription drugs, and clinical laboratory tests.

The new payment system, which was required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), is designed to improve the efficiency of care, while promoting high quality services.
Today's notice proposes three quality measures that CMS plans to use for its quality incentive program (QIP) and lays out a conceptual model for public comment.

"Combining a fully bundled prospective payment system with required performance standards would encourage facilities to operate more efficiently and ensure that beneficiaries receive high quality care, while saving dollars for both beneficiaries and the Medicare program," said Jonathan Blum, director of the CMS Center for Medicare Management.

ESRD is the only category for Medicare eligibility that is based on a specific diagnosis, without regard to the age of the patient. Patients diagnosed with ESRD must rely on dialysis or receive a kidney transplant for survival. In 2007, there were about 591 hospital-based and 4,330 freestanding ESRD facilities furnishing outpatient dialysis services to nearly 330,000 Medicare patients. This total cost of this service was $9.2 billion including the dialysis service and other ESRD-related items such as drugs.

ESRD services are furnished on an outpatient basis in independent or hospital-based dialysis facilities.

Currently, Medicare pays for certain dialysis services under a partial bundled rate, referred to as the composite rate. Payments for these composite rate services represent about 60 percent of total Medicare payments to ESRD facilities. The remainder of Medicare spending for dialysis services is for separately billed items such as drugs, but may also include laboratory services, supplies and blood products.

Under the proposed rule, CMS would establish a base bundled payment rate of $198.64 for all of the services related to a dialysis session, including the services in the current composite rate as well as items, including oral drugs that are billed separately. The proposed base rate was derived from 2007 claims data for both composite rate and separately billable services and updated to reflect projected 2011 prices. It would also be adjusted for case-mix factors such as the patient's age, gender, body size, and time on dialysis. A special case-mix adjustment would apply to pediatric patients. Additional adjustments to the payment rate would be made for specific conditions, or co-morbidities that have a significant impact on a course of treatment. By accounting for more characteristics of patients, the new PPS would target payments more appropriately, paying higher rates to those facilities with the most costly patients.

The base rate would also be adjusted to reflect geographic differences in labor costs. In addition, CMS is proposing to provide an adjustment for low-volume facilities, as well as an outlier policy that would make an adjustment for particularly expensive cases.

CMS will accept comments on the proposed rule through November 16, 2009, and will respond to them in a final rule to be issued in 2010. The new payment system would apply to dialysis services furnished to Medicare beneficiaries on or after January 1, 2011.

For more information, please see http://www.cms.hhs.gov/ESRDPayment/. ❖

Source: CMS PERL 200909-21

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

SKILLED NURSING FACILITY SERVICES

Medicare Part A skilled nursing facility prospective payment system PRICER update fiscal year 2010

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Skilled nursing facilities (SNFs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services paid under the SNF prospective payment system (PPS).

Provider action needed

This article is a reminder that the SNF PPD rates are updated annually. The article is based on change request (CR) 6568 which provides information on the updates to the payment rates used under the PPS for SNFs for fiscal year (FY) 2010, as required by statute. **The SNF PPS rates will be effective for service dates beginning October 1, 2009, through September 30, 2010.** The rates will be published in the *Federal Register* on August 11, 2009 (74 FR 40288).

Background

Annual updates to the PPS rates are required by the Social Security Act (Section 1888(e); see on the Internet *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*), relating to Medicare payments and consolidated billing for SNFs as amended by the:

- Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA)
- Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA)
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA).

The statute mandates an update to the federal rates using the latest SNF full market basket The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS (acquired immune deficiency syndrome). This update includes new case-mix indexes using the recalculated case-mix adjustments based on actual data.

Additional information

The official instruction, CR 6568, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1807CP.pdf*.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6568
Related Change Request (CR) Number: 6568
Related CR Release Date: August 28, 2009
Related CR Transmittal Number: R1807CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1807, CR 6568

Skilled nursing facility prospective payment system fact sheet

The revised *Skilled Nursing Facility Prospective Payment System* fact sheet (August 2009), which outlines the elements of the skilled nursing facility prospective payment system, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200909-11

Enrollment Application Reminder

Providers submitting a Medicare enrollment application CMS-855A, CMS-855B or CMS-855I must submit the **nine-digit ZIP** code for each practice location listed on the form.

2010 annual update of HCPCS codes for skilled nursing facility consolidated billing

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

This article is based on change request (CR) 6619 which provides the 2010 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) that will be used in Medicare claims processing systems. Be sure billing staff are aware of these updates.

Background

Medicare claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. These edits only allow services that are excluded from SNF CB to be separately paid by Medicare contractors. The related policy is contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6) which is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf*.

Physicians and providers are advised that, by the first week in December 2009, new code files will be posted on the CMS Web site at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Institutional providers should note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS Web site in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Additional Information

You may find information related to SNFs and Medicare on the CMS Skilled Nursing Facility Center on the CMS Web site at *http://www.cms.hhs.gov/center/snf.asp*.

The official instruction, CR 6619, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1814CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6619
Related Change Request (CR) Number: 6619
Related CR Release Date: September 4, 2009
Related CR Transmittal Number: R1814CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1814, CR 6619

Keep Informed

Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2009 update of the hospital outpatient prospective payment system

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed stop – impact to you

This article is based on change request (CR) 6626 which describes changes to and billing instructions for various payment policies implemented in the October 2009 OPPS update.

CAUTION – what you need to know

The October 2009 integrated outpatient code editor (I/OCE) and OPPS PRCER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions for October. Those revisions to the I/OCE data files, instructions, and specifications are provided in CR 6618, "October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3." Once CR 6618 is published, a related *MLN Matters*® article will be available on the Centers for Medicare & Medicaid services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6618.pdf*.

GO – what you need to do

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

Key Points of change request 6626

Changes to Procedure and Device Edits for October 2009

Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device-to-procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits may be found under "Device, Radiolabeled Product, and Procedure Edits" on the Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

Billing for drugs, biologicals, and radiopharmaceuticals

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

For hospitals under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

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

- **Drugs and biologicals with payments based on average sales price effective October 1, 2009**
  For calendar year (CY) 2009, payment for nonpass-through drugs and biologicals is made at a single rate of average sale price (ASP) plus four percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP plus six percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program is suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during

October 2009 update to the hospital outpatient prospective payment system (continued)

CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.
In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2009 release of the OPPS PRICER. The updated payment rates, effective October 1, 2009 will be included in the October 2009 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp*.

- **New HCPCS code effective for certain drugs and biologicals**
A new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for October 2009. HCPCS code Q2024 is listed in Table 1 below and is effective for services furnished on or after October 1, 2009. This HCPCS code is assigned status indicator "K," to indicate separate payment may be made for the product.

Table 1 – New HCPCS code effective for certain drugs and biologicals effective October 1, 2009

HCPCS code	Long descriptor	APC	Status indicator effective October 1, 2009
Q2024	Injection, bevacizumab, 0.25 mg	1281	K

- **Adjustment to status indicator for HCPCS code Q4115 Effective October 1, 2009**
CMS assigned HCPCS code Q4115, Skin substitute, alloskin, per square centimeter, a status indicator of "M" for services billed on or after July 1, 2009, through September 30, 2009, indicating that the service is not billable to the FI/MAC. For services furnished on or after October 1, 2009, CMS is changing the status indicator for Q4115 to "K" to indicate that separate payment may be made for this product. HCPCS code Q4115 is assigned to ambulatory payment classification (APC) 1287 (alloskin skin sub).

- **Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008**
The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS PRICER. The corrected payment rates are listed in Table 2 below and have been installed in the October 2009 OPPS PRICER, effective for services furnished on April 1, 2008, through implementation of the July 2008 update. If you have claims for these HCPCS codes for dates of service of April 1, 2008, through June 30, 2008 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPPS PRICER is installed.

Table 2 – Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J1440	K	0728	Filgrastim 300 mcg injection	$197.37	$39.47
J1441	K	7049	Filgrastim 480 mcg injection	$303.75	$60.75
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,179.44	$435.89
J2788	K	9023	Rho d immune globulin 50 mcg	$26.06	$5.21
J2790	K	0884	Rho d immune globulin inj	$83.63	$16.73
J9050	K	0812	Carmus bischl nitro inj	$155.30	$31.06

- **Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008, through September 30, 2008**
The payment rates for several HCPCS codes were incorrect in the July 2008 OPPS PRICER. The corrected payment rates are listed in Table 3 below and have been installed in the October 2009 OPPS PRICER, effective for services furnished on July 1, 2008, through implementation of the October 2008 update. If you have claims for these HCPCS codes for dates of service of July 1, 2008, through September 30, 2008, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPPS PRICER is installed.

Table 3 – updated payment rates for certain HCPCS codes effective July 1, 2008, through September 30, 2008

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J1438	K	1608	Etanercept injection	$172.44	$34.49
J1440	K	0728	Filgrastim 300 mcg injection	$197.44	$39.49
J1626	K	0764	Granisetron HCl injection	$5.28	$1.06
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,154.48	$430.90

October 2009 update to the hospital outpatient prospective payment system (continued)

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J2788	K	9023	Rho d immune globulin 50 mcg	$26.70	$5.34
J2790	K	0884	Rho d immune globulin inj	$84.15	$16.83
J9208	K	0831	Ifosfomide injection	$34.10	$6.82
J9209	K	0732	Mesna injection	$7.86	$1.57
J9226	G	1142	Supprelin LA implant	$14,463.26	$2,865.36

- **Updated payment rates for certain HCPCS codes effective October 1, 2008, through December 31, 2008**
The payment rates for several HCPCS codes were incorrect in the October 2008 OPPS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the October 2009 OPPS PRICER, effective for services furnished on October 1, 2008, through implementation of the January 2009 update. If you have claims for these HCPCS codes for dates of service of October 1, 2008, through December 31, 2008, (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPPS PRICER is installed.

  Table 4 – updated payment rates for certain HCPCS codes effective October 1, 2008, through December 31, 2008

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J1441	K	7049	Filgrastim 480 mcg injection	$304.32	$60.86
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,175.85	$435.17
J9209	K	0732	Mesna injection	$6.99	$1.40
J9226	G	1142	Supprelin LA implant	$14,413.33	$2,855.47
J9303	G	9235	Panitumumab injection	$81.86	$16.22

- **Updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009**
The payment rates for several HCPCS codes were incorrect in the July 2009 OPPS PRICER. The corrected payment rates are listed in Table 5 below and have been installed in the October 2009 OPPS PRICER, effective for services furnished on July 1, 2009, through implementation of the October 2009 update. If you have claims for these HCPCS codes for dates of service of July 1, 2009, through September 30, 2009 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPPS PRICER is installed.

  Table 5 – updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
90585	K	9137	Bcg vaccine, precut	$115.47	$23.09
C9359	G	9359	Implnt,bon void filler-putty	$65.21	$12.80
J9031	K	0809	Bcg live intravesical vac	$114.73	$22.95
J9211	K	0832	Idarubicin hcl injection	$126.12	$25.22
J9265	K	0863	Paclitaxel injection	$7.62	$1.52
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$66.26	$13.25
Q0179	K	0769	Ondansetron hcl 8 mg oral	$7.91	$1.58

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

October 2009 update to the hospital outpatient prospective payment system (continued)

- **Correct reporting of drugs and biologicals when used as implantable devices**
  When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.
  When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS code, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.
- **Correct reporting of units for drugs**
  Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS code descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be "1". As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be "4." Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS code descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only **one** vial was administered. The HCPCS code short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.
- **Correct reporting of diagnostic radiopharmaceuticals and their associated nuclear medicine procedures furnished in separate calendar years**
  There are certain rare instances when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year. As Medicare billing does not allow multiple calendar year services to be reported on a single claim, some hospitals have had difficulty reporting the radiolabeled product on the same claim as the nuclear medicine procedure when these associated services are not provided to the beneficiary in the same calendar year. Because of the nuclear medicine procedure-to-radiolabeled product claims processing edits included in the I/OCE, payment for a nuclear medicine procedure requires reporting of an appropriate radiolabeled product on the same claim. In this limited circumstance, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare, and CMS expects that the majority of hospitals will not encounter this situation.
- **H1N1 vaccine and administration level II HCPCS codes**
  In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, CMS is creating two new level II HCPCS codes that are effective October 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)). More information on the H1N1 flu and the associated vaccine may be found at the Centers for Disease Control and Prevention Web site on the Internet at *http://www.cdc.gov/h1n1flu/*.

  Under the OPPS, HCPCS code G9142 will be assigned status indicator "E," indicating that payment will not be made by Medicare when this code is submitted on an outpatient bill type because CMS anticipates that the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPS and non OPPS providers), and CMS is assigning HCPCS code G9141 to APC 0350 (Administration of flu and PPV vaccine) with a payment rate of $24.89 for CY 2009. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

October 2009 update to the hospital outpatient prospective payment system (continued)

The effective date of G9141 and G9142 is September 1, 2009. This effective date is earlier than originally anticipated, and therefore, the effective date reflected in the October IOCE will be October 1, 2009. For the January IOCE release, CMS will change the effective date for these HCPCS to be retroactive to September 1, 2009. Claims containing G9141 and G9142 with dates of service on or after September 1, 2009, but prior to October 1, 2009, will be held until the successful installation of the January IOCE release.

Updating wage indices for hospitals receiving Medicare Modernization Act (MMA) Section 508 reclassification

Table 6 of CR 6626 contains the October 1, 2009, to December 31, 2009 Wage Indexes for Section 508 hospitals that receive payment under the OPPS. This article will not repeat Table 6, but Section 508 hospitals may view the table in CR 6626 by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1803CP.pdf*.

Clarification related to condition code 44

CR 6626 also makes changes to the *Medicare Claims Processing Manual*, Chapter 1, Section 50.3, incorporate minor revisions clarifying the use of condition code 44. The revised section of the manual is attached to CR 6626.

Coverage determinations

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

Additional iformation

The official instruction, CR 6626, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1803CP.pdf*.

If you have any questions, please contact your FI, A/B MAC, or RHHI, at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6626
Related Change Request (CR) Number: 6626
Related CR Release Date: August 28, 2008
Related CR Transmittal Number: R1803CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1803, CR 6626

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

October 2009 integrated outpatient code editor specifications version 10.3

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare administrative contractors (MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for outpatient services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6618, which notifies providers that the I/OCE specifications Version 10.3 is effective October 1, 2009. Be sure billing staffs are aware of these changes.

Background

CR 6618 describes changes to billing instructions for various payment policies implemented in the October 2009 OPPS update. The October 2009 integrated outpatient code editor (I/OCE) changes are also discussed in CR 6618. Attached to CR 6618 are lengthy specifications for the I/OCE. A summary of the changes for October 2009 is within Appendix M of Attachment A of CR 6618 and that summary is captured in the following key points.

Key points of change request 6618

1. The program will assign payment adjustment flag #4 (deductible not applicable) to all lines on any OPPS claim where condition code "MA" is present on the claim. This modification is effective January 1, 2003.
2. Modifier 77 will be added to the list of modifiers that will bypass edit 17 – Inappropriate specification of bilateral procedure. This modification is effective January 1, 2003.
3. If HCPCS code G0379 has been denied or rejected it will not be included in any subsequent special direct admission logic. The default SI (Q3) will be retained as the final SI. An exception is if line item adjustment flag (LIAF) = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent direct admission logic and that logic will determine the final SI). This modification is effective January 1, 2008.
4. STVX/T-packaged codes (Q1, Q2) that are denied or rejected will not be included in any subsequent special packaging logic. The default SI (Q1, Q2) will be retained as the final SI. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored, the line will be included in subsequent special packaging logic and that logic will determine the final SI). This modification is effective January 1, 2008.
5. For codes with SI (status indicator) of S, T, V or X that have been denied or rejected, those codes will be ignored in subsequent special S, T, V, X/T logic for packaging Q1 or Q2 codes. An exception is if LIAF = 1 has been assigned to the line, the denial/rejection will be ignored and the line will be included in subsequent logic for packaging the Q1 or Q2 codes. This modification is effective October 1, 2009.
6. For multiple imaging composite processing, any independently bilateral composite candidate with modifier 50 will count as two units in applying the composite criteria. If any composite ambulatory payment classification (APC) is assigned on an independent or conditional bilateral line with modifier 50 the modifier will be ignored in assigning the discount formula. This modification is effective January 1, 2009.
7. Any T-packaged (Q/Q2) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification is effective January 1, 2008.
8. Any STVX-packaged (Q/Q1) independent or conditional bilateral code with modifier 50 that is paid separately will have the modifier ignored in assigning the discount formula. This modification is effective January 1, 2007.
9. Medicare has made numerous changes to diagnosis codes, APCs, HCPCS/CPT codes and modifiers. Those changes may be found in Attachment to CR6618 that is titled "Preliminary Summary of Data Changes Integrated OCE v 10.3 Effective October 1, 2009."
10. Version 15.2 of the national correct coding initiatives will be implemented effective with the October 2009 version of the I/OCE.

Additional Information

The official instruction (CR 6618) issued to your Medicare MAC and/or FI is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1809CP.pdf*.

CMS also has a Web-based training module on the OCE. The module is available on the Internet at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*.

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6618
Related Change Request (CR) Number: 6618
Related CR Release Date: August 28, 2009
Related CR Transmittal Number: R1809CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1809, CR 6618

ELECTRONIC DATA INTERCHANGE

Claim status category code and claim status code update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, A/B Medicare administrative contractors [MAC] and durable medical equipment MACs [DME MACs]) for Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 6609, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 were updated during the June 2009 meeting of the National Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on the Internet on or about June 30, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction, CR 6609, issued to your Medicare contractor regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1797CP.pdf*.

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

MLN Matters® Number: MM6609
Related Change Request (CR) Number: 6609
Related CR Release Date: August 14, 2009
Related CR Transmittal Number: R1797CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1797, CR 6609

Enhancements and updates to the national plan and provider enumeration system

On September 13, 2009, the national plan and provider enumeration system (NPPES) underwent system maintenance. As such, neither NPPES nor the national provider identifier (NPI) registry was available on September 13, 2009.

Upon successful login, the following security enhancements have been incorporated into NPPES:

- NPPES Web users will be prompted to select five secret questions and provide answers to those questions. These five secret questions and answers will be saved and used for verification in order to allow NPPES Web users to reset their own passwords.
- NPPES Web users will be required to wait 24 hours before attempting to change their passwords once they have already successfully reset their passwords.

Electronic file interchange

In addition, the electronic file interchange (EFI) user manual and technical companion guide have been revised. The upcoming changes will not impact the EFI XML schema.

Additional information

Health care providers can apply for an NPI online at *https://nppes.cms.hhs.gov*. Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI enumerator at 1-800-465-3203 or e-mail the request to the NPI enumerator at *CustomerService@NPIEnumerator.com*.

Not sure if you have already obtained an NPI or cannot remember your NPI, you can visit the NPI registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do* to search for the information. The NPI registry enables you to search for a provider's NPPES information, which includes the NPI. All information displayed in the NPI registry is done so in accordance with the NPPES data dissemination notice. Information in the NPI registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or legal name/legal business name. There is no charge to use the NPI registry.

For additional NPI education and information, visit the Centers for Medicare & Medicaid Services' dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand*. ❖

Source: CMS PERL 200909-16

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
October – November 2009

Topic – Discover your gateway to Medicare

When: Wednesday, October 21, 2009

Time: 3:00 p.m. – 4:00 p.m. ET **Delivery language:** Spanish

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Get on the right track tour

When: Monday, November 2, 2009 – San Juan, Puerto Rico
Tuesday, November 3, 2009 – Ponce, Puerto Rico
Wednesday, November 4, 2009 – San German, Puerto Rico

Time: 3:00 p.m. – 4:00 p.m. ET **Delivery language:** Spanish

Type of Event: In-person seminar **Focus:** Puerto Rico

Topic – Recovery audit contractor (RAC)

When: Wednesday, November 4, 2009

Time: 11:30 p.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

To search and register for events on *www.fcsomedicaretraining.com* click on the following links:

- "Course Catalog" from the top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "FL – Part A or FL – Part B" from list in the middle of the page.

Select **Register** in the Options column located next to the specific course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail to *fcsohelp@geolearning.com*.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

Keep checking our Web site, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers. ❖

Discover your gateway to Medicare

Wednesday, October 21
3:00 p.m.-4:00 p.m.
Delivery language: Spanish

Do you know where to find the resources you need to help ensure your success as a Medicare provider? Don't worry. You won't have far to go. They're only one click away – on the FCSO Medicare provider Web sites. Whether you're an experienced Medicare provider or a health care professional considering participation in the program for the first time, First Coast Service Options (FCSO) has the knowledge and resources to assist you every step of the way.

During this informative webcast, we'll explore the vast array of online resources by taking participants on a virtual tour of medicareespanol.fcso.com. During your "journey," we'll not only show you helpful insider tips but also how you can use them to save your valuable time.

In this webcast, you'll learn:

- How taking three easy steps can help you view only the information that pertains to your geographic area and line of business
- How to take advantage of navigational shortcuts that offer quick access to the areas of the site you use the most
- How to find exclusive online tools that will help you bill Medicare correctly the first time
- How to find out about the latest changes to the Medicare program – first
- How to find answers to the Medicare questions most frequently asked by other providers
- How to target information searches to publications, FAQs, or the Centers for Medicare & Medicaid Services (CMS) Web site

We'll also provide a brief overview of recent enhancements to the FCSO Medicare provider Web sites including the new medical coverage page, additions to the FAQ reference library, and the redesigned publications page.

To participate in this webcast, please register by October 20.

Note: An open question-and-answer period will follow the presentation.

Join us for this informative webcast and learn how to find the Medicare resources you need . . . when you need them. Register today. ❖

PREVENTIVE SERVICES

September is Prostate Cancer Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered prostate cancer screenings. Medicare provides annual coverage for digital rectal exams (DREs) and prostate specific antigen tests (PSAs) for qualified beneficiaries.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients by educating them about their risk factors and reminding them of the importance of getting screenings that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered prostate cancer screenings:

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including prostate cancer screening.

  http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products, including Medicare-covered prostate cancer screenings, and resources for health care professionals and their staff.

  http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

- *Quick Reference Information: Medicare Preventive Services* – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including prostate cancer screenings.

  http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

September is Prostate Cancer Awareness Month (continued)

- *Cancer Screenings brochure* – this brochure provides information on coverage for Medicare-covered cancer screenings, including screenings for prostate cancer.

  http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of taking advantage of cancer screenings and other preventive services covered by Medicare.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200909-06

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

Order form for Medicare Part A materials

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to FCSO Account # (use appropriate account number)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
	Total	**$**

Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

PART A REDETERMINATION
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

MSPRC DPP Debt Recovery
Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING
Direct Data Entry (DDE) Startup
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

POST-PAY MEDICAL REVIEW
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

PROVIDER ENROLLMENT
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT
American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

SPECIAL DELIVERY
Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-888-664-4112

Interactive voice response (IVR)
1-888-664-4112

Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

PROVIDER EDUCATION & OUTREACH
Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-9043610359

Medicare Web sites

PROVIDERS
Florida Medicare Contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

REDETERMINATION and REDETERMINATION OVERPAYMENTS
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

MSPRC DPP Debt Recovery
Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING
Direct Data Entry (DDE) Startup
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

POST-PAY MEDICAL REVIEW
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

PROVIDER ENROLLMENT
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT
American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

SPECIAL DELIVERY
Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-888-664-4112

Interactive voice response (IVR)
1-888-664-4112

Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
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1-800-MEDICARE
1-800-633-4227
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1-800-754-7820

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

First Coast Service Options, Inc ♦ P.O. Box 2078 ♦ Jacksonville, FL 32231-0048

♦ ATTENTION BILLING MANAGER ♦