Medicare A Bulletin

A Newsletter for Florida Medicare Part A Providers

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**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 website at *www.floridamedicare.com.***

**Routing Suggestions:**

- ☐ Medicare Manager
- ☐ Reimbursement Director
- ☐ Chief Financial Officer
- ☐ Compliance Officer
- ☐ DRG Coordinator
- ☐ _____
- ☐ _____
- ☐ _____

CMS Centers for Medicare & Medicaid Services

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*Medicare A Bulletin*

**Vol. 8, No. 5**
**August 2006**

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The *Medicare A Bulletin* is published monthly by Medicare Communication and Education, to provide timely and useful information to Medicare Part A providers in Florida.

Questions concerning this publication or its contents may be directed in writing to:

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**P.O. Box 45270**
**Jacksonville, FL**
**32232-5270**

## About *The Medicare A Bulletin*

The Medicare A Bulletin is a comprehensive magazine published by First Coast Service Options, Inc. (FCSO) for Medicare Part A providers in Florida in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Medicare Communication and Education Provider Publications team will begin distributing the *Medicare A Bulletin* on a monthly basis. We are making this change to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications have become too large in scope and size making it difficult to navigate through the large volume of information.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website *http://www.floridamedicare.com*.

In some cases, additional unscheduled special issues may also be posted and or published.

### Who Receives the *Bulletin*?

Anyone may view, print or dowload the *Bulletin* from our provider education website. Providers who cannot obtain the *Bulletin* from the Internet are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form on page 90).

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 Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

### What Is in the *Bulletin*?

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

- The publication starts with a column by the Intermediary Medical Director.
- Following an administrative section are usually general information and coverage sections with informational and billing issues, processing guidelines, and medical coverage applicable to all Medicare Part A providers and facilities.
- 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.)
- As needed, the *Bulletin* contains Electronic Data Interchange and Fraud and Abuse sections.
- The Local Coverage Determination (LCD) section contains notification of revisions to finalized medical policies 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. Whenever possible, the LCD section will be placed in the center of the *Bulletin* to allow readers to remove it separately, without disturbing the rest of the publication.
- The Educational Resources section includes educational material, such as seminar schedules, Medicare provider education website 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 who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

### Do You Have Comments?

The publications staff welcomes your feedback on the *Bulletin* and appreciates your continued support. Please mail comments to:

Editor, *Medicare A Bulletin* – 10T
Medicare Communication & Education
P.O. Box 45270
Jacksonville, FL 32232-5270

### Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

# GENERAL INFORMATION

## Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers [[DMERCs], and fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs])

### Provider Action Needed

### STOP – Impact to You

Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

### CAUTION – What You Need to Know

An ICD-9-CM code is required for all professional claims, e.g., physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is **not required** for ambulance supplier claims.

### GO – What You Need to Do

Be ready to use the updated codes on October 1, 2006. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

### Background

This instruction is a reminder that Medicare carriers, DMERCs, FIs, and RHHIs will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2006
- Discharges on or after October 1, 2006 for institutional providers

Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094, dated February 6, 2004 on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3094.pdf*).

### Implementation

The implementation date for this instruction is October 2, 2006.

### Additional Information

**Publication of ICD-9-CM Codes**

- The Centers for Medicare & Medicaid Services (CMS) places the new, revised, and discontinued codes on the CMS website at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*.

  The update should be available at this site in June.

- The updated codes can also be viewed at the National Center for Health Statistics (NCHS) website at: *http://www.cdc.gov/nchs/icd9.htm*.

  This posting should be available at this site in June.

- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). Chapter 23 may be accessed on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

To view CR 5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR 5142 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5142
Related Change Request (CR) Number: 5142
Related CR Release Date: June 23, 2006
Related CR Transmittal Number: R990CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 990, CR 5142

# July 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Other Revisions

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

## Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B fee-for-service claims to Medicare contractors (fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs], and carriers including durable medical equipment regional carriers [DMERCs]) for services.

## Provider Action Needed

## STOP – Impact to You

CR 5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 quarterly average sales price (ASP) Medicare Part B drug pricing files.

## CAUTION – What You Need to Know

Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and not otherwise classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR 5110.

## GO – What You Need to Do

Make certain that your billing staffs are aware of this change.

## Background

According to section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf*), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the ASP.

The local Medicare contractor performs pricing for compounded drugs.

### ESRD Drugs

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP.

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on **106 percent** of the ASP. CMS will update the payment allowance limits quarterly.

### Exceptions

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf*.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP, unless the drug is compounded.

### Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient's illness or injury.
- There is a medical reason that the medication cannot be taken orally.
- The skills of the nurse are needed to infuse the medication effectively.

### How the ASP Is Calculated

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.
- The July 2006 payment allowance limits apply to dates of service July 1, 2006, through September 30, 2006.

*July 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Other Revisions (continued)*

**Note:** The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

### Implementation

The implementation date for the instruction is July 3, 2006.

### Additional Information

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf*.

Quarterly Part B drug pricing files and information are also available on the CMS website at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice*.

CR 5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR 5110 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5110
Related Change Request (CR) Number: 5110
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R974CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 974, CR 5110



## MCS Announces Proposed Changes To Physician Fee Schedule Methodology

### Substantial Increases in Payments for Time Spent With Patients

The Centers for Medicare & Medicaid Services (CMS) issued a notice proposing changes to the Medicare physician fee schedule (MPFS) that will improve the accuracy of payments to physicians for the services they furnish to Medicare beneficiaries. The proposed notice includes substantial increases for "evaluation and management" services, that is, time and effort that physicians spend with patients in evaluating their condition, and advising and assisting them in managing their health. The changes reflect the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association.

The proposed notice will appear in the June 29 *Federal Register*. Comments will be accepted until August 21, 2006. CMS responses to public comments on the proposals in this notice will be combined with those for the upcoming MPFS notice of proposed rulemaking in a final MPFS rule scheduled for publication this fall. If adopted, the RVU revisions in this proposed notice would be fully implemented for services to Medicare beneficiaries on or after January 1, 2007, while the practice expense revisions would be phased in over a four-year period.

To view the entire press release, go to *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1887*.

To view the display copy of the proposed notice (CMS-1512-PN), go to *http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1183724*.

To view more MPFS information, go to the CMS website at *http://www.cms.hhs.gov/PhysicianFeeSched/*. ❖

Source: CMS Provider Education Resource 200606-11

### Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

# New Current Procedural Terminology Code

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

## Provider Types Affected

All Medicare providers

## Provider Action Needed

## STOP – Impact to You

Effective July 1, 2005, Medicare carriers and intermediaries must use the new *Current Procedural Terminology (CPT)* code *90714* (*Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use*) for services previously billed under *CPT* code *90718*.

## CAUTION – What You Need to Know

Effective for services on or after July 1, 2005, if you do not use the new *Current Procedural Terminology (CPT)* code *90714*, reimbursements may be impacted. CR 4222 provides notification of this new *CPT* code for tetanus and diphtheria toxoids (see information below).

## GO – What You Need to Do

Make sure that your billing staffs are aware of this new CPT code.

## Background

Effective July 1, 2005, the following vaccine *CPT* code is being added to the *CPT* system.

*CPT* code *90714*
Short Descriptor Td vaccine no prsrv >/= 7 im
Long Descriptor *Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individual 7 years or older, for intramuscular use*

**Note:** Your carriers and fiscal intermediaries will assign the CPT code 90714 to status indicator "E" in the Medicare physician fee schedule database. Deductible and coinsurance apply.

Effective July 1, 2005, the following vaccine are used:

- *CPT* code *90718 – Tetanus and diphtheria toxoids (Td) absorbed for use in an individual seven years or older, for intramuscular use*.
- *CPT 90714 – Tetanus and diphtheria toxoids (T[d]) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use.*

## Additional Information

Medicare will not search its files to retract payment for claims already paid or to retroactively pay claims. However, carriers/intermediaries will adjust claims brought to their attention.

The official instruction issued to your carrier/intermediary is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R910CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM4222
Related Change Request (CR) Number: 4222
Related CR Release Date: April 21, 2006
Related CR Transmittal Number: R910CP
Effective Date: July 1, 2005
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 910, CR 4222



# Deficit Reduction Act of 2005–Nine-Day Payment Hold

This message is a reminder for all providers and physicians who bill Medicare contractors for their services. A brief hold will be placed on Medicare payments for all claims during the last nine days of the 2006 federal fiscal year (September 22 through September 30, 2006).

These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments.

**All claims held during this time will be paid on October 2, 2006.**

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other nonclaim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this nine-day hold.

For more information, please view the MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf*. ❖

Source: CMS Provider Education Resource 200607-01
CMS Joint Signature Memorandum 06549, July 12, 2006

# Issue with Correct Coding Initiative Code Pair *92526*/G0283

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

## Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for electrical stimulation services using Healthcare Common Procedure Coding System (HCPCS) G0283 when billed with *Current Procedural Terminology (CPT) 92526* for the treatment of swallowing dysfunction and/or oral function for feeding

## Background

The Centers for Medicare & Medicaid Services (CMS) announces an erroneous indicator in the outpatient prospective payment system (OPPS) outpatient code editor (OCE) **for one Correct Coding Initiative (CCI) code pair edit** that resulted in a line item rejection of HCPCS G0283 when billed with *CPT 92526*. The edit for code pair *92526*/G0283 was incorrectly coded with an indicator of "0" – instead of a "1" – since the implementation of the CCI code pair on January 1, 2005, for OPPS hospitals.

## Key Points

This special edition article outlines the method that is in place to remedy the error as follows:

- The modifier indicator for the *92526*/G0283 code pair will be corrected and changed to a "1" with the OPPS OCE July 2006 release.
- On July 3, 2006, the "1" indicator will permit the use of modifier 59 with G0283 for reporting of this service with *CPT 92526* when performed by different therapy disciplines in outpatient providers of Part B therapy services.
- In addition to the OPPS hospitals (billing with type of bills (TOB) 12x and 13x), this edit was effective on January 1, 2006, for the following providers:
  - Skilled nursing facilities (TOBs 22x and 23x)
  - Comprehensive outpatient rehabilitation facilities (TOB 75x)
  - Outpatient physical therapy and speech language pathology service providers (TOB 74x)
  - Home health agencies (TOB 34x)

**Note:** After the implementation of the July 2006 OPPS OCE, FIs and RHHIs shall begin to reprocess claims where payment for HCPCS G0283 was rejected based on the "0" indicator. Until the OPPS OCE is updated in July 2006, providers should continue to bill this code pair as the CCI indicates—without a modifier—and should NOT hold claims.

## Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: SE0636
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 SE0636



# CMS Electronic Mailing List Fact Sheet and Listservs

The Division of Provider Information Planning and Development (DPIPD) within the Centers for Medicare & Medicaid Services (CMS) has developed a mailing list fact sheet informing providers about the advantage of receiving Medicare updates through the listservs. The mailing list fact sheet may be downloaded from the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf*.

CMS mailing list fact sheet may be used as handouts at medical and professional association meetings, conference, etc. Hardcopies may be ordered by going to the MLN products ordering page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* and then click on the first item under "Informational Resources".

CMS electronic mailing lists (listservs) can help you and your business to get Medicare news as it happens. To subscribe to any provider-specific CMS electronic mailing list, access the following URL on the CMS website: *http://www.cms.hhs.gov/apps/mailinglists/*. ❖

Source: CMS Joint Signature Memorandum 06504, June 22, 2006

# Instructions for Medicare Credit Balance Reporting Activities

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

## Provider Types Affected

All providers who bill fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) and who are required to submit a quarterly Medicare credit balance report (CMS-838)

## Background

This article and CR 5084 replaces CR 2810 and existing FI/RHHI and provider instructions related to provider reporting of Medicare credit balances. The instructions include revised and new material for non-Medicare Secondary Payer (Non-MSP) and the Medicare Secondary Payer (MSP) Medicare credit balance reporting process. Also, CR 5084 manualizes the provider credit balance reporting instructions in the *Medicare Financial Management Manual.*

Providers use the quarterly CMS-838 report to disclose Medicare credit balances. They determine the number and amount of these balances for refunds due to the Medicare program. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit."

However, Medicare credit balances include money due to the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period, such as 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies from these credit balance accounts to the Medicare program.

## Key Points for Providers

The following instructions provide guidance for providers when completing CMS-838:

**Submit Completed CMS-838 Within 30 Days of Each Quarter**

Providers must submit a completed CMS-838 to your FI/RHHI within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

The current version of the Medicare credit balance report (Form CMS-838 certification page and detail page) and instructions for its completion are available on the CMS website at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage*.

**Report all Medicare Credit Balances**

Providers report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program.

Providers need an officer or the administrator of their facility to sign and date the certification page. If no Medicare credit balances are shown in your records for the reporting quarter, the officer or administrator should sign the form and submit it to attest to this fact.

**Detail Page**

Providers should use the detail page that requires specific information on each credit balance on a claim-by-claim basis. The detail page provides space to address 17 claims. You may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you report. Submit the detail page(s) on diskette/CD, which is available from your intermediary. Submit the certification page in hard copy.

**Part A Versus Part B Credit Balances**

Providers should segregate the Part A credit balances from Part B credit balances by reporting them on separate detail pages. Part B pertains only to services you provide which are billed to your intermediary. It does not pertain to physician and supplier services billed to Medicare carriers. Providers should place an "A" if the report page(s) reflects Medicare Part A credit balances or a "B" if it reflects Part B credit balances.

**Other Instructions**

Providers should complete the CMS-838 detail form, providing the information required in the heading area of the detail page(s).

Providers must show the full name of the facility and provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine, and rehabilitation), complete a separate Medicare credit balance report for each provider number, including the month, day, and year of the reporting quarter, e.g., 12/31/02.

Providers should write the number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., page 1 of 3); and the name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Providers should complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim).

Providers complete columns 1-15. Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report. Providers must pay all amounts owed Medicare as shown in column 9 of the credit balance report at the time you submit the CMS-838. Make payment by check or by submission of adjustment bills. Submit adjustment bills in hard copy or electronic format.

Providers should include a separate adjustment bill, electronic or hard copy if payments are made by a check for all individual credit balances. The FI will ensure that the monies are not collected twice.

Providers should not submit credit balance information on the CMS-838 detail page as a substitute for adjustment bills. This will not be accepted by the FI as a substitute for adjustment bills.

Providers should send in claim adjustments, whether as payment or in connection with a check, by submitting them as adjustment bills (electronic or hard copy).

If the claim adjustment was submitted electronically,

*Instructions for Medicare Credit Balance Reporting Activities (continued)*

this should be shown on the CMS-838 (see instruction for column 11).

**MSP Rules**

Providers should follow the MSP rules for MSP credit balances. There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that "if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare…" the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due.

If you are not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, you must furnish the date the credit balance was received. Otherwise, the FI will assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.

**Extended Repayment Schedule**

Providers may request an extended repayment schedule, if the amount owed Medicare is so large that immediate repayment would cause financial hardship.

**Documentation Procedures**

Providers should develop and maintain documentation that shows that each patient record with a credit balance (transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed for preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether or not the patient is an eligible Medicare beneficiary.
- Identify other liable insurers and the primary payer.
- Adhere to applicable Medicare payment rules.
- Ensure that the credit balance is due and refundable to Medicare.

FIs will impose a suspension of Medicare payments and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

**Submission of CMS-838**

Provider-based HHAs submit their CMS-838 to their regional home health intermediary even though it may be different from the FI servicing the parent facility.

Providers with extremely low Medicare utilization are not required to submit a CMS-838. A *low utilization provider* is defined as a facility that files a low utilization Medicare cost report as specified in the *Provider Reimbursement Manual (*PRM-1), section 2414.4.B, or files less than 25 Medicare claims per year. The PRM-1 manual is available on the CMS website at *http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage*.

**Repayment of Credit Balances Resulting from MSP Payments**

Providers must repay credit balances resulting from MSP payments within the 60-day period. Federal regulations at 42 CFR 489.20(h) require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of a CMS-838 and adherence to CMS' instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Providers must report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it in the CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in your records.

Providers are required to report a MSP credit balance, if an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.

## Implementation

The implementation date for this instruction is October 2, 2006**.**

## Additional Information

The official instructions issued to your Medicare FI or RHHI regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R99FM.pdf*.

The *Medicare Financial Management Manual*, Chapter 12, Instructions for Medicare Credit Balance Report Activities, is attached to CR 5084.

The current version of the Medicare credit balance report (certification page and detail page) and instructions for its completion are available on the CMS website at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5084
Related Change Request (CR) Number: 5084
Related CR Release Date: June 30, 2006
Related CR Transmittal Number: R99FM
Effective Date: October 2, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-06, Transmittal 99, CR 5084

# Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information

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

## Provider Types Affected

Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet

## Background

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

## Key Points of CR5138

Change request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

**EDI Enrollment**

The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI enrollment form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA privacy rule mandates the protection and privacy of all health information.

**Authenticating Data Elements for HIPAA 270/271 Eligibility Data**

Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card)
- Beneficiary first name or first initial (must match the information on the Medicare card)
- Assigned Medicare Claim Number (also referred to as the Health Insurance
- Claim Number (HICN) including both alpha and numerical characters
- Date of birth.

**Medicare Beneficiary as First Source of Health Insurance Eligibility Information**

The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare claim number as reflected on the Medicare health insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare health insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare health insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare health insurance card from RRB.

**Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information**

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare.
- Determine beneficiary payment responsibility with regard to deductible/coinsurance.
- Determine eligibility for services such as preventive services.
- Determine if Medicare is the primary or secondary payer.
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage).
- Determine proper billing.

**Note:** Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

***Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information (continued)***

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individually identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

**Note:** Medicare health benefit beneficiary eligibility inquiries are monitored.

Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquires to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

**Criminal Penalties' Provisions**

Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

**1. Trading Partner Agreement Violation**

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part … (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person."

Offenders shall "(1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than $250,000, imprisoned not more than 10 years, or both."

**2. False Claim Act**

Under the False Claims Act, **31 U.S.C. sections 3729-3733**, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

**3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HHS may impose civil money penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year…A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

## Implementation

The implementation date for this instruction is July 24, 2006.

## Additional Information

CR 5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf*.

The revised section Chapter 31 – ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual is attached to CR 5138.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5138
Related Change Request (CR) Number: 5138
Related CR Release Date: June 23, 2006
Effective Date: July 24, 2006
Related CR Transmittal Number: R991CP
Implementation Date: July 24, 2006

Source: CMS Pub. 100-04, Transmittal 991, CR 5138

## Hold on Medicare Payments for End of Fiscal Year 2006

Section 5203 of the Deficit Reduction Act of 2006 mandates a one-time hold on Medicare payments for the **last nine days** of the federal fiscal year 2006 (September 22, 2006 through September 30, 2006).

The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to place a brief hold on Medicare claims subject to payment during the period of September 22, 2006 through September 30, 2006.

As stipulated within the law, claims held as a result of this one-time policy will be released for payment on the first business day of October, **which will be October 2, 2006.**

CMS regulations for the 14-day electronic claim payment floor and 29-day paper claim payment floor will continue to apply. All payments will be dated and issued on October 2, 2006.

As stated in the law, **no interest** or late penalty will be paid for these claims subject to this one-time policy.

The one-time hold policy on Medicare payments does **not** apply to:

- Full denial claims
- No-pay claims
- Periodic interim payments (PIPs)
- Home health requests for anticipated payments
- Cost report settlements
- Other nonclaim payments

Claims subject to the end of fiscal year 2006 payment hold will be placed under location P/B9996 until October 2, 2006, that they will be released to location P/B9997.

The issuance of electronic remittance advices, standard paper remittance and Medicare summary notices related to this nine-day payment hold will be retained and released on October 2, 2006. ❖

Source: CMS Pub. 100-04, Transmittal 944, CR 5047

## First Contract for a Part A/Part B Medicare Administrative Contractor To Be Awarded in Near Future—First A/B MAC News

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

### Provider Types Affected

All Medicare physicians, providers, and practitioners that bill Medicare fiscal intermediaries (FIs) or carriers for their services, especially those in the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

### Background

Section 911 of the Medicare Modernization Act (MMA) requires the Secretary to implement Medicare contracting reform by 2011. The law mandates that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by fiscal intermediaries and carriers in administering the Medicare fee-for-service program.

Medicare contracting reform will:

- Improve administrative services within the fee-for-service claims processing environment by reducing the number of contracts, focusing on correct claims payment and creating performance incentives related to timeliness, accuracy, and quality of services to CMS and to providers of services to Medicare beneficiaries.
- Lead to more efficiency and greater accountability among companies performing claims administration and provider education, and services by promoting competition and basing awards on good performance.
- Generate operational savings to the federal government and taxpayers through consolidation and competition of large and high value contracts.

With Medicare contracting reform, providers of health care in the original Medicare program can expect:

- Better educational and training resources on correct claims submission, Medicare coverage rules, and Medicare payment rules
- Easier communications with a single A/B MAC serving as the point-of-contact for both Part A and Part B claims administration and payment.
- Increased payment accuracy and consistency in payment decisions resulting from CMS' increased focus on financial management by MACs.
- An opportunity for input in evaluation of their MAC's performance through satisfaction surveys conducted by CMS.

### Key Points for Providers

CMS soon will announce the result of the first full and open competition for a Part A/Part B Medicare administrative contractor (A/B MAC) conducted as part of the agency's Medicare contracting reform implementation strategy. This award will be for a single fee-for-service claims processing contract that will combine the workloads for a multi-state jurisdiction currently serviced both by FIs and carriers.

This first A/B MAC award will be for jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Jurisdiction 3 represents **three percent** of the national fee-for-service Medicare claims volume.

With this contract award, CMS will begin to achieve efficiencies and administrative savings through the consolidation of the traditional cost-reimbursable contracts and by implementing improved contracting processes quickly.

The request for proposal (RFP) for the jurisdiction 3 A/B MAC was released in September 2005. Full implementation of the new contractor is scheduled for July 2007. CMS will work with the current carriers and FIs in jurisdiction 3, whose contracts will end with the MAC implementation, to ensure a smooth transfer of records and information to the new jurisdiction 3 A/B MAC.

***First Contract for a Part A/Part B Medicare Administrative Contractor To Be Awarded in Near Future (continued)***

The carries and FIs whose contracts will end are Montana Blue Cross Blue Shield, Wyoming Blue Cross, Arizona Blue Cross, and Noridian Administrative Services. CMS recognizes with gratitude the strong commitment by these corporations to serving the Medicare program for more than 40 years.

The jurisdiction 3 A/B MAC contract award will be the first of 15 A/B MAC contracts. Each of these contracts will be for the administration of both the Medicare Part A and Part B benefits in a specified geographic jurisdiction of the country. (See the *Additional Information* section of this article for the Web page containing a map showing the 15 jurisdictions.) All 15 contracts are to be awarded, and all A/B MACs are to be operational, by October 2011.

CMS has extensive experience in overseeing the successful transfer of Medicare claim-processing work from one contractor to another. The agency is committed to ensuring that the implementation of the new A/B MAC environment will be as seamless as possible for the Medicare providers and beneficiaries.

CMS will devote full resources and manage the A/B MAC contract implementation so as to ensure continuity, accuracy, and timeliness in claim processing and issuance of payments. In jurisdiction 3, CMS plans to implement the new A/B MAC contract by transferring the claims processing workload from the current contractors incrementally (rather than all at once) to ensure that neither providers nor beneficiaries will be adversely affected.

### Additional Information

Information on the jrisdiction 3 A/B MAC procurement, including the scope of work to be performed, is available on the Federal Business Opportunities website at *http://www1.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html*.

A map displaying the 15 A/B MAC jurisdictions is available on the Medicare contracting reform website on the CMS website at *http://www.cms.hhs.gov/MedicareContractingReform/05_A_BMACJurisdictions.asp#TopOfPage*.

Individual fact sheets and data on each jurisdiction are also available there.

Suppliers may want to consult *MLN Matters* article SE0628 to see how Medicare contracting reform affects durable medical equipment regional carriers (DMERCs). That article is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf*.

MLN Matters Number: SE0642
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 SE0642



## Medicare Telehealth Services Update

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

### Provider Types Affected

Providers who bill Medicare carriers and fiscal intermediaries (FIs) for telehealth services

### Provider Action Needed

### STOP – Impact to You

When billing for telehealth services provided on or after January 1, 2006, do not use *Current Procedure Terminology (CPT)* codes *99261-99263* (hospital inpatient follow-up consultations) or *99271-99275* (confirmatory consultations). These codes no longer exist, and using them could impact your reimbursement.

### CAUTION – What You Need to Know

The American Medical Association has deleted *CPT* codes *9926-99263* (hospital inpatient follow-up consultations) and *CPT* codes *99271-99275* (confirmatory consultations). Effective January 1, 2006, these *CPT* codes no longer exist and were removed from the physician fee schedule.

### GO – What You Need to Do

Make sure that your billing staffs are aware that *CPT* codes *99261-99263* and *99271-99275* are no longer usable for telehealth services.

### Background

CR 5122, from which this article is taken, is issued to alert you that, effective January 1, 2006, the AMA has deleted the following CPT codes:

- *99271-99275* (Confirmatory consultation)
- *99261-99263* (Follow-up inpatient consultation).

Thus, the *CPT* codes that describe these services (hospital inpatient follow-up consultations – *99261* through *99263* and confirmatory consultations – *99271* through *99275*) no longer exist.

In response, also effective January 1, 2006, CMS has removed confirmatory consultation and inpatient follow-up consultation from the list of Medicare telehealth services as referenced in the *Medicare Benefit Policy Manual* (Publication 100-02) and the *Medicare Claims Processing Manual* (Publication 100-04). The relevant sections of these Manuals (Publication 100-02, Chapter 15, Section 270.2 [List of Medicare Telehealth Services] and Publication 100-

*Medicare Telehealth Services Update (continued)*

04 Chapter 12, Section 190.3 [List of Medicare Telehealth Services]) have been revised to reflect these policy changes.

As displayed in Table 1 below, office and other outpatient consultations and initial inpatient consultations are included in Medicare telehealth consultations as described by *CPT* codes *99241 through 99255*. The table displays the current Medicare telehealth services and *CPT* and HCPCS codes.

**Current Medicare Telehealth Services and Associated *CPT*/HCPCS Codes**

| Service | *CPT*/HCPCS Codes |
|---|---|
| Consultations | *99241-99255* as of January 1, 2006 |
| Office or other outpatient visits | *99201-99215* |
| Individual psychotherapy | *90804-90809* |
| Pharmacologic management | *90862* |
| Psychiatric diagnostic interview examination | *90801* |
| End-Stage Renal Disease (ESRD) related services | G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 |
| Individual Medical Nutrition Therapy | G0270, *97802*, and *97803* |

## Additional Information

You may find more information about current Medicare telehealth services and the associated CPT/HCPCS codes in CR 5122, located at *http://cms.hhs.gov/Transmittals/downloads/R53BP.pdf* for the changes to Publication 100-02, Chapter 15, Section 270.2 (List of Medicare Telehealth Services) and at *http://www.cms.hhs.gov/Transmittals/downloads/R997CP.pdf* for the changes to Publication 100-04, Chapter 12, Section 190.3 (List of Medicare Telehealth Services).

If you have any questions, please contact your carrier/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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5122
Related Change Request (CR) Number: 5122
Related CR Release Date: July 7, 2006
Effective Date: January 1, 2006
Related CR Transmittal Number: R997CP and R53BP
Implementation Date: August 7, 2006

Source: CMS Pub. 100-04, Transmittal 997, CR 5122



# Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

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

**Note:** CMS has revised this MLN Matters article on July 6, 2006, to reflect revisions made to change request (CR) 5105, which CMS released on July 3, 2006. The transmittal number, CR release date, and Web address for accessing CR 5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed-care plans. All other information remains the same. This article was originally published in the July 2006 Medicare A Bulletin (pages 14-15).

## Provider Types Affected

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare advantage (MA) organizations.

## Impact on Providers

This article is based on CR 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR 5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in an MA organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

## Background

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs.

When CMS data systems recognize a beneficiary has enrolled in a MA organization, the MA organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service which was paid by the fee-for-service Medicare contractor to the provider.
- Second, by the MA payment systems in the monthly capitation rate paid to the MA plan for the beneficiary.

*Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment (continued)*

**Overview of the Medicare Advantage Plan Enrollment Process**

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the MA plan enrollment period are identified by Medicare's common working file (CWF) system.
- An informational unsolicited response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the MA plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR 2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted.
- Medicare contractors will initiate overpayment recovery procedures.

**Note:** CR 2801 (Transmittal AB-03-101, dated July 18, 2003) may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf*.

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters* article, SE0638, which is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf*.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate reason code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the MA plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  - That the beneficiary was in a MA plan on the date of service
  - That the provider should bill the managed care plan
  - What the plan identification number is
  - Where to find the plan name and address associated with the plan number on the CMS website.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

**Note:** To associate plan identification numbers with the plan name, go to the CMS website *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage*.

In summary, CMS issued CR 5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Pub.100-06, Ch. 3, Section 190), which is included as part of CR 5105. Instructions for accessing CR 5105 are in the *Additional Information* section of this article.

## Implementation

The implementation date for the instruction is June 26, 2006.

## Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R100FM.pdf*.

Also, if you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5105 – Revised
Related Change Request (CR) Number: 5105
Related CR Release Date: July 3, 2006
Related CR Transmittal Number: R100FM
Effective Date: October 1, 2003
Implementation Date: June 26, 2006

Source: CMS Pub. 100-06, Transmittal 100, CR 5105

# Medicare Common Working File Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes

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

## Provider Types Affected

Physicians, providers, and suppliers who provide services to Medicare beneficiaries enrolled under Medicare Part C

## Impact on Providers

CR 5118 provides notice that **effective January 2006**, Medicare Part C plan contract numbers can begin with a character other than an "**H**."

As a result of changes in the assignment of Medicare Part C plan contract numbers, the entire five-position alpha/numeric Medicare Part C plan contract number will be provided to the common working file (CWF), which is a key file used by Medicare systems to provide beneficiary information to providers.

Currently, the CWF places an "H" in front of the Part C plan number, since prior to January 1, 2006, all plan numbers began with an "H." Once this change is implemented, the correct and complete plan contract numbers will then be on the CWF and will be given to providers when they inquire about Medicare beneficiaries.

## Background

CWF contains data indicating when a beneficiary is enrolled under a Medicare Part C contract. Medicare Part C contracts are Medicare Advantage Managed Care plans that provide Part A and B benefits for beneficiaries enrolled under the contract. CWF receives this Part C data on a data feed from the enrollment database (EDB), another Medicare database. Effective January 1, 2006, Part C contract numbers can begin with a letter other than "H" and the Medicare CWF is being modified to handle this change, so correct numbers are sent to providers as part of beneficiary information.

To associate plan identification numbers with the plan name, go to the CMS website *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage*.

The number that will appear on CWF will begin with "H." For the following 11 plans, the alpha prefix is actually an "R." Prior to October, when using the Web page look-up tool, make sure to replace the "H" with an "R." The 11 plans are the following:

| | | | | |
|---|---|---|---|---|
| R3175 | R5566 | R5863 | R5287 | R5595 |
| R5941 | R5342 | R5674 | R9943 | R5553 |
| R5826 | | | | |

## Implementation

The implementation date for the instruction is October 2, 2006.

## Additional Information

CR 5118 is the official instruction issued to your Medicare carrier/durable medical equipment regional carrier (DMERC) or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5118 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R995CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5118
Related Change Request (CR) Number: 5118
Related CR Release Date: June 30, 2006
Related CR Transmittal Number: R995CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 995, CR 5118

# MEDICARE SECONDARY PAYER

## Modification to Online Medicare Secondary Payer Questionnaire—Full Replacement of and Rescinding Change Request 3504

*CMS has issued the following Medlearn Matters... Information for Medicare Providers" article.*

**Note:** CMS has revised this MLN Matters article on July 15, 2006, because change request (CR) 4098, on which this article is based, has been superseded by CR 5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf*.

The article for CR 4098 was originally published in the January 2006 *Medicare A Bulletin* Special Issue (pages 30-31). The article for CR 5087 was originally published in the July 2006 *Medicare A Bulletin* (pages 18-19).

### Provider Types Affected

Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

### Provider Action Needed

### STOP – Impact to You

CR 4098 clarifies recent changes made to the "Medicare Secondary Payer Questionnaire."

### CAUTION – What You Need to Know

This change request (CR) identifies all of the changes that were made to CR 3504 ***and*** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

### GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

### Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR 3504) did not specifically mention all of the changes that were made to the "Medicare Secondary Payer (MSP) Questionnaire." CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR 4098, provides a model: "Admission Questions to Ask Medicare Beneficiaries." The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV** and **V** of the model questionnaire adds the response: "No, Never Employed."
- In **Parts IV, V, and VI** of the model questionnaire, providers should use "Policy Identification Number" to mean a number that is sometimes referred to as the health insurance benefit package number.
- **Parts IV, V, VI** of the model questionnaire adds "Membership Number" and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses "spouse" instead of "family member."
- **Part V**, question 4 changes the model questionnaire to read:
  *Are you covered under the group health plan of a family member other than your spouse? _____Yes _____No.*

  *Name and address of your family member's employer:_____*
- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI,** question 6 now reads: "Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?"

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

### Implementation

The implementation date for the instruction is January 21, 2006.

### Additional Information

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire may be found on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Medlearn Matters Number: MM4098 – Revised
Related Change Request (CR) Number: 4098
Related CR Release Date: October 21, 2005
Related CR Transmittal Number: 41
Effective Date: January 21, 2006
Implementation Date: January 21, 2006

Source: CMS Pub. 100-5, Transmittal 41, CR 4098

# NATIONAL PROVIDER IDENTIFICATION

## Stage 2 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22—Remittance Advice

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

### Provider Types Affected

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, and durable medical equipment regional carriers [DMERCs] and durable medical equipment administrative contractors [DME MACs])

### Background

This article instructs the shared system maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA) – transaction 835, and standard paper remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, national supplier clearinghouse (NSC), provider identification numbers (PIN), national council of prescription drug plans (NCPDP) pharmacy identifiers, and unique physician identification numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as employer identification numbers (EINs) or social security numbers (SSNs).

Medicare has published CR 4320 (*http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf*) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via direct data entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006**: Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007**: Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward**: Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

### Key Points

**During Stage 2,** if an NPI is received on the claim, it will be cross-walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

**Scenario I:** Single NPI – cross walked to single legacy number

**Scenario II:** Multiple NPIs – cross walked to single Medicare legacy number

**Scenario III:** Single NPI – cross walked to multiple Medicare legacy numbers

**Note:** The standard paper remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The remittance advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers.

The companion documents will be updated to reflect these changes and the updated documents will be posted on the CMS website at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage*.

**Scenario I – Single NPI Cross Walked to Single Legacy Number**

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. **SPR:** Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. **MREP Software:** Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

*Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice,... (continued)*

**Scenario II: Multiple NPIs Cross Walked to Single Medicare Legacy Number**

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. **SPR:** Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. **MREP Software:** Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III: Single NPI Cross Walked to Multiple Medicare Legacy Numbers**

1. **ERA:** Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. **SPR:** Insert the appropriate legacy number at the header level and theNPI at the claim and/or at the service level, if needed.
3. **PC Print Software:** Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. **MREP software:** Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

### Implementation

The implementation date for this instruction is October 2, 2006.

### Additional Information

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf*.

The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR 5081.

The MLN Matters article that provides additional information about Stage 1 Use of NPI is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

If you have questions, please contact your Medicare carrier, FI, RHHI, DMERC, 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*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5081
Related Change Request (CR) Number: 5081
Related CR Release Date: June 30, 2006
Related CR Transmittal Number: R996CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 996, CR 5081



## Southern Healthcare Administrative Regional Process Presents Free Teleconferences

The Centers for Medicare & Medicaid Services (CMS) Atlanta and Dallas CMS regional offices are sponsoring free audio conferences regarding the NPI panel discussion. Please feel free to join the future free audio conference listed below:

### Electronic Health Records – Physician Perspective

Wednesday, August 16, 2006, 1:00 – 2:00 p.m., ET

Conference ID Number – 2512447

Dr. Jim Morrow with the North Fulton Family Medicine will discuss choosing an EHR system. He will share his experiences and lessons learned.

### Electronic Health Records – RHIO Perspective

Wednesday, August 23, 2006, 1:00 – 2:00 p.m., ET

Conference ID Number – 2512465

Liesa Jenkins, Executive Director of CareSpark, will provide an overview of CareSpark and of its experience in improving the health of people in Northeast TN and Southwest VA through collaborative use of health information.

**Note:** Please call 1-877-203-0044 fifteen minutes prior to call start time and provide the conference ID number. ❖

Source: CMS Provider Education Resource 200607-10

## Do You Have Your National Provider Identifier Number Yet?

If so, that's great! If not, remember there are three ways that you can obtain your national provider identifier number (NPI):

- Complete the **online application** at the NPPES website at *https://NPPES.cms.hhs.gov*.
- Download the **paper application** form CMS-10114 available at *http://www.cms.hhs.gov/forms*.
- Call the NPI Enumerator at 1-800-465-3203 and request a paper application.

In addition, you may also authorize an employer or other approved organization that has obtained the permission of the provider, to obtain the NPI for you through bulk enumeration, known as **Electronic File Interchange** (EFI).

Regardless of how you obtain your NPI, it is important that you **retain the notification documentation that NPPES sends to you containing your NPI**. You will need to share this notification with other health care partners, when enrolling in Medicare for the first time, or making changes to your current Medicare provider file.

### National Provider Identifier Timeline

**Electronic claim submitters only**

**January 3, 2006 – October 1, 2006**
NPI optional and Medicare numbers required

**October 2, 2006 – May 22, 2007**
NPI and Medicare number

**May 23, 2007 – Forward**
NPI only

Small health plans have until May 23, 2008.

### Important Note

**Paper claim submitters**

Submission of the NPI on paper claims will not be applicable until the new CMS-1500 form (08/05) and the CMS-1450 (UB-04) is implemented.

### EDI Information

For specific electronic claim guidelines for NPI submission, visit the EDI section of the website at: *http://www.floridamedicare.com*.

Beginning January 3, 2006, through October 1, 2006, electronic Medicare claims may be submitted with the NPI number along with the existing Medicare number. If the NPI is submitted alone, the claims will reject as unprocessable.

Beginning October 2, 2006, through May 22, 2007, CMS systems (including those used by the fiscal intermediaries and carriers) will accept the NPI with or without an existing Medicare number on claims. If there is an issue with the provider's NPI, the claim may not be paid. Therefore, **Medicare strongly recommends** that providers, clearinghouses, and billing services continue to submit the Medicare number in addition to the NPI.

Beginning May 23, 2007, CMS systems will only accept the NPI. Small health plans have until May 23, 2008 to begin using the National Provider Identifier.

For more information, go to *http://www.cms.hhs.gov/NationalProvIdentStand/*. ❖

Source: CMS Pub. 100-20, Transmittal 190, CR 4023

## National Provider Identifier Enumeration System—Countdown Reminder

Countdown has begun; do you have your national provider identifier (NPI)? Don't risk disruption to your cash flow – Get your NPI now! National provider identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting the CMS website *at* *http://www.cms.hhs.gov/apps/npi/01_overview.asp*.

This page also contains a section for Medicare fee-for-service (FFS) providers with helpful information on the Medicare NPI implementation. A countdown clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at *http://www.wedi.org/npioi/index.shtml*. ❖

Source: Joint Signature Memorandum 06468, May 30, 2006

## Upcoming NPI Outreach Events

The Centers for Medicare & Medicaid Service (CMS) and the Workgroup for Electronic Data Interchange (WEDI) are working together to ensure that all healthcare providers are educated and informed on the new National Provider Identifier (NPI). As such, there are a few upcoming outreach events, sponsored by WEDI, that health care providers may find helpful:

**WEDI NPI Industry Forum IV: NPI Is Knocking At Your Door—Will You Let It In?**

August 15th and 16th at the Hyatt Fair Lakes in Fairfax, VA

*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=1EFC0000000A*

Please note that there is a cost to participate in these events. To learn more about the events, as well as the latest news on WEDI NPI outreach, visit on the Web *http://www.wedi.org/npioi/index.shtml*. ❖

Source: CMS Provider Education Resource 200606-13

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# GENERAL COVERAGE

## Lumbar Artificial Disc Replacement

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

### Provider Types Affected

All physicians and providers who bill Medicare carriers and fiscal intermediaries (FIs) for lumbar artificial disc replacement (LADR)

### Providers Action Needed

This article and change request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three-pronged:

1. Effective May 16, 2006, the LADR with the Charite™ lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary's 61st birthday.
2. Medicare coverage under the investigational device exemption (IDE) and/or clinical trail policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted.
3. For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

### Background

The Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for LADR, determined that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare patients over 60 years of age and is, therefore, noncovered for this patient population. For Medicare beneficiaries 60 years of age and younger, there is no NCD, leaving such determinations to be made by the local Medicare carrier or FI.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1.

The addition of section 150.10 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

### Billing Requirements

The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice,** (advance beneficiary notice [ABN] or hospital issued notice of noncoverage [HINN]), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
  - Under the "Items or Service" Section: Lumbar Artificial Disc Replacement (LADR) with the Charite lumbar artificial disc.
  - Under the "Because" Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is noncovered for beneficiaries over 60 years of age. Medicare never pays for this service for this Medicare population.
- Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

**Information for Providers Billing Carriers**

- For patients over 60 years of age, claims submitted with *CPT* category III codes *0091T* (*Single interspace, lumbar*) and/or *0092T* (*Each additional interspace*) will be denied unless performed under an approved IDE/clinical trial. **(Note:** The Charite lumbar artificial disc is the only artificial disc approved by the FDA, therefore the procedure (*CPT* code *0091T or 0092T*) would be using the Charite unless under an IDE/clinical trial.)
- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with *CPT* code *0091T or 0092T* and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

**Information for Providers Billing FIs**

For patients over 60 years of age, claims submitted with ICD-9-CM procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is never payable and will be denied unless performed under an approved IDE/clinical trial.

*Lumbar Artificial Disc Replacement (continued)*

For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, the FI will pay for LADR only when submitted with ICD-9 procedure code 84.65 with condition code 30 and diagnosis code V70.7 when submitted on type of bill (TOB) 11x.

- For services submitted on TOB 11x in critical access hospitals (CAH), the payment will be 101 percent of reasonable cost.
- For services submitted on TOB 11x from inpatient hospitals, including Indian health services (IHS) inpatient hospitals, will be paid under the inpatient prospective payment system (IPPS) based on the DRG (diagnosis related group).
- For services submitted/performed on TOB 11x, IHS CAHs will be paid under 101 percent facility specific per diem rate.

**Medicare Summary Notice (MSN) and Claim Adjustment Reason Code Messages for Denied Claims**

- The following MSN: 21.24 will be issued: "This service is not covered for patients over age 60." along with a claim adjustment reason code such as: 96 "Noncovered charge(s)."

### Implementation

The implementation date for this instruction is July 17, 2006, for claims submitted to carriers and October 1, 2006, for claims submitted to Medicare FIs. But, in both instances, the change applies to services provided on or after May 16, 2006.

### Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change are in two transmittals for CR5057. Transmittal R60NCD contains the NCD instructions and may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R60NCD.pdf*.

The claims processing instructions are in Transmittal R992CP, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R992CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5057
Related Change Request (CR) Number: 5057
Related CR Release Date: June 23, 2006
Related CR Transmittal Number: R60NCD and R992CP
Effective Date: May 16, 2006
Implementation Date: July 17, 2006 (carriers); October 1, 2006 (FIs)

Source: CMS Pub. 100-04, Transmittal 992, CR 5057



## Payment for Islet Cell Transplantation in NIH-Sponsored Clinical Trials

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers and fiscal intermediaries (FIs))

### Provider Action Needed
### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in the National Institutes of Health (NIH)-sponsored clinical trials.

### CAUTION – What You Need to Know

Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation **on or after May 1, 2006, modifier QV is no longer valid**. **Modifier QR** (item or service provided in a Medicare-specified study) **will replace modifier QV for services on or after May 1, 2006.**

### GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this article for more information. Be ready to use the new modifier QR for payment of islet cell transplantation and routine follow-up care when appropriate.

### Background

As a result of section 733 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173), for services performed/ discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with Type I diabetes who are participating in an NIH-sponsored clinical trial. The islet cell transplantation may be done alone or in combination with kidney transplantation.

### Additional Information

Effective for services on or after **May 1, 2006**, Medicare will **accept modifier QR** for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

***Payment for Islet Cell Transplantation in NIH-Sponsored Clinical Trials (continued)***

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
  - Performed in an outpatient department of a hospital; and
  - Billed on type of bill (TOB) 13x or 85x.

For additional information, please refer to MM3385, "MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial," which may be found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3385.pdf*.

Also, refer to the *Medicare National Coverage Determinations Manual,* publication 100-03, Chapter 1, Part 4, Section 260.3.1 "Islet Cell Transplantation in the Context of a clinical trial (Effective October 1, 2004)," located on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf*.

CR 5140 is the official instruction issued to your Medicare carrier or FI regarding changes mentioned in this article, and the manual attachment to CR 5140, the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 32, "Billing Requirements for Special Services," Section 70 "Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial." CR 5140 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R986CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5140
Related Change Request (CR) Number: 5140
Related CR Release Date: June 16, 2006
Related CR Transmittal Number: R986CP
Effective Date: May 1, 2006
Implementation Date: July 31, 2006

Source: CMS Pub. 100-04, Transmittal 986, CR 5140



## Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds

*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 carriers, fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for chronic nonhealing wound related services furnished to Medicare beneficiaries.

### Impact on Providers

This article is based on change request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHIs) that claims submitted for **becaplermin**, a self-administered, nonautologous growth factor for chronic, nonhealing, subcutaneous wounds **will remain noncovered**.

Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157,** is nationally non-covered because it is usually self-administered by the patient.

### Background

After releasing a national noncoverage determination (NCD) on autologous blood-derived products for chronic non-healing wounds in December of 2003, an error was printed in the NCD manual.

To correct that error, the Centers for Medicare & Medicaid Services (CMS) is revising section 270.3 of the *National Coverage Determinations (NCD) Manual* (Publication 100-03, Chapter 1, Part 3, "Blood-Derived Products for Chronic Non-Healing Wounds") to accurately reflect the payment policy for nonautologous blood derived products for chronic non-healing wounds, effective April 27, 2006.

In this revision, the following sentence is being deleted:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration."

The correct statement should read:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally noncovered** under Part B based on section 1861(s)(2)(A) and section 1861(s)(2)(B) because this product is usually self-administered by the patient."

While CMS makes every effort to provide accurate and complete information, the erroneous coverage statement printed in the NCD Manual regarding nonautologous blood-derived products was not intended, and is not part of the decision memorandum (DM) posted on December 15, 2003. Nonautologous blood-derived products are not in the same class as the products referred to in the December 15, 2003, DM.

NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1060)(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage

*Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds (continued)*

organization. In addition, an ALJ may not review an NCD (see section 1869(f)(1)(A)(i) of the Social Security Act).

### Additional Information

CR 5123 is the official instruction issued to your Medicare carrier or FI/RHHI regarding changes mentioned in this article. There are two transmittals for CR 5123. Transmittal 59, containing the NCD revision, is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R59NCD.pdf*.

Transmittal 977, containing the Medicare claims processing instructions, is on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R977CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5123
Related Change Request (CR) Number: 5123
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R977CP and R59NCD
Effective Date: April 27, 2006
Implementation Date: July 10, 2006

Source: CMS Pub. 100-04, Transmittal 977, CR 5123



## Requirements for Diagnostic X-ray, Diagnostic Laboratory, and Other Diagnostic Tests and Clinical Psychologist Services

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

### Provider Types Affected

Physicians, providers, and/or clinical psychologists who submit claims to Medicare carriers, for diagnostic psychological testing services

### Impact on Providers

- Change request (CR) 4400 alerts providers that Medicare may now pay for the services of a clinical psychologist when they supervise the performance of diagnostic psychological testing.
- Under the physician supervision level of four, Medicare's physician supervision policy is modified so the policy does not apply when the procedure is furnished under the general supervision of a clinical psychologist.
- Medicare carriers are not required to retroactively process claims for the period between January 1, 2005, and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2005.

### Background

Diagnostic psychological testing may now be performed under the general supervision of a clinical psychologist. This change may be found in the revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Section 160 - Clinical Psychologist Services.

As a reminder, to qualify as a clinical psychologist (CP), a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology.
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

### Implementation

The implementation date for this instruction is September 21, 2006.

### Additional Information

The revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Sections 80 and 160, Clinical Psychologist Services, is attached to CR 4400, which is the official instruction issued to your carrier regarding this change. CR 4400 may be found by going to the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R51BP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM4400
Related Change Request (CR) Number: 4400
Related CR Release Date: June 23, 2006
Related CR Transmittal Number: R51BP
Effective Date: January 1, 2005
Implementation Date: September 21, 2006

Source: CMS Pub. 100-02, Transmittal 51, CR 4400

# HOSPITAL SERVICES

## Inpatient Rehabilitation Facility Interrupted Stays

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

### Provider Types Affected

Inpatient rehabilitation facilities (IRFs) billing Medicare fiscal intermediaries (FIs) for services billed under the inpatient rehabilitation facility prospective payment system (IRF PPS)

### Background

The purpose of this special edition article is to highlight the Centers for Medicare & Medicaid Services (CMS) language that reinforces the IRF interrupted stay policy. An investigation found that providers were incorrectly billing Medicare for interrupted stays

### Key Points

**Case Level Payment Adjustment**

- A case level payment adjustment is made under the IRF PPS if the patient has an interrupted stay.
- An **interrupted stay is defined** as those cases in which a Medicare beneficiary is discharged from the IRF and returns to the same IRF within three-consecutive calendar days.
- The three-consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day.
- The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption.
- The interruption of the stay days will not be used to calculate the patient's length of stay.

**Case-Mix Group Payment**

- Only one case-mix group (CMG) payment will be made for a claim in which data identifying one or more interrupted stays have been recorded, and the payment will be based on the initial patient assessment data.
- For example, if a Medicare beneficiary is discharged on August 1, 2006, and is readmitted to the same IRF on August 3, 2006, the patient's hospitalization is considered to include an interrupted stay and only one CMG payment will be made based on the initial assessment.
- However, if the Medicare beneficiary was readmitted on August 4, 2006, then the time the patient was away from the facility would not be considered to meet the interrupted stay definition and **a new IRF stay would begin.** A new patient assessment using the IRF patient assessment instrument would have to be performed, and the CMG resulting from that new patient assessment may be used to bill as a separate claim.
- On the IRF Medicare bill, the presence of occurrence **span code 74 indicates an interrupted stay has occurred.** Report occurrence span code 74 with the "From' and 'Through' dates of the interruption in the stay. The day of discharge from the IRF is the FROM date and the last day the patient is not in the IRF at midnight is the THROUGH date. Report accommodation revenue code 18x (leave of absence) and the quantity of leave days.

Occurrence span code 74 should be reported for each interruption of more than 1 day along with the dates of each interruption. Revenue code 018x should reflect the total number of days for all occurrence span code 74 entries.

In other words, revenue code 018x should be listed on one line, with all interrupted days included in the units column. **No charges** should be added to this charge line.

### Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

Pages 239-240 of the *Medicare Claims Processing Manual* contain language regarding interrupted stays and can be viewed on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

*Transmittal A-01-110* issued on September 14, 2001 also provides information on the IRF interrupted stay and may be viewed on the CMS website at *https://www.cms.hhs.gov/Transmittals/downloads/A01110.pdf* .

MLN Matters Number: SE0647
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 SE0647

# Long-Term Care Hospital Prospective Payment System—Year 2007 Rate Update

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

## Provider Types Affected

Long-term care hospitals paid under the LTCH prospective payment system (PPS) by Medicare fiscal intermediaries (FIs)

## Provider Action Needed

## STOP – Impact to You

Change request (CR) 5202, from which this article is taken, updates the changes to LTCH PPS for then year 2007 (July 1, 2006 – June 30, 2007) rate. It also announces a policy change regarding payment for LTCH patients during a three-day or less interruption of an LTCH stay if the treatment was grouped to surgical diagnosis related groups (DRGs) in the acute care hospital.

CR 5202 also announces changes to short stay outlier (SSO) payment calculations.

## CAUTION – What You Need to Know

CR 5202 provides updates to rates, budget neutrality factors, wage indexes, and so on, for the new rate year for LTCH PPS.

## GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

## Background

In accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000), on October 1, 2002, CMS implemented a Medicare prospective payment system for LTCHs.

Payments under this system are made on a per-discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients; and the most recently available hospital discharge data.

## Annual Update

CMS is required to update the LTCH PPS payments annually: the rate year is updated each July, and the DRGs are updated each October.

CR 5202, upon which this article is based, provides the LTCH PPS rates for year 2007 (July 1, 2006 – June 30, 2007):

- The standard federal rate is $38,086.04.
- The fixed loss amount is $14,887.00.
- The budget neutrality adjustment is zero percent. (The PPS pricing software [PRICER] payment amount will include the adjustment factor as 1.00.)
- The wage index phase-in percentage for cost reporting periods, beginning on or after October 1, 2006, is 5/5ths (100 percent). Note that the wage index table within PRICER will include three columns:
  - A 3/5ths column for discharges occurring in LTCH cost-report periods beginning during fiscal year 2005.
  - A 4/5ths column for discharges occurring in LTCH cost-report periods beginning during fiscal year 2006.
  - A 5/5ths column for discharges occurring in LTCH cost report periods beginning during fiscal year 2007.
- The labor-related share is 75.665 percent.
- The nonlabor related share is 24.335 percent.

## Other Important Facts in CR 5202

### Short-Stay Outlier Cases

One notable policy change affects payments to SSO cases.

Currently, SSO cases (i.e., cases with a length of stay less than or equal to 5/6ths of the geometric average length of stay (ALOS) of the LTC DRG), are paid the least of:

1. 120 percent of the estimated cost of the case
2. 120 percent of the LTC-DRG per diem amount, or
3. The full LTC-DRG payment.

However, in the year 2007 rate LTCH PPS final rule, CMS revised the SSO case payment formula in two ways.

First, the current SSO payment formula option that is based on estimated costs has been reduced from 120 percent to 100 percent (effective for SSO discharges occurring on or after year 2007 rate). In addition, a fourth option is being added to the SSO payment formula. This option is a blended payment that is based on:

- A percentage of an inpatient prospective payment system (IPPS) comparable amount, computed as a per-diem and capped at the full IPPS comparable amount.
- A percentage of the 120 percent of the LTC-DRG per diem amount.

Under this new blended fourth component of the SSO payment formula, as the length of the stay increases, it begins to resemble less of a short-term acute care IPPS hospital stay and more of a typical LTCH one.

Consequently, the LTCH PPS payment for the SSO case under this blend option is based on a **decreasing** percentage of the IPPS comparable per diem amount and an **increasing** percentage of the 120 percent of the LTC-DRG per diem amount as the LOS of the SSO case increases.

Therefore, effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case will equal the lesser of:

- 100 percent of estimated cost of the case
- 120 percent of the LTC-DRG per diem amount
- The full LTC-DRG payment, or
- A blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and 120 percent of the LTC-DRG per diem amount.

*Long-Term Care Hospital Prospective Payment System—Year 2007 Rate Update (continued)*

**Note:** The IPPS comparable amount portion of the blend will be computed in the LTCH PRICER software program. In determining the IPPS comparable amount, appropriate IPPS adjustments will be made for DRG weights, wage index, cost-of living for LTCHs located in Alaska and Hawaii, and when applicable, the treatment of a disproportionate share of low-income patients (DSH) and the costs of indirect medical education (IME) (IPPS outlier payments are not included in this calculation).

As under the existing SSO policy, SSO cases are eligible for LTCH PPS high-cost outlier payments if the estimated cost of the SSO case exceeds the LTCH PPS outlier threshold (i.e., the SSO payment plus the fixed-loss amount).

CR 5202 contains further details regarding the SSO calculations and also includes two very detailed examples of SSO calculations, one for a stay of 11 days and the other for a stay of 27 days. You may view these details by accessing CR 5202 on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R981CP.pdf*.

### Revised Payment Policy for Three-Day or Less Interruption of Stay

Another important subject addressed in CR 5202 is the revised payment policy for a three-day or less interruption of stay**.** Currently, all inpatient and outpatient treatment and/or care delivered to LTCH patients by acute care hospitals, IRFs, and SNFs during a three-day or less interruption is the LTCH's responsibility "under arrangements," unless the patient's treatment during such an interruption was at an acute care hospital, and was grouped to a surgical DRG.

This means that the acute care hospital was allowed to submit a separate bill for these services (although the patient's re-admittance to the LTCH following the surgical procedure remained governed by the interrupted stay policy).

For year 2007 rate, this surgical-DRG exception to the three-day or less interruption of stay policy that was in effect for years 2005 and 2006 rates is discontinued, and LTCHs are required to cover such treatment "under arrangements" as they do for all other medical care or services provided to inpatients during a three-day or less interruption of stay.

Therefore, in these instances acute care hospitals will no longer be able to submit a separate bill to Medicare for such treatment but must turn to the LTCH for payment.

### Additional Information

CR 5202, the official guidance that CMS has provided to your FIs, is located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R981CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5202
Related Change Request (CR) Number: 5202
Related CR Release Date: June 15, 2006
Related CR Transmittal Number: R981CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 981, CR 5202



## New Use of Hospital Issued Notice of Noncoverage

*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 fiscal intermediaries (FIs) for hospital inpatients services

### Provider Action Needed
### STOP – Impact to You

This article is based on change request (CR) 5070, which introduces model language for a new hospital issued notice of noncoverage (HINN), specifically HINN 11, and describes its uses with hospital inpatients.

### CAUTION – What You Need to Know

CR 5070 offers model language for a new HINN that may be used as a liability notice for fee-for-service inpatient hospital beneficiaries who are due to receive specific diagnostic or therapeutic procedures that are separate from treatment covered/paid/bundled into the inpatient stay.

### GO – What You Need to Do

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

### Background

Limitation of liability (LOL) notices are required under Section 1879 of the Social Security Act (*http://www.ssa.gov/OP_Home/ssact/title18/1879.htm*) in order to hold beneficiaries liable for certain noncovered services. The hospital issued notice of noncoverage (HINN) is the only limitation of liability notice for fee-for-service beneficiaries who are hospital inpatients, but traditionally these notices have only addressed entire hospital stays.

**Note:** Basic LOL information may be found in the Medicare Claims Processing Manual (Publication 100-4, Chapter 30) on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf)*.

Information on the HINNs may be found at Section V of the attachment to CR 3903 Transmittal 594, dated June 24, 2005 on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R594CP.pdf*.

*New Use of Hospital Issued Notice of Noncoverage (continued)*

While there are several different versions of the HINN, none of the current versions adequately address the ability of hospitals to charge their inpatients for certain noncovered services that are severable from the inpatient stay (i.e., not bundled or integral to payment or treatment for the diagnoses/reasons justifying the stay under Medicare policy).

The ability to charge beneficiaries for such items (medically unnecessary diagnostic and therapeutic services) is codified under the *Code of Federal Regulations* at 42 CFR 412.42 (d); (*http://www.gpoaccess.gov/cfr/retrieve.html*).

The attachment to CR 5070 provides model language for a new HINN to fit this specific case, "HINN 11," and instructions for use of this language are also provided. This attachment to CR 5070 includes the following major sections:

- Introduction (HINN 11 Model Language and Instructions)
- Use of HINN 11
- Delivery of HINN 11
- Model language
- Completion of the HINN 11
- Procedures after signature

Quality improvement organizations (QIOs), which review most other HINNs, will not automatically review this HINN.

In this case, QIOs will only exercise medical judgment and review cases related to this new HINN (after services have been delivered) when specifically requested by the:

- Involved beneficiary
- Beneficiary representative
- Intermediary

Intermediaries have the discretion to review this HINN for other than inpatient hospital stays if relevant to a claim being reviewed as part of the progressive corrective action process. Intermediaries must include this cost as part of the review of the claim.

## Implementation

The implementation date for the instruction is September 18, 2006.

## Additional Information

For complete details, including the revised manual section and model language, please see the official instruction (CR 5070) issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R982CP.pdf*.

Hospitals may choose to begin using this HINN immediately and need not wait for the September 18, 2006, implementation date.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5070
Related Change Request (CR) Number: 5070
Related CR Release Date: June 16, 2006
Related CR Transmittal Number: R982CP
Effective Date: September 18, 2006
Implementation Date: September 18, 2006

Source: CMS Pub. 100-04, Transmittal 982, CR 5070

# Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update

*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 fiscal intermediaries (FIs) for inpatient psychiatric services furnished to Medicare beneficiaries

## Impact on Providers

This article is based on change request (CR) 5129 which informs your intermediary that changes are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update for rate year 2007. These changes include the following:

- Market basket update
- New CBSA designations used for assigning a wage index value.
- The PRICER update.

## Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (*http://www.access.gpo.gov/su_docs/fedreg/a041115c.html*) establishing the prospective payment system for inpatient psychiatric facilities under the Medicare program (in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 [BBRA]).

Payments to IPFs under the IPF PPS are based on a federal per-diem base rate that:

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

CMS is required to make updates to the IPF PPS annually. In addition:

- The rate year update is effective July 1 – June 30 of each year; while
- The diagnosis related groups (DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

**Note:** This is the first rate year update to the IPF PPS.

CR 5129 announces that, effective July 1, 2006, all IPFs (freestanding psychiatric hospitals and distinct part units of acute care hospitals and critical access hospitals) must meet the physician certification requirements specified in 42 CFR 424.14. Certification is required at the time of admission or as soon thereafter as is reasonable and practicable.

The first re-certification is required as of the 12th day of hospitalization and subsequent re-certifications are required at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days. The physician must also re-certify that the patient continues to need, on a daily basis, active inpatient psychiatric treatment furnished directly by or requiring the supervision of IPF personnel.

Also, CR 5129 identifies changes that are required as part of the annual IPF PPS update from the rate year 2007 IPF PPS final rRule published on May 9, 2006. This final rule is available at *http://frwebgate5.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=319357120150+0+0+0&WAISaction=retrieve.*

These changes are **applicable to IPF discharges** occurring during the rate year beginning on July 1, 2006, through June 30, 2007. These changes include the following:

1. **Market Basket Update**
   CMS is now using the new rehabilitation/psychiatric/long-term care (RPLTC) market basket to update the IPF PPS portion of the blended payment rate (that is, the federal per diem base rate).
   A re-based, 2002-excluded hospital market basket is used to update the costbased portion (TEFRA). It is effective for cost reports periods beginning on or after October 1 of each year and is applied to the TEFRA target amount.

2. **PRICER Updates for IPF PPS Rate Year 2007, (July 1, 2006 – June 30, 2007)**
   - The federal per-diem base rate is $595.09.
   - The fixed-dollar loss threshold amount is $6,200.
   - The revised standardization factor is 82.54 percent.
   - The IPF PPS transition blend percentage for cost reporting periods beginning on or after January 1, 2006, but before January 1, 2007, is 50 percent PPS and 50 percent TEFRA.
   - The transition blend percentage for cost reporting periods beginning on or after January 1, 2007, but before January 1, 2008, is 75 percent PPS and 25 percent TEFRA.
   - Core-based statistical area (CBSA) designations will be used for assigning a wage index value for discharges occurring on or after July 1, 2006. There will be no separate transition blend under IPF PPS for conversion to the CBSA based labor market areas.
   - The labor-related share is 75.665 percent.
   - The nonlabor-related share is 24.335 percent.
   - The electroconvulsive therapy (ECT) rate is $256.20.

3. **Teaching Status Adjustment**
   The teaching adjustment is made on a claim basis as an interim payment and the final payment in full for the claim is made during the final settlement of the cost report. The difference between those interim payments and the actual teaching adjustment amount computed in the cost report is adjusted through lump sum payments/recoupments when the cost report is filed and later settled.

*Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)*

**4. Electroconvulsive Therapy (ECT) Update**

The new update methodology for the ECT rate is to use the CY 2005 ECT rate as a base and update that amount by the market basket increase each rate year.

This methodology is consistent with the methodology CMS uses to update the federal per-diem base rate because CMS will use the rehabilitation, psychiatric and long-term care market basket increase to increase both rates. The ECT adjustment per treatment is $256.20 for RY 2007.

**5. Diagnosis Related Group (DRG) Adjustment Update**

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or in the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG 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 the identified 15 psychiatric DRGs, the IPF receives the federal per-diem base rate and all other applicable adjustments.

Table 1 below lists the new FY 2006 ICD-9-CM diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. When coded as a principal diagnosis, the IPF receives the correlating DRG adjustment.

This table is only a listing of new codes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

**TABLE 1. FY 2006 New Diagnosis Codes**

| ICD-9-CM Diagnosis Code | Description | DRG |
|---|---|---|
| 291.82 | Alcohol induced sleep disorders | 521, 522, 523 |
| 292.85 | Drug induced sleep disorders | 521, 522, 523 |
| 327.00 | Organic insomnia, unspecified | 432 |
| 327.01 | Insomnia due to medical condition classified elsewhere | 432 |
| 327.02 | Insomnia due to mental disorder | 432 |
| 327.09 | Other organic insomnia | 432 |
| 327.10 | Organic hypersomnia, unspecified | 432 |
| 327.11 | Idiopathic hypersomnia with long sleep time | 432 |
| 327.12 | Idiopathic hypersomnia without long sleep time | 432 |
| 327.13 | Recurrent hypersomnia | 432 |
| 327.14 | Hypersomnia due to medical condition classified elsewhere | 432 |
| 327.15 | Hypersomnia due to mental disorder | 432 |
| 327.19 | Other organic hypersomnia | 432 |

Table 2 below lists ICD-9-CM diagnosis codes whose titles have been modified in FY 2006. Title changes do not impact the DRG adjustment. When used as a principal diagnosis, these codes still receive the correlating DRG adjustment. This table is only a listing of FY 2006 changes and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

**TABLE 2. Revised Diagnosis Code Titles**

| ICD-9-CM Diagnosis Code | Description | DRG |
|---|---|---|
| 307.45 | Circadian rhythm sleep disorder of nonorganic origin | 432 |
| 780.52 | Insomnia, unspecified | 432 |
| 780.54 | Hypersomnia, unspecified | 432 |
| 780.55 | Disruption of 24 hour sleep wake cycle, unspecified | 432 |
| 780.58 | Sleep related movement disorder, unspecified | 432 |

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the DRG adjustment factors, the ICD-9-CM coding changes, and the DRG classification changes, are shown below in Table 3. Please note these are the same adjustment factors that are currently in effect, since implementation.

*Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)*

**TABLE 3. FY 2006 DRGs and Adjustment Factor**

| DRG | DRG Definition | Adjustment Factor |
|---|---|---|
| 424 | O.R. Procedure with principal diagnosis of mental illness | 1.22 |
| 425 | Acute adjustment reaction & psychosocial dysfunction | 1.05 |
| 426 | Depressive neurosis | 0.99 |
| 427 | Neurosis, except depressive | 1.02 |
| 428 | Disorders of personality & impulse control | 1.02 |
| 429 | Organic disturbances & mental retardation | 1.03 |
| 430 | Psychoses | 1.00 |
| 431 | Childhood mental disorders | 0.99 |
| 432 | Other mental disorder diagnoses | 0.92 |
| 433 | Alcohol/drug abuse or dependence, leave against medical advice (LAMA) | 0.97 |
| 521 | Alcohol/drug abuse or dependence with CC | 1.02 |
| 522 | Alcohol/drug abuse or dependence with rehabilitation therapy without CC | 0.98 |
| 523 | Alcohol/drug abuse or dependence without rehabilitation therapy without CC | 0.88 |
| 12 | Degenerative nervous system disorders | 1.05 |
| 23 | Non-traumatic stupor & coma | 1.07 |

In order to maintain consistency with the IPPS, for discharges occurring on or after October 1, 2005, ICD-9-CM code 305.1, Tobacco use disorder, will not be a covered principal diagnosis under the IPF PPS.

All IPFs must follow the ICD-9-CM official guidelines for coding and reporting, including code first. The ICD-9-CM Official Guidelines for Coding and Reporting may be found at *http://www.cdc.gov/nchs/data/icd9/icdguide.pdf*.

**6. Comorbidity Adjustment Update**

The IPF PPS has 17 comorbidity groupings, each containing ICD–9-CM codes of 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.

IPFs must enter the full ICD-9-CM codes for up to eight additional diagnoses if they coexist 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 coexist at the time of admission, develop subsequently, affect the treatment received, affect the length of stay (LOS) or affect both treatment and LOS.

CMS is using the FY 2006 GROUPER, version 23.0, effective for discharges occurring on or after October 1, 2005.

Table 4 lists the updated FY 2006 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. Table 4 only lists the FY 2006 new codes and does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

**TABLE 4. FY 2006 New ICD-9-CM Codes Applicable for the Comorbidity Adjustment**

| ICD-9-CM Diagnosis Code | Description | DRG | Comorbidity Category |
|---|---|---|---|
| 585.3 | Chronic kidney disease, Stage III (moderate) | 315 – 316 | Renal failure, chronic |
| 585.4 | Chronic kidney disease, Stage IV (severe) | 315 – 316 | Renal failure, chronic |
| 585.5 | Chronic kidney disease, Stage V | 315 – 316 | Renal failure, chronic |
| 585.6 | End stage renal disease | 315 – 316 | Renal failure, chronic |
| 585.9 | Chronic kidney disease, unspecified | 315 – 316 | Renal failure, chronic |
| V46.13 | Encounter for weaning from respirator [ventilator] | 467 | Chronic obstructive pulmonary disease |
| V46.14 | Mechanical complication of respirator [ventilator] | 467 | Chronic obstructive pulmonary disease |

Since the purpose of the comorbidity adjustment is to account for the higher resource costs associated with comorbid conditions that are expensive to treat on a per-diem basis, CMS is not providing a comorbidity adjustment for the following ICD-9-CM codes:

**ICD-9-CM Code Description**

585.1 Chronic kidney disease, Stage I
585.2 Chronic kidney disease, Stage II (mild)

These conditions (585.1 and 585.2) are less costly to treat on a per-diem basis because patients with these conditions are either asymptomatic or may have only mild symptoms.

***Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)***

Table 5 lists the invalid ICD-9-CM codes no longer applicable for the comorbidity adjustment. This table does not reflect all of the currently valid ICD-9-CM codes applicable for the IPF PPS comorbidity adjustment.

**TABLE 5. FY 2006 Invalid ICD-9-CM Codes No Longer Applicable for the Comorbidity Adjustment**

| ICD-9-CM Diagnosis Code | Description | DRG | Comorbidity Category |
|---|---|---|---|
| 585 | Chronic renal failure | 315 – 36 | Renal Failure, Chronic |

CMS is aware that ICD-9-CM code 404.03 (hypertensive heart and renal disease, malignant, with heart failure and renal failure) has caused confusion, since this ICD-9-CM code is currently used to code an adjustment in two separate IPF comorbidity categories, (that is, both "Renal Failure, Chronic" and "Cardiac Conditions").

It more appropriately corresponds to the "Cardiac Conditions" comorbidity than to the "Renal Failure, Chronic" comorbidity. Therefore, to be more clinically cohesive and to eliminate confusion, CMS:

- Removed ICD-9-CM code 404.03 from the comorbidity adjustment category "Renal Failure, Chronic," but
- Retained ICD-9-CM code 404.03 in the "Cardiac Conditions" comorbidity category.

For discharges occurring during the RY July 1, 2006, through June 30, 2007, the Comorbidity Category factors, the ICD-9-CM coding changes, and Comorbidity Category classification changes that are **currently** being paid are shown below in Table 6. Please note these are the same adjustment factors in place since implementation.

**TABLE 6. FY 2006 Diagnosis Codes and Adjustment Factors for Comorbidity Categories**

| 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, V451, 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 |
| 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 |

*Inpatient Psychiatric Facilities Prospective Payment System—Year 2007 Rate Update (continued)*

**7. Payment Rate**

Payments to IPFs under the IPF PPS are based on a federal per-diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services) but excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

**Per-Diem Rate**

| | |
|---|---|
| Federal per-diem base rate | $595.09 |
| Labor share (0.75665) | $450.27 |
| Nonlabor share (0.24335) | $144.82 |

The rates for RY 2007 were published in the final rule and may also be found on the CMS website at *http://www.cms.hhs.gov/InpatientPsychFacilPPS*.

**8. The National Urban and Rural Cost to Charge Ratios for the IPF PPS RY 2007**

| Cost to Charge Ratio | Median | Ceiling |
|---|---|---|
| Urban | 0.55 | 1.7179 |
| Rural | 0.71 | 1.7447 |

CMS is applying the national median cost-to-charge ratios (CCRs) to the following situations:

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

## Implementation

The implementation date for CR 5129 is July 3, 2006.

## Additional Information

For complete details, please see the official instruction (CR 5129) issued to your intermediary regarding this change. There are two transmittals associated with CR 5129. The first transmittal contains information on the physician certification requirements and is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R39GI.pdf*.

The second transmittal includes claims processing information and is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R978CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5129
Related Change Request (CR) Number: 5129
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R39GI and R978CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-01, Transmittal 39, CR 5129

# Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

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

**Note:** CMS has revised this MLN Matters article on July 10, 2006, to clarify example 3 to be consistent with change request (CR) 4229. All other information remains the same. This article was originally published in the Third Quarter 2006 *Medicare A Bulletin* (pages 77-78).

## Provider Types Affected

Providers billing fiscal intermediaries (FIs) for services related to blood clotting factors administered to hemophilia inpatients.

## Provider Action Needed

This article is based on CR 4229, which clarifies the pricing methodologies used for blood clotting factors. It is especially important to point out that the provider determines the dosage furnished to the patient and, using the definition of the appropriate HCPCS code, translates the dosage into units of services on the claim submitted to Medicare.

## Background

The Centers for Medicare & Medicaid Services (CMS) provided CR 4229 to clarify billing practices for providers to ensure that units of service for blood clotting factor are reported accurately. Some Medicare providers have been billing units of drugs and biologicals incorrectly on outpatient bills as well as on inpatient claims for hemophilia clotting factors. The erroneous reporting of units of service has resulted in Medicare overpayments.

**Note:** The provider must determine the actual dosage furnished to the patient and, using the long version of the description of the HCPCS code, translate the dosage into UNITS OF SERVICE. Note: Not all short version descriptions of HCPCS codes define units for the HCPCS code.

The examples below include the Healthcare Common Procedure Coding System (HCPCS) code, and indicate the dosage amount specified in the descriptor of that HCPCS code. Facilities are instructed to use the units field as a multiplier to arrive at the dosage amount.

**Example 1**

| HCPCS Code | Drug | Dosage |
|---|---|---|
| J9355 | Trastuzumab | 10 mg |

**Actual dosage:** 140 mg

On the bill, the facility shows HCPCS code J9355 and **14 in the units of service** field (140 mg divided by 10 mg equals 14).

When the dosage amount is **greater than** the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is **less than** the amount indicated for the HCPCS code, use one as the unit of measure.

**Example 2**

| HCPCS Code | Drug | Dosage |
|---|---|---|
| J3100 | Tenecteplase | 50 mg |

**Actual Dosage:** 40 mg

The provider would bill for one unit, even though less than one full unit was furnished (40 mg divided by 50 mg equals 0.8).

**Example 3**

| HCPCS Code | Drug | Dosage |
|---|---|---|
| J7189 | Factor VIIa | 1 mcg |

**Actual Dosage:** 13365 mcg

The provider would bill for J7189 with 13,365 in the units field (13,365 mcg divided by 1 mcg equals 13,365). Note that the process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

At times, a facility provides less than the amount provided in a single use vial and there is waste, i.e., some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life.

Since an individual patient may receive less than the fully reconstituted amount, CMS encourages hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus with the amount administered, as illustrated in examples 4 and 5.

**Example 4**

**Drug X** is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore:

- **30 units** are billed on behalf of the first patient seen
- **30 units** are billed on behalf of the second patient seen
- **40 units** are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

**Example 5**

**Drug X** is available only in a 100-unit size. An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug.

For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

## Additional Requirements

CR 4229 further instructs your intermediary to:

- Calculate the payment amount and subtract the charge from those submitted to PRICER so that the clotting factor charges are not included in cost outlier computations.

*Payment for Blood Clotting Factors Administered to Hemophilia Inpatients (continued)*

- Use the blood-clotting factors HCPCS codes from the Medicare Part B drug-pricing file, which is made available on a quarterly basis.
- Use the average sales price (ASP) plus six percent to make payment to facilities that are not paid on cost or prospective payment system (PPS).
- Pay a covered for hemophilia clotting factors during a covered part A stay in a PPS hospital at ASP plus six percent in addition to the diagnosis related group (DRG) payment.
- Pay the ambulatory patient classification (APC) rate to outpatient prospective payment system (OPPS) hospitals for hemophilia clotting factors administered in inpatient Part B and outpatient settings.
- Pay for hemophilia clotting factors to beneficiaries based on cost for Part B skilled nursing facility (SNF) services, including inpatient Part B, and all such factors administered by critical access hospitals (CAHs).
- Pay for hemophilia clotting factors based on cost for non-PPS swing bed services.
- **Not** pay a separate add-on under SNF PPS for SNF or swing bed services.

**Note:** Providers should no longer divide the number of units by 100 when billing for clotting factors.

## Implementation

The implementation date for the instruction is July 14, 2006.

## Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R903CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM4229 – Revised
Related Change Request (CR) Number: 4229
Related CR Release Date: April 14, 2006
Related CR Transmittal Number: R903CP
Effective Date: July 14, 2006
Implementation Date: July 14, 2006

Source: CMS Pub. 100-04, Transmittal 903, CR 4229

# 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 the provider education website *http://www.floridamedicare.com*. 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 medical policies 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 website 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 sign on to the provider education website, *http://www.floridamedicare.com*; click on the *eNews*" link on the navigational menu and follow the prompts.

## More Information

For more information, or to obtain a hardcopy of a specific LCD if you do not have Internet access, contact the Medical Policy department at:

Medical Policy – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048
or call 1-904-791-8465

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**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 Website at *http://www.floridamedicare.com*.**

# NEW LCD IMPLEMENTATION

## AJ7504: ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin [Equine])—New LCD

ATGAM is a nonpasteurized, purified, concentrated and sterile gamma globulin, primarily momomeric IgG, from hyperimmune serum of horses immunized with human thymus lymphocytes. ATGAM mainly exhibits immunosuppressive activity; inhibiting cell mediated immune responses, such as allograft rejection and delayed hypersensitivity reactions. ATGAM reduces the number of circulating T lymphocytes measured by the E-rosette inhibition assay.

This local coverage determination (LCD) was developed based on data analysis for HCPCS code J7504. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD. A coding guideline was also developed.

### Effective Date

This LCD is effective for services provided **on or after September 29, 2006.**

The full text for this LCD may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

# ADDITIONS/REVISIONS TO LCDS

## A93798: Cardiac Rehabilitation Programs—Addition to the LCD

The local coverage determination for cardiac rehabilitation programs was last updated on August 18, 2005. Since that time, the national coverage determination indications (NCD Pub. 100-3, Section 20.10) have been expanded based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 4401, dated April 21, 2006.

The LCD was revised to include three additional indications for beneficiaries who: 1) have had heart valve repair/ replacement; 2) have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or 3) have had a heart or heart-lung transplant. The following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

| | |
|---|---|
| V42.1 | Heart replaced by transplant |
| V42.2 | Heart valve replaced by transplant |
| V42.6 | Lung replaced by transplant |
| V43.3 | Heart valve replaced by other means |
| V45.82 | Percutatneous transluminal coronary angioplasty status |

According to the 2006 ICD-9-CM volume 1 and 2, diagnosis codes V42.1, V42.2, V42.6, V43.3 and V45.82 are secondary diagnosis codes and must not be billed as a primary diagnosis.

In addition, language was added for clarity and the window of time during which services must be rendered has been extended.

### Effective Date

These additions are effective for services provided **on or after March 22, 2006.**

The full text for this LCD (L1420) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## ABotulinum Toxins—Revision to the LCD

The local coverage determination (LCD) for botulinum toxins was last revised effective April 4, 2005. This LCD has been revised to expand coverage for botulinum toxin type B (Myobloc®) to include treatment of spasticity caused by stroke or brain injury.

The following ICD-9-CM codes have been added to the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code J0587 (Botulinum toxin type B [Myobloc®]):

| | | |
|---|---|---|
| 342.10–342.12 | 344.00–344.09 | 344.1 |
| 344.2 | 344.30-344.32 | 344.40–344.42 |
| 344.5 | 438.20–438.22 | 438.30–438.32 |
| 438.40–438.42 | 754.1 | |

The "Indications and Limitations of Coverage and/or Medical Necessity" and "Sources of Information and Basis for Decision" sections have been revised accordingly.

In addition, the "Coding Guidelines" LCD attachment has been revised to include information regarding the use of *CPT* codes *46505* and *64650* when performed in conjunction with HCPCS code J0585 (Botulinum toxin type A [Botox®]).

### Effective Date

This revision is effective for services provided **on or after May 11, 2006.**

The full text for this LCD (L1382) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖



## AEPO: Epoetin alfa—Revision to the LCD

The local coverage determination (LCD) for epoetin alfa was last updated on April 1, 2006. Since that time, the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for HCPCS code J0885 (non-ESRD) – 273.3 (Macroglobulinemia) and 285.21 (Anemia in chronic kidney disease). For procedure code J0885 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (Chronic kidney disease, stage V). The coding guideline attachment was revised as appropriate for these changes.

### Effective Date

This revision is effective for services provided **on or after June 29, 2006.**

The revised full text for this LCD (L895) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## AG0104: Colorectal Cancer Screening—Addition to the LCD and Coding Guideline

The local coverage determination (LCD) for colorectal cancer screening was last updated on July 1, 2004. Since that time, the LCD has been revised based on instructions issued in *Change Request 4272, transmittal 821*, dated February 1, 2006. Type of bill (TOB) 14x was added to the list of appropriate types of bill found in the LCD.

In addition, the following statement was added to the coding guideline attachment: Hospitals submitting claims containing HCPCS G0107 (fecal-occult blood tests) and G0328 (immunoassay, fecal-occult blood test) for a nonpatient laboratory specimen should use TOB 14x.

### Effective Date

These additions are effective for services provided **on or after April 1, 2006.**

The full text for this LCD (L1446) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## AINPTPSYCH: Psychiatric Inpatient Hospitalization—Revision to the LCD

The local coverage determination (LCD) for psychiatric inpatient hospitalization was effective January 1, 2006. Since that time, Change Request 5129, Transmittal 39, dated June 9, 2006, implemented changes to the language in the Medicare General Information, Eligibility, and Entitlement Manual, Pub 100-01, Chapter 4, Section 10.9, which will be titled "Inpatient Psychiatric *Facility* Services Certification and Recertification". This language change removes the word 'hospital' and replaces it with 'facility'.

> *First certifications will be required as of the 12th day of hospitalization. Subsequent recertifications will be required at intervals established by the hospital's utilization review committee (on a case-by-case basis), but no less frequently than every 30 days.* Also, effective July, 1, 2006, physicians will also be required to include a statement recertifying that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

Therefore, this LCD has been revised to update the language under the Documentation Requirements section for certifications/recertification's to include these changes.

*AINPTPSYCH: Psychiatric Inpatient Hospitalization—Revision to the LCD (continued)*

### Effective Date

This revision is effective for services provided **on or after July 1, 2006.**

The full text for this LCD (L21632) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## AJ9000: Antineoplastic Drugs—Revision to the LCD

The local coverage determination (LCD) for antineoplastic drugs was last updated on March 1, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section for HCPCS code J9263:

**J9263 (Oxaliplatin)**

- The word "complete" was added in front of "resection of primary tumor" for the FDA approved adjunctive treatment of stage III colon cancer patients, to correspond with the USP DI verbiage.
- Under the off-label indications for Oxaliplatin, added the following indication:
  "Oxaliplatin will be considered as medically necessary in combination with other FDA approved ("on-label") or compendia supported chemotherapy drugs for the treatment of pancreatic carcinoma in accordance to the clinical practice guidelines in oncology – v.1.2006, National Comprehensive Cancer Network (NCCN) protocols."

Under the "ICD-9 Codes that Support Medical Necessity" section, the following additional diagnosis codes were added to HCPCS codes J9045 and J9263:

**J9045 (Carboplatin) for treatment of melanoma**

- 190.6 – Malignant neoplasm of choroid (melanoma of the choroid)
- 197.7 – Secondary malignant neoplasm of liver, specified as secondary (metastatic melanoma to the liver)

**J9263 (Oxaliplatin)**

- 157.0 – 157.9 – Malignant neoplasm of pancreas

The "Sources of Information and Basis for Decision" section was also updated.

These revisions are effective for HCPCS codes J9045 and J9263 for services provided **on or after June 15, 2006.**

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following revisions were made for HCPCS codes J9170 and J9310:

**J9170 (Docetaxel)**

- Added the FDA approved indication for treatment of patients with advanced gastric adenocarcinoma, including adenocarcinoma of the gastroesophageal junction, who have not received prior chemotherapy for advanced disease.

**J9310 (Rituximab)**

- Added the FDA approved indication for rheumatoid arthritis and verbiage of other approved indications based on the FDA label.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following additional diagnosis codes were added to HCPCS code J9310:

**J9310 (Rituximab)**

- 714.0 – Rheumatoid arthritis
- 714.1 – Felty's syndrome (Rheumatoid arthritis with splenoadenomegaly and leukopenia)
- 714.2 – Other rheumatoid arthritis with visceral or systemic involvement

These revisions are effective for the above HCPCS codes J9170 and J9310 for services provided **on or after June 29, 2006**

The full text for this LCD (L1447) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## ANESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to the LCD

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last updated on April 1, 2006. Since that time, the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for HCPCS code J0881 (non-renal) – 273.3 (Macroglobulinemia) and 285.21 (Anemia in chronic kidney disease). For HCPCS code J0881 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (Chronic kidney disease, stage V). The coding guideline attachment was revised as appropriate for these changes.

The indications and limitations section of the LCD was revised based on new FDA-approved labeling information related to dosing for cancer patients with chemotherapy-associated anemia. The recommended starting dose for Aranesp® administered once every three weeks for this indication is 500 mcg.

### Effective Date

This revision is effective for services provided **on or after June 29, 2006.**

The revised full text for this LCD (L13796) is available through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

## ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD

The local coverage determination (LCD) for therapy and rehabilitation services – ATHERSVCS was last updated on April 6, 2006. Since that time, the following changes have been made to the LCD. Change request 4364, dated February 13, 2006 states that contractors shall require providers to document services in accordance with the Centers for Medicare & Medicaid Services Internet only manual (IOM) Pub 100-02, Chapter 15, Section 220.3 and Pub 100-04, Chapter 5, Section 10.2. The language from the IOM appears under the "Documentation Requirements" section of the LCD. In addition to this language the following statement appears: "First Coast Service Options requires that progress reports be documented weekly". After further clarification of the business requirements found in CR 4364, this statement has been removed from the LCD.

### Effective Date

This revision is effective for claims processed on or after May 10, 2006 for services provided **on or after January 1, 2006.**

The full-text for this LCD (L1125) may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date. ❖

# ADDITIONAL MEDICAL INFORMATION

## Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration—Revised

**Note:** This article supersedes an article on this subject matter posted to the provider education website on April 7, 2006, and published in the Third Quarter 2006 *Medicare A Bulletin* (page 72). The only change is in the documentation requirement under the first bullet: The diagnosis of wet AMD (ICD-9-CM code 362.52) with leakage/fluid in the macula must have been confirmed by optical coherence tomography (OCT) or fluorescein angiography, as opposed to fluorescein angiography only, as had been communicated in the previous publication.

Bevacizumab, FDA approved for intravenous use in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The United States Pharmacopeia (USP) supports one unlabeled indication: advanced/metastatic non-squamous non-small cell lung cancer.

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD. Even though the intravitreal administration looks promising and may be cost effective, there are still a number of concerns, specifically about safety.

Currently, publications in peer-reviewed literature are not sufficient to support a positive coverage statement by means of a local coverage determination (LCD).

> **Until appropriately designed and powered studies are published and evaluated, bevacizumab for the treatment of age-related macular degeneration will be considered on an individual case-by-case basis.**

HCPCS code J9035 (injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent.

Providers billing for intravitreal bevacizumab should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina). Documentation in the medical record must support the following:

- The diagnosis of wet AMD (ICD-9-CM code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- The patient does not have any contraindications to bevacizumab.
- The patient has been thoroughly educated about the benefits and risks of this therapy and that it is being used "off-label."
- Actual dose administered.

When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

Providers should not submit additional information with the claim. First Coast Service Options, Inc. may request it separately with an additional documentation request (ADR) letter.

Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. For further details about CMS' Beneficiary Notice Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. ❖

## Self-Administered Drugs—Addition to the List

The Center for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the CMS Pub-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.2.

Effective for services provided **on or after September 1, 2006,** the following drugs have been added to the Florida Part A self-administered drug (SAD) list.

- J3110 Injection, teriparatide, 10 mcg (Forteo®)
- J2354 Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg (Sandostatin®)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The SAD list may be viewed in its entirety at *http://www.floridamedicare.com*. ❖

# CRITICAL ACCESS HOSPITAL SERVICES

## Billing of Temporary "C" HCPCS Codes by Non-Outpatient Prospective Payment System Providers

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

### Provider Types Affected

Outpatient prospective payment system (OPPS) and non-OPPS providers billing Medicare fiscal intermediaries (FIs) for hospital outpatient department services and procedures

### Provider Action Needed

### STOP – Impact to You

This article is based on change request (CR) 5027, which revises the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 20.7, Billing of 'C' HCPCS Codes by Non-OPPS Providers).

### CAUTION – What You Need to Know

CR 5027 gives non-OPPS providers the option of billing under a C-code or an appropriate *CPT* code. CR 5027 does not change existing requirements when non-OPPS provider claims require the use of a *CPT* or HCPCS code.

### GO – What You Need to Do

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

### Background

**The Evolution of C-Codes**

The Centers for Medicare & Medicaid Services (CMS) established temporary Healthcare Common Procedure Coding System (HCPCS) C-codes to permit implementation of the Balanced Budget Refinement Act of 1999 (BBRA, Section 201B).

C-codes are unique temporary pricing codes established by CMS for the PPS and are only valid for Medicare on claims for hospital outpatient department services and procedures.

Prior to October 1, 2006, C-codes could not be used to bill services payable under other payment systems, and they were used exclusively by hospitals subject to OPPS to identify:

- Items that may have qualified for transitional pass-through payment under OPPS.
- Items or services for which an appropriate HCPCS code did not exist for the purposes of implementing the OPPS.

Since they were originally established by CMS, C-codes have evolved and they now also target uniquely hospital services that may be provided by:

- OPPS providers
- Other providers
- Providers paid under other payment systems.

Non-OPPS providers subsequently requested the option to bill using C-codes or appropriate *Current Procedure Terminology (CPT)* codes.

**Using C-Codes**

In response to this request, CMS is issuing CR 5027, which instructs that (effective October 1, 2006) the following non-OPPS providers may elect to bill using C-codes (or appropriate *CPT* codes) on type of bills (TOBs) 12x, 13x, or 85x:

- Critical access hospitals (CAHs)
- Indian health service hospitals (IHS)
- Hospitals located in American Samoa, Guam, Saipan, or the Virgin Islands
- Maryland waiver hospitals.

**Note:** Claims will be returned to the provider that contain a temporary C-code when billed on TOB 85x with revenue codes 96x, 97x, or 98x.

Note that method I and method II CAHs:

- Are limited to using C-codes to bill for facility (technical) services
- Method II CAHs should not use C-codes to bill for professional services with revenue codes 96x, 97x, or 98x.

**Payment Methodology is Unchanged**

CR 5027 is not changing the payment methodology for OPPS and non-OPPS providers:

- OPPS providers will continue to receive pass-through payment on items or services that qualify for pass-through payment.
- Non-OPPS providers:
  - Are not eligible for pass through payments.
  - Will be paid under their normal payment methodologies
  - Should comply with all existing requirements when claims require the use of a HCPCS or *CPT* code.

Effective October 1, 2006, processing note 0093 will be updated as follows:

> *"C-codes are unique temporary pricing codes that were initially established by CMS for the Hospital Outpatient Prospective Payment System (OPPS). The C-codes are used on Medicare OPPS claims but may also be recognized on claims from other providers or by other payment systems."*

***Billing of Temporary "C" HCPCS Codes by Non-Outpatient Prospective Payment System Providers (continued)***

**Note:** C-codes may be replaced with permanent codes. Whenever a permanent code is established to replace a temporary code, the temporary code is deleted and cross-referenced to the new permanent code. Upon deletion of a temporary code, OPPS and non-OPPS providers shall bill using the new permanent code.

### Implementation

The implementation date for CR 5027 is October 2, 2006.

### Additional Information

Providers are encouraged to access the CMS website to view the quarterly HCPCS Code updates on the CMS website at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/*.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R976CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5027
Related Change Request (CR) Number: 5027
Related CR Release Date: June 9, 2006
Related CR Transmittal Number: R976CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 976, CR 5027



## Anesthesia and Ambulance Services in Critical Access Hospital

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

**Note:** CMS has revised this MLN Matters article on July 18, 2006, to reflect more recent instructions issued to Medicare fiscal intermediaries (FI). Please review the article to learn about these instructions. This article was originally published in the July 2006 *Medicare A Bulletin* (page 47).

### Provider Types Affected

Providers submitting claims to Medicare FIs for critical access hospital (CAH) anesthesia and ambulance services provided to Medicare beneficiaries

### Impact on Providers

This special edition article is based on recent instructions from the Centers for Medicare & Medicaid Services (CMS) to your FI to hold the following until errors with Medicare's Fiscal Intermediary Shared System (FISS) are corrected on June 5, 2006:

- All CAH method II claims that have revenue code 0964 (CRNA professional services) and anesthesia *CPT* code range *00100-01999*.
- All CAH claims with revenue codes 054x (ambulance services).

The FISS is used by FIs to process your claims.

**However, the FISS system was NOT corrected by June 5 and will NOT be corrected until September 4, 2006.**

### Background

Recently, CMS became aware of these two CAH claims processing issues:

1. CAH method II claims **are reimbursing at an incorrect rate** when the claims have both:
   - **Revenue code 0964** (certified registered nurse anesthetist [CRNA] professional services)
   - Anesthesia Healthcare Common Procedure Coding System (HCPCS) codes *00100-01999*
2. All CAH claims with ambulance services (revenue codes 054x) are suspending because the **line level coinsurance total does not match the claim level coinsurance.**

Until the appropriate corrections are made to Medicare's systems, affected claims will be handled as follows:

- On CAH method II claims with revenue 0964 (Professional fees, anesthetist (CRNA)): FIs will change revenue code from 0964, used to bill CRNA services, to revenue code 0379 (Other anesthesia). This will allow the correct reimbursement to be calculated. Once Medicare's FISS system is changed, CRNA services can again be processed under 0964.
- All CAH claims with ambulance services (revenue codes 054): your FI will return these claims to you, asking that you remove the ambulance charges from the claim and submit a separate bill with just the ambulance charges for payment.

Providers can resume billing both services on a single claim once the FISS system is modified **on or about September 4, 2006.**

### Additional Information

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

***Anesthesia and Ambulance Services in Critical Access Hospital (continued)***

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: SE0631 Revised
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 SE0631



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# CORF SERVICES

## Special Issues Associated with the Advance Beneficiary Notice for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities

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

### Provider Types Affected

Hospices and comprehensive outpatient rehabilitation facilities (CORFs) billing Medicare fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs) for services

### Background

Before July 2005, the only limitation of liability (LOL) notice given to beneficiaries in original Medicare in hospices was the advance beneficiary notice (ABN). The updated instructions in CR 5117 offer more specific language for hospice providers to alert them when an ABN is appropriate and it gives them model language to use for specific cases. It also clarifies ABN use by CORFs.

This language is authorized by section 1879 of the Social Security Act (the Act) and specifically under regulations at 42 CFR 411-404.

LOL notices are required under section 1879 of the Act in order to hold beneficiaries liable for certain noncovered services.

The revised Sections 50.9 and 50.9.1 of Chapter 30 of the *Medicare Claims Processing Manual* – Financial Liability Protections – are attached to CR 5117 and the Centers for Medicare & Medicaid Services (CMS) Web address for CR 5117 is listed in the *Additional Information* section of this article.

### Key Points

Section 1879 of the Social Security Act requires that providers give beneficiaries notice of their liability of noncovered care. The following information, excerpted from the revised *Medicare Claims Processing Manual* sections, helps guide hospice providers in fulfilling that requirement.

**From Chapter 30, Section 50.9 – Special Issues Associated with the ABN for Hospices**

**I. General Use**

There are three situations in which hospice services may be denied that could trigger liability protection under section 1879 of the Act:

1. Ineligibility because the beneficiary is not "terminally ill" as defined in section 1879 (g)(2) of the Act.
2. Specific item(s) and/or service(s) that are billed separately from the hospice payment, such as physician services, were not reasonable and necessary defined in either section 1862(a)(1)(A) or section 1862(a)(1)(C).
3. The level of hospice care is determined not reasonable or medically necessary as defined in section 1862(a)(1)(A) or section 1862(a)(1)(C) specifically for the management of the terminal illness and related conditions.

**Note:** Regarding number three, CMS payment policy requires that the provider, not the beneficiary, absorb liability, if any, resulting from a change in level of care made during claim adjudication. Also, since providers are billing what they believe to be a covered level of care, there would be no anticipation of noncoverage in these cases. Therefore, this case would never involve delivery of an ABN to a hospice beneficiary.

**Examples of Approved Language**

Examples of approved language for Box 1, "Items or Services," and Box 2, "Because", on the ABN, under each of the other two conditions where an ABN would be required are the following:

**A.** Ineligibility for the Hospice Benefit:

- Box 1: "The Medicare hospice benefit"
- Box 2: "The documentation submitted does not support that your illness is terminal."

**B.** Item(s) or Service(s) not Medically Necessary:

- Box 1: "Physician services from other than your attending physician"
- Box 2: "According to Medicare hospice requirements, this service is not covered because it was provided by a nonattending physician."
- Box 1: "Surgical removal of a cataract."
- Box 2: "This service is not covered because you are enrolled in a hospice."

**II. Beneficiaries Who Have Elected the Hospice Benefit and Receive Care in Another Facility Not Authorized by the Hospice Provider**

When a beneficiary who has elected the hospice benefit accesses an inpatient setting that has not been arranged by the hospice provider, it is the hospice's responsibility to inform the beneficiary of his liability with an ABN, as required by the instructions.

For example:

- If a hospice beneficiary is in a hospital under contract with the hospice for general inpatient care, and the beneficiary decides to stay in the hospital after the hospice provider tells the beneficiary this level of care is no longer required and the beneficiary chooses not to revoke the hospice benefit, it is the hospice provider's responsibility to see that the beneficiary receives an ABN or comparable liability notice with notification of costs, such as room and board, for which the beneficiary will be financially liable.

*Special Issues Associated with the Advance Beneficiary Notice for Hospice Providers and CORF (continued)*

- It is permissible for the hospice to arrange in advance that the hospital will give applicable notice in such cases, especially if the hospital will be billing for the noncovered care. Where hospices issue the ABN, HINNs (hospital issued notices of noncoverage) are issued by hospitals for inpatient hospitals stays.
- If, however, the beneficiary revokes the hospice benefit while in an inpatient setting, it becomes that facility's responsibility alone as the rendering provider, subsequent to the end of hospice care, to give the appropriate liability notice.

For example:

- If a hospice beneficiary enters a hospital and revokes the hospice benefit during the hospital stay, the hospital would then become responsible for notifying the beneficiary with a HINN if the hospital stay was not covered.
- The hospital is responsible for giving the HINN to the beneficiary according to applicable instructions since the facility has become the provider of care.

**III. When ABNs Are Not Required for Hospice Service Revocations**

Hospice beneficiaries or their representatives as defined by regulation, can revoke the hospice benefit. Revocations are not considered terminations under liability notice policy since the beneficiary is exercising his/her own freedom of choice. Therefore, no ABN is required.

**Respite Care**

No mandatory notification is required when respite care exceeds five consecutive days, because payment for respite care is limited to this period under the Act.

Respite care on the sixth consecutive day is therefore considered outside the definition of the hospice benefit, and the hospice provider is not required to issue an ABN.

However, CMS encourages hospice providers to give the notice of exclusions from Medicare benefits (NEMB) to notify patients of possible financial liability in such cases. The *Medicare Claims Processing Manual, C*hapter 30, Section 90, provides NEMB instructions and states that: "NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions."

**Transfers**

A beneficiary is only allowed one transfer to another hospice during a benefit period. A second transfer is not allowed. In either case, an ABN is not required.

**Noncovered Care Outside the Hospice Benefit**

Hospice providers may choose to give services such as palliative care that Medicare does not cover to beneficiaries who have not elected hospice. In such cases, Medicare does not require an ABN to be issued.

However, CMS encourages hospice providers to give advance voluntary notice to beneficiaries of possible financial liability when it exists in these cases. The NEMB may be used for this purpose.

**Special Issues Associated with ABNs and Expedited Determinations for Hospices and CORFs**

Since July 2005, beneficiaries in original Medicare whose Medicare-covered services are being terminated for reasons related to coverage in hospices or CORFs have access to an expedited review process. This affects the use of ABNs for terminations of covered care.

In the past, hospice providers and CORFs would have only used the general ABN for all terminations where the beneficiary faced financial liability. Now hospice providers and CORFs will be required to issue the **Notice of Medicare Provider Non-Coverage (generic notice)** under the expedited review process for termination when covered care is ending for coverage reasons.

Hospice providers and CORFs will also issue the ABN in addition to the expedited notice at terminations only when they continue to provide care to the beneficiary on a noncovered basis after the date Medicare coverage ends.

**Note:** Hospice providers and CORFs are not required to use the ABN to inform beneficiaries in original Medicare of potential financial liability when terminations of covered care occur for reasons unrelated to coverage. An example is when care is terminated due to hospice staff safety issues in the beneficiary home. These providers may, however, use the NEMB for voluntary notification in such cases, and CMS recommends that providers always ensure that beneficiaries understand that care will be discontinued when this occurs.

## Implementation

The implementation date for the instruction is September 29, 2006.

## Additional Information

The official instructions issued to your Medicare FI or RHHI regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R994CP.pdf*.

The revised Section 50.9 and 50.9.1 of Chapter 30 of the *Medicare Claims Processing Manual* – Financial Liability Protections – are attached to CR 5117.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5117
Related Change Request (CR) Number: 5117
Related CR Release Date: June 30, 2006
Related CR Transmittal Number: R994CP
Effective Date: September 29, 2006
Implementation Date: September 29, 2006

Source: CMS Pub. 100-04, Transmittal 994, CR 5117

# Therapy Caps Exception Process

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

**Note:** CMS has revised this MLN Matters article on July 3, 2006, to modify the transmittal number and Web address for the change made to the Medicare Benefit Policy Manual. All other information remains the same. This article was originally published in the Third Quarter 2006 *Medicare A Bulletin* (pages 104-106).

## Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

## Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

  Outpatient rehabilitation services include:

  - **Physical therapy –** including outpatient speech-language pathology: Combined annual limit for 2006 is $1,740.
  - **Occupational therapy –** annual limit for 2006 is $1,740.

- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

  You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.
- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

## Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of $1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

## Additional Information

### Billing Guidelines

- **Modifier KX –** You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests –** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care –** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.

***Therapy Caps Exception Process (continued)***

- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

**ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity**

CR 4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.

You may wish to bookmark that link so you may easily reference these codes.

**Documentation**

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02 Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR 4364. CR 4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf*.
- The *Medicare Claims Processing Manual*, located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** – 1-2 documents.
2. **Certification** – Physician/NPP approval of the plan required 30 days after initial treatment or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The treatment encounter note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for progress reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.
5. **For therapy caps exceptions purposes,** records justifying services over the cap, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf* for more details about the types of documentation required and explanations of what that documentation should contain. When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary.
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation.
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service.
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

## Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

***Therapy Caps Exception Process (continued)***

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

**Note:** If your Medicare contractor does not make a decision within 10 business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed approved as medically necessary for the number of future visits requested (not to exceed 15).

### Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR 4364. The examples include:

- Letter #1 – Approved
- Letter #2 – Negative Decision-Medical Necessity
- Letter #3 – Denied-Insufficient Documentation

**Revised Medicare Summary Notice (MSN) Messages**

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR 4364.

Once again, there are three transmittals that comprise CR 4364. They are:

- The *Medicare Benefit Policy Manual* revision on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf*.
- The *Medicare Claims Processing Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

If you have any questions, contact your Medicare contractor at their toll free number, which is available on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM4364 – Revised
Related Change Request (CR) Number: 4364
Related CR Release Date: February 15, 2006
Related CR Transmittal Number: R52BP, R140PI, R855CP
Effective Date: January 1, 2006
Implementation Date: No later than March 13, 2006

Source: CMS Pub. 100-2, Transmittal 52 CR 4364



## Changes Conforming to Change Request 3648 for Therapy Services

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

**Note:** CMS has revised this MLN Matters article on June 15, 2006, to reflect changes made to change request (CR) 4014, which was reissued on June 14, 2006. The transmittal number, CR release date and the Web address for viewing CR 4014 were revised. All other information remains the same. This article was originally published in the July 2006 *Medicare A Bulletin* (pages 50-51).

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for therapy services

### Provider Action Needed
### STOP – Impact to You

This article is based on change request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term "speech therapy" to "speech-language pathology."

### CAUTION – What You Need to Know

To conform to changes in CR 3648, CR 4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist.

Requirements for therapy services incident to a physician have not been changed.

### GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

### Background

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and

***Changes Conforming to Change Request 3648 for Therapy Services (continued)***

the *Medicare Claims Processing Manual* (Publication 100-04) as follows: The term "speech therapy" is being changed to "speech-language pathology."

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR 3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR 3648 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf*.

The Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer's adjudication process:

- Date last seen; and
- The unique provider identification number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided "incident to" the services of a physician or nonphysician practitioner (NPP), in which this case it is required. CR 4014 updates instructions in CR 3648 (related to claims for services "incident to" a physician's/NPP's service) by acknowledging that:

- The "incident to" service may be identified only on prepay or postpay review.
- Manual review of all therapy claims is not required.
- "Incident to" policies have not changed and still apply to therapy services.

CR 4014 also clarifies selected business requirements in CR 3648 to indicate that some contractor actions:

- Will occur on prepay or postpay review. For example, compare the following:
  - Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with
  - BR 4014.8 – On prepay or postpay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.
- Should not be applied to services "incident to." (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review).

CR 3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed "incident to" a physician.

Therefore, when a therapy service is billed "incident to," the following requirements remain in effect because they are required by "incident to" policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

## Implementation

The implementation date for this instruction is October 2, 2006.

## Additional Information

CR 3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230, Therapy Services) may be reviewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf*.

The MLN Matters article, MM3648 may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf*.

For complete details, please see the official instructions (CR 4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR 4014, the NCD, transmittal 55 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf*.

Transmittal 980 is the *Medicare Claims Processing Manual* update, which is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R980CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM4014 – Revised
Related Change Request (CR) Number: 4014
Related CR Release Date: June 14, 2006
Related CR Transmittal Number: R980CP and R55NCD
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 980, CR 4014

# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## July 2006 Update of the Hospital Outpatient Prospective Payment System—Summary of Payment Policy 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 fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the OPPS.

### Impact on Providers

This article is based on change request (CR) 5121, which describes changes to the OPPS to be implemented in the July 2006 OPPS update.

### Background

CR 5121 describes changes to the hospital outpatient prospective payment system (OPPS) to be implemented in the July 2006 OPPS update. The July 2006 OPPS outpatient code editor (OCE) and OPPS PRICER reflects the Healthcare Common Procedure Coding System (HCPCS) and ambulatory payment classification (APC) additions, changes, and deletions identified in CR 5121.

In addition, the July 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in CR 5065, "July 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.2." CR 5065 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R970CP.pdf*.

Key changes in CR 5121 are as follows:

**1. Category III *CPT* Codes**

The American Medical Association (AMA) releases category III *Current Procedural Terminology (CPT)* codes in:

- January, for implementation beginning the following July
- July, for implementation beginning the following January.

Prior to calendar year (CY) 2006 CMS implemented new category III CPT codes once a year, in January.

As stated in the November 10, 2005 final rule (with comment period (70 FR 68567) for CY 2006; *http://www.access.gpo.gov/su_docs/fedreg/a051110c.html*), CMS has modified the process for implementing the category III codes that the AMA releases each January for implementation in July.

**Note:** Beginning July 1, 2006, the OCE will recognize tracking codes that AMA implements in July, rather than deferring recognition until the following January.

The following seven category III *CPT* codes (that the AMA released in January 2006 for implementation in July 2006) will be reportable for services furnished on or after July 1, 2006. The codes, along with their status indicators and ambulatory payment classifications (APCs), are shown in the following table.

**Category III *CPT* Codes Implemented in July 2006**

| HCPCS Code | Long Descriptor | SI | APC | Payment Rate | Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| *0155T* | *Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)* | T | 0130 | $1,896.93 | $379.39 |
| *0156T* | *Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)* | T | 0130 | $1,896.93 | $379.39 |
| *0157T* | *Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)* | C | | | |
| *0158T* | *Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)* | C | | | |
| *0159T* | *Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI* | | | | |
| *0160T* | *Therapeutic repetitive transcranial magnetic stimulation treatment planning* | X | 0340 | $36.52 | $7.30 |
| *0161T* | *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session* | X | 0340 | $36.52 | $7.30 |

*July 2006 Update of the Hospital OPPS —Summary of Payment Policy Changes (continued)*

**2. Replacement of Upgraded Devices with Full Credit for the Replaced Device**

Occasionally, recalled or defective devices are replaced with an upgraded device and the cost to the hospital of the upgraded device is greater than the cost of the replaced device. The device manufacturer may give the hospital a credit for the sales price of the device being replaced. The hospital may then have to pay the manufacturer for the difference in the prices of the two devices and hospitals have asked how to bill Medicare for these differences.

The hospital should report the following:

- The HCPCS code for the upgraded device being implanted.
- Condition code 50 denoting "Product Replacement for Known Recall of a Product—Manufacturer or the Food and Drug Administration has identified the product for recall and therefore replacement."
- Report the charge for the upgraded replacement device that equals the difference between its usual charge for the replaced device and its usual charge for the upgraded device.

**Note:** Do not report modifier FB because the device is not being furnished without cost by the manufacturer.

**3. Drugs and Biologicals**

**a) Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective July 1, 2006**

The CY2006 OPPS final rule (70 FR 68643; *http://www.access.gpo.gov/su_docs/fedreg/a051110c.html*) stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the July 2006 release of the OPPS PRICER. The updated payment rates effective July 1, 2006 will be included in the July 2006 update of the OPPS Addendum A and Addendum B, which will be posted at the end of June on the CMS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*.

**b) Newly-Approved Drugs Eligible for Pass-Through Status**

The following drugs have been designated as eligible for pass-through status under the OPPS effective July 1, 2006. Payment rates for these items can be found in the July 2006 update of OPPS Addendum A and Addendum B, which will be posted on the CMS website at the end of June.

| HCPCS Code | APC | SI | Long Description |
|---|---|---|---|
| C9229 | 9229 | G | Injection, ibandronate sodium, per 1 mg |
| C9230 | 9230 | G | Injection, abatacept, per 10 mg |

**c) Payment for New, Unclassified Drugs or Biologicals Approved by the Food and Drug Administration (FDA) before January 1, 2004, but before Assignment of a Product-Specific Drug/Biological HCPCS Code**

CR 3287, Transmittal 188, dated May 28, 2004, (*http://www.cms.hhs.gov/transmittals/Downloads/R188CP.pdf*) requires hospitals to report C9399 to bill for new drugs and biologicals that were approved by the FDA on or after January 1, 2004, for which pass-through status had not been approved and a C-code and APC payment are not assigned. Medicare Contractors should not allow payment for any drugs billed using C9399 for which FDA approval was granted before January 1, 2004. Information on approval dates is available at *http://www.fda.gov*.

**d) Payment Rates for Tetanus and Diphtheria Vaccine Effective July 1, 2005, through December 31, 2005**

The payment rates for these vaccines were not included in the April 2006 OPPS PRICER, but are included in the July 2006 OPPS PRICER. For *CPT* codes *90714*, APC 1634 (Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use), the payment rate for this period is $17.81 and the minimum unadjusted copayment is $3.56.

Medicare FIs/RHHIs will adjust as appropriate claims you bring to their attention that meet all of the following conditions:

- Were incorrectly paid for services furnished on or after July 1, 2005 through December 31, 2005.
- Were processed by the FI/RHHI before the installation of the July 2006 OPPS PRICER with updated ASP payment rates.
- Contain *CPT* code *90714*.

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 descriptor.

For 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 four.

**Note:** Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. If the HCPCS 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.

HCPCS short descriptors are limited to 28 characters (which includes 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.

*July 2006 Update of the Hospital OPPS —Summary of Payment Policy Changes (continued)*

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from the CMS website at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage*.

**Note:** Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

4. **Overpayment of Certain Blood Products**
Effective for dates of service on or after July 1, 2005, providers should report charges for processing/storage of blood (revenue code 39x) when they also report a charge for blood or blood products under revenue code 38x. PRICER determines a ratio of the total 38x charges to the combined 38x-39x charges.
This allows PRICER to pay each line according to the respective blood portion so that only one APC payment is made per unit. CMS recently discovered that the OPPS PRICER is only computing this ratio for blood products to which the blood deductible applies, and not for all blood products.
This means that PRICER is overpaying what it should on revenue code 38x-39x line pairs for HCPCS codes: P9011, P9012, P9017, P9019, P9020, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9043, P9044, P9048, P9050, P9053, P9055, P9059, and P9060. Claims for dates of service on or after July 1, 2005, will be mass adjusted by the FIs to recover these overpayments.

5. **Error in CR3681 Regarding Use of Bill Type 12x to Bill Blood and Blood Products**
CR 3681 incorrectly listed bill type 12x as a bill to be used for blood and blood products under the OPPS. However, blood and blood products cannot be billed on the type of bill 12x because blood and blood products, like drugs, are covered as incident to a physician's service when furnished in a hospital outpatient department and cannot be paid when the service is furnished to a hospital inpatient, notwithstanding that the beneficiary has exhausted Part A benefits (the circumstance where type of bill 12x is used).

6. **Modification to the Long Descriptor for C8952**
To clarify the current policy for drug administration, effective July 1, 2006, CMS is modifying the long descriptor for C8952 as shown in the following table:

**Old HCPCS Long Descriptor for HCPCS code C8952:**
Therapeutic, prophylactic or diagnostic injection; intravenous push
New HCPCS Long Descriptor for HCPCS code C8952:
Therapeutic, prophylactic or diagnostic injection; intravenous push of each new substance/drug

7. **Revised Descriptors for C1767**
As a reminder, the revised long descriptor for C1767 is "Generator, neurostimulator (implantable), nonrechargeable" and the revised short descriptor is "Generator, neuro nonrecharge."

8. **Payment for *CPT* code *20979*, Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)**
Effective for services furnished on or after July 1, 2006, *CPT* code *20979* is assigned to APC 0340, minor ancillary procedures, with status indicator "X" under OPPS.

9. **Payment for Certain Pathology Services**
Effective for services furnished on or after the dates listed in the table below, *CPT* codes listed in the following table are assigned to APC 0342, level I pathology, with status indicator "X" under OPPS:

| *CPT* Code | Long Descriptor | Effective Date |
|---|---|---|
| *81099* | *Unlisted urinalysis procedure* | 08/01/00 |
| *84999* | *Unlisted chemistry procedure* | 08/01/00 |
| *85999* | *Unlisted hematology and coagulation procedure* | 08/01/00 |
| *86849* | *Unlisted immunology procedure* | 08/01/00 |
| *87999* | *Unlisted microbiology procedure* | 08/01/00 |
| *88199* | *Unlisted cytopathology procedure* | 10/01/00 |
| *88399* | *Unlisted surgical pathology procedure* | 10/01/00 |
| *89240* | *Unlisted miscellaneous pathology test* | 01/01/04 |

10. **Coverage Determinations**
The fact that a drug, device, procedure, or service is assigned an 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.

Fiscal intermediaries (FIs) determine whether a drug, device, procedure, or service meets all program requirements for coverage. For example:

- That the drug, device, procedure, or service is reasonable and necessary to treat the beneficiary's condition; and
- Whether the drug, device, procedure, or service is excluded from payment.

CR 5121 further instructs your intermediary to:

- Not allow payment for any drugs billed using C9399 for which FDA approval was granted before January 1, 2004.
- Check the FDA's website at *http://www.fda.gov/* to obtain the information on the FDA approval dates.
- Adjust as appropriate claims brought to their attention:
  - Whose dates of service fall within the timely filing limit; and
  - That contain at least one of the following HCPCS codes:

*July 2006 Update of the Hospital OPPS —Summary of Payment Policy Changes (continued)*

| ***CPT* Code** | **Long Descriptor** |
|---|---|
| *81099* | *Unlisted urinalysis procedure* |
| *84999* | *Unlisted chemistry procedure* |
| *85999* | *Unlisted hematology and coagulation procedure* |
| *86849* | *Unlisted immunology procedure* |
| *87999* | *Unlisted microbiology procedure* |
| *88199* | *Unlisted cytopathology procedure* |
| *88399* | *Unlisted miscellaneous pathology test* |
| *89240* | *Unlisted miscellaneous pathology tes*t |

- Mass adjust claims that meet all of the following conditions:
  - Were incorrectly paid for services furnished on or after July 1, 2005 through June 30, 2006.
  - Were processed before the installation of the July 2006 OPPS PRICER
  - Contain any of the following HCPCS codes:

| **HCPCS Code** | **Descriptor** |
|---|---|
| P9011 | Blood (split unit) |
| P9012 | Cryoprecipitate |
| P9017 | Fresh frozen plasma (single donor) frozen within 8 hrs |
| P9019 | Platelet concentrate |
| P9020 | Platelet rich plasma P9048 Infusion, plasma protein fraction (human) 5% |
| P9023 | Plasma, pooled multiple donor, solvent/ detergent treated, frozen |
| P9031 | Platelets, leukocytes reduced |
| P9032 | Platelets, irradiated P9055 Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis |
| P9033 | Platelets, leukocytes reduced, irradiated |
| P9034 | Platelets, pheresis |
| P9035 | Platelets, pheresis, leukocytes reduced |
| P9036 | Platelets, pheresis, irradiated |
| P9037 | Platelets, pheresis, leukocytes reduced, irradiated |
| P9043 | Infusion, plasma protein fraction (human), 5% |
| P9044 | Plasma, cryoprecipitate, reduced |
| P9050 | Granulocytes, pheresis |
| P9053 | Platelets pheresis, leukocytes reduced, CMV-negative, irradiated |
| P9059 | Fresh frozen plasma, between 8-24 hours of collection |
| P9060 | Fresh frozen plasma, donor retested |

## Implementation

The implementation date for the instruction is July 3, 2006.

## Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R970CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5121
Related Change Request (CR) Number: 5121
Related CR Release Date: May 30, 2006
Related CR Transmittal Number: R970CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Source: CMS Pub. 100-04, Transmittal 970, CR 5121

# PROVIDER AUDIT ISSUES

## Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under Demonstration

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

### Provider Types Affected

Rural hospitals participating under the demonstration authorized by section 410A of the Medicare Modernization Act (MMA) that bill Medicare fiscal intermediaries (FIs) for their services

### Key Points

- The Centers for Medicare & Medicaid Services (CMS) has changed the method of reimbursement for inpatient services for rural hospitals participating under the demonstration authorized by section 410A of the Medicare Modernization Act (MMA) by changing the way interim payments are calculated and administered for the project. Change request (CR) 5020 provides further instructions on the settlement process for the first and second years of the demonstration.
- CR 5020 applies **only** for the 13 identified demonstration hospitals as shown in Tables A and B of this article. As shown in CR 5020, the reasonable cost payment will apply to the four hospitals that discontinued participation in the demonstration for the period during which they did participate.
- For specific information relating to the calculation and payment methodology and administration of the interim payments for rural hospitals participating under the demonstration authorized by section 410A of the MMA, please refer to "*Attachment A – Payment Methodology for Years 2 through 5*" and to the *Business Requirements* attached to CR 5020.

### Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) mandates a demonstration that establishes rural community hospitals.

Eligible rural community hospitals are located in a rural area, have fewer than 51 acute care beds, make available 24-hour emergency services, and are not eligible for critical access hospital designation. Thirteen hospitals participated in the first year of the demonstration. Of these, four terminated their participation in December 2005.

### Additional Information

CR 5020 is the official instruction issued to your FI regarding changes mentioned in this article, MM5020. CR 5020 may be found by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R45DEMO.pdf*.

Please refer to your local FI if you have questions about this issue. To find your FI toll-free phone number, go to the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

### Appendix A

**Table A: Currently participating hospitals selected for the demonstration and their fiscal intermediaries**

| Provider No. | Hospital Name | City, State | Contractor Number | Contractor Name | Cost Report End Date |
|---|---|---|---|---|---|
| 20024 | Central Peninsula General Hospital | Soldotna, Alaska | 430 | Noridian | 6/30 |
| 20008 | Bartlett Regional Hospital | Juneau, Alaska | 430 | Noridian | 6/30 |
| 270002 | Holy Rosary Healthcare | Miles City, Montana | 250 | BCBS of Montana | 5/31 |
| 270032 | Northern Montana Hospital | Havre, Montana | 250 | BCBS of Montana | 6/30 |
| 280111 | Columbus Community Hospital | Columbus, Nebraska | 52280 | Mutual of Omaha | 4/30 |
| 290006 | Banner Churchill Community Hospital | Fallon, Nevada | 52280 | Mutual of Omaha | 12/31 |
| 320013 | Holy Cross Hospital | Taos, New Mexico | 400 | Trailblazers | 5/31 |
| 430048 | Lookout Memorial Hospital | Spearfish, South Dakota | 11 | Cahaba | 6/30 |
| 460033 | Garfield Memorial Hospital | Panguitch, Utah | 350 | Noridian | 12/31 |

*Method of Cost Settlement for Inpatient Services for Rural Hospitals Participating Under Demonstration (continued)*

**TABLE B: Hospitals that withdrew from the demonstration in December 2005**

| Provider No. | Hospital Name | City, State | Contractor Number | Contractor Name | Cost Report End Date |
|---|---|---|---|---|---|
| 280117 | Tri-County Area Hospital District | Lexington, Nebraska | 260 | BCBS of Nebraska | 6/30 |
| 280054 | Beatrice Community Hospital and Health Center | Beatrice, Nebraska | 52280 | Mutual of Omaha | 9/30 |
| 280108 | Phelps Memorial Health Center | Holdrege, Nebraska | 260 | BCBS of Nebraska | 12/30 |
| 280021 | Community Hospital | McCook, Nebraska | 260 | BCBS of Nebraska | 6/30 |

**Note:** Hospitals in Table B will undergo audit and cost report settlement for the period during which they participated in the demonstration. However, since the hospitals will not continue to participate, their settlement amounts will not be used to calculate payment amounts for future years.

Source: CMS Pub. 100-19, Transmittal 45, CR 5020

# THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## Ending the HIPAA Contingency for Remittance Advice

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

### Provider Types Affected

All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers [DMERCs], DME Medicare administrative contractors [DME MACs], and fiscal intermediaries (FIs), including regional home health intermediaries [RHHIs])

### What You Need to Know

Effective October 1, 2006, Medicare will send only HIPAA-compliant electronic remittance advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

### Background

In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance.
- Assess the readiness of their provider communities.
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying noncompliant electronic claims.

Now, CMS is moving to end the contingency plan for ERA transactions. Currently, 99 percent of all ERA receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May 2006, was 96 percent. (The rate for professional providers was 97 percent and for institutional providers was 93 percent.)

Therefore, CMS announces that, **effective October 1, 2006,** it will end the contingency plan for the remittance advice transaction.

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

### Additional Information

You may find more information about HIPAA on the CMS website at *http://www.cms.hhs.gov/HIPAAGenInfo/*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: SE0646
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 SE0646



## Important News Regarding HIPAA Contingency for Remittance Advice

The Centers for Medicare & Medicaid Services (CMS) has announced that its contingency plan for the HIPAA compliant transaction 835, or electronic remittance advice, will expire on **October 1, 2006**. A special edition *MLN Matters* article has been developed to help the Medicare fee-for-service provider community prepare for this change.

You may access article on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0646.pdf.*

This *MLN Matters* article is being published on this page of the August 2006 Medicare Part A Bulletin. ❖

Source: CMS Provider Education Resource 200607-06

# 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

Physicians, providers, and suppliers who submit health care claim status transactions to Medicare contractors (carriers, durable medical equipment regional carriers [DMERCs], fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs])

### Provider Action Needed

### STOP – Impact to You

This article is based on change request (CR) 5137, which provides the October 2006 updates of the claim status codes and claim status category codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

### CAUTION – What You Need to Know

Medicare contractors are to use codes with the "**new as of 10/06**" designation and prior dates, and they must inform affected providers of the new codes. CR 5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7, Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

### GO – What You Need to Do

Please refer to the *Background* section of this article for further details.

### Background

Claim status category codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). Further detail is provided by the claim status code(s).

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use claim status category and claim status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the version 004010X093A1 health care claim status request and response transaction.

The Health Care Code Maintenance Committee maintains the claim status category and claim status codes. The Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

**Note:** The updated claim status category and claim status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company website at *http://www.wpc-edi.com/codes*.

At this website, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this website approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

### Implementation

The implementation date for this instruction is October 2, 2006.

### Additional Information

For complete details, please see CR 5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article.

CR 5137 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 1-877-602-8816.

MLN Matters Number: MM5137
Related Change Request (CR) Number: 5137
Related CR Release Date: June 23, 2006
Related CR Transmittal Number: R987CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Source: CMS Pub. 100-04, Transmittal 987, CR 5137

# EDUCATIONAL RESOURCES

## Medicare Learning Network Products for Providers

The Centers for Medicare & Medicaid Services (CMS) has the following educational products available on the Medicare Learning Network (MLN) website:

- *The Facilitator's Guide*, which provides facilitators with everything needed to prepare for and conduct a Medicare program training course and is a companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*, is now available in downloadable format on the MLN publication page located at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*.
- *The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* in CD-ROM format is available free of charge from the MLN product ordering page located at *http://www.cms.hhs.gov/mlngeninfo/*. ❖

Source: CMS Provider Education Resource 200606-12

## Free Print Format of the Medicare Physician Guide Now Available

*The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* is now available in print format free of charge from the Medicare Learning Network at *http://www.cms.hhs.gov/mlngeninfo* on the Centers for Medicare & Medicaid Services (CMS) website.

Select "MLN Product Ordering Page" under the Related Links inside CMS section to place your order. ❖

Source: CMS Provider Education Resource 200607-09

# PREVENTIVE SERVICES

## Together We Can Close the Prevention Gap—July Prevention Awareness Message

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Although chronic diseases are among the most common and costly health problems, they are also some of the most preventable. Over the years Medicare has continued to expand the range of preventive services for which it pays and now provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Cardiovascular Disease Screening
- Cancer Screenings
  - Breast (mammography)
  - Cervical & vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Diabetes Screening
  - Self-management training
  - Medical nutrition therapy
  - Supplies
- Initial Preventive Physical Exam (IPPE) ("Welcome to Medicare" Physical Exam)
- Bone Mass Measurements
- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Glaucoma Screening
- Smoking and Tobacco-Use Cessation Counseling Services

While the number of Medicare-covered preventive services is higher than ever, we are finding that many beneficiaries are not taking advantage of the full range of services for which they may be eligible. Some of the reasons for this underutilization include beneficiaries:

- Not knowing that Medicare covers these services.
- Being afraid to talk with their physician or not knowing how or what questions to ask.
- Not understanding the value of prevention, early detection and treatment.
- Fearing the pain that may occur during the preventive service procedure.
- Fearing the results of the preventive service procedure.

*Together We Can Close the Prevention Gap—July Prevention Awareness Message (continued)*

In addition, there may be physical and social barriers that prevent Medicare beneficiaries from obtaining preventive services.

### How Can You Help?

Regardless of the reason for your Medicare patient not using a service, you are in a key role to help address this problem. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare are aware that Medicare provides coverage for preventive services that could save their lives. You can help by doing the following:

- Talk with your patients about their risk for disease and the value of prevention and early detection, and encourage utilization of appropriate Medicare-covered preventive services.
- Perform or provide referrals for the appropriate preventive services
- Follow-up with patients on all screening results, even negative ones
- Provide information about appropriate lifestyle modifications that support a healthy lifestyle

### For More Information

CMS has developed a variety of educational products and resources to help healthcare professionals and their staff become familiar with coverage, coding, billing, and reimbursement for preventive services covered by Medicare.

The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

The CMS website provides information for each preventive service covered by Medicare. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention".

For products to share with your Medicare patients, visit *http://www.medicare.gov* on the Web.

As a trusted source of patient health care information, your recommendation is one of the most important factors in increasing the utilization of preventive services covered by Medicare. We hope that you will join with CMS as we strive to close the prevention gap and encourage appropriate utilization of preventive services. It could save seniors' lives.

Thank you so much for your help! ❖

Source: CMS Provider Education Resource 200607-05

## Medicare Provides Coverage for Many Preventive Services and Screenings

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

**Note:** CMS has revised this MLN Matters article on June 30, 2006, to remove reference to the flu billing videos, which are no longer available on the CMS website. All other information remains the same. This article was originally published in the Third Quarter 2006 *Medicare A Bulletin* (pages 136-138).

### Provider Types Affected

All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

### Provider Action Needed

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

### Introduction

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This special edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

**Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):**

- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammography)
  - Cervical & vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
  - Self-Management Training
  - Medical Nutrition Therapy
  - Supplies

***Medicare Provides Coverage for Many Preventive Services and Screenings (continued)***

- Glaucoma Screening
- Initial preventive physical exam (IPPE)
- Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

## Educational Products and Informational Resources for Health Care Professionals

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare's coverage of disease prevention and early detection
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

**Product Ordering Instructions**
To order a product, free of charge, access this link: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

***You may click on the title of the publications below to view them online.***

**Brochures**

***The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals –*** This series of tri-fold brochures provides an overview of Medicare's coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure.)

- Adult Immunizations [PDF 279KB]
- Bone Mass Measurements [PDF 269KB]
- Cancer Screenings [PDF 295KB]
- Expanded Benefits [PDF 255KB]
- Glaucoma Screening [PDF 242KB]
- Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB] (available in download only at this time)

**Guides**

***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB]*** – This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005. See the errata sheet for corrections identified since May 2005 printing.)

***Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services [PDF 304KB]*** – This guide provides information on interpreting the Medicare beneficiary preventive services "next eligible date" data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access common working file (CWF) records. (September 2005; available in download only)

**Medicare Preventive Services CD ROM**

***Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals –*** This CD ROM contains The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals; six brochures: 1) Expanded Benefits, 2) Glaucoma Screenings, 3) Cancer Screenings, 4) Bone Mass Measurements, 5) Adult Immunizations, and 6) Smoking and Tobacco-Use Cessation Counseling Services; and a Quick Reference Information: Medicare Preventive Services chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. *(*See errata sheets for corrections identified since May 2005 printing of these products. See product ordering instructions above.)

**Quick Reference Information Chart**

***Quick Reference Information: Medicare Preventive Services [PDF 74KB]*** – This two-sided laminated chart gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005. See errata sheet for corrections identified since May 2005 printing.)

**Web-Based Training Courses**

**Web-Based Training Modules (WBTs)** – Three Web-based training courses covering coding, billing, overage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products Web page at *http://www.cms.hhs.gov/MLNProducts/*, scroll to the bottom of the page to "Links Inside CMS" and click on Web-based Training Modules.

*Medicare Provides Coverage for Many Preventive Services and Screenings (continued)*

**Web Page**

***MLN Preventive Services Web Page –*** This Medicare Learning Network (MLN) Web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

## Other Useful Provider Resources

Other useful provider resources include the following:

***Prevention Toolkit*** – This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

***Immunizations Toolkit*** – This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

**CMS Prevention Web Pages**

CMS has created individual Web pages for each of the preventive services and screenings covered by Medicare. For additional information visit *http://www.cms.hhs.gov/home/medicare.asp* and scroll down to the Prevention section.

**Medicare Learning Network (MLN)**

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's Web page on the CMS website at *http://www.cms.hhs.gov/MLNGenInfo*.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits
- Help you file preventive services claims more effectively.

**Note:** These products have been developed for you, the health care professional. Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

**Preventive Benefit Information for Medicare Beneficiaries**

Medicare beneficiaries may obtain information about Medicare preventive benefits by going to *http://www.medicare.gov/* and clicking on "Preventive Services."

They may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

MLN Matters Number: SE0630
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 SE0630

# ORDER FORM - PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: BCBSFL-FCSO, account number 700284).

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**Medicare Publications - ROC 10T**

**P.O. Box 45280**

**Jacksonville, FL 32232-5280**

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***NOTE:*** *The Medicare A Bulletin is available* ***free of charge*** *online at* ***www.floridamedicare.com****.*

# IMPORTANT ADDRESSES , TELEPHONE NUMBERS AND WEBSITES

## Addresses

### *CLAIMS STATUS*

**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 (MSP)*

**Information on Hospital Protocols**
**Admission Questionnaires**
**Audits**
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

**General MSP Information**
**Completion of UB-92 (MSP Related)**
**Conditional Payment**
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

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

### *PROVIDER EDUCATION*

Medicare Communication and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

**Seminar Registration Hotline**
1-904-791-8103

### *ELECTRONIC CLAIM FILING*

**"DDE Startup"**
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

### *FRAUD AND ABUSE*

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

### *PART A RECONSIDERATION*

**Claims Denied at the Redetermination Level**
MAXIMUS
QIC Part A East Project
Eastgate Square
50 Square Drive
Victor, NY 14564-1099

### *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 Skilled Nursing Facility Routine Cost Limit Exceptions**
**Freedom of Information Act Requests (relative to cost reports and audits)**
Provider Audit and Reimbursement Department (PARD)
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

### *MEDICARE REGISTRATION*

**American Diabetes Association Certificates**
Medicare Registration – ADA
P. O. Box 2078
Jacksonville, FL 32231-2078

## Telephone Numbers

### *PROVIDERS*

**Customer Service Center Toll-Free**
1-877-602-8816
**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 MEDIA CLAIMS*

**EMC Start-Up**
1-904-791-8767, option 4

**Electronic Eligibility**
1-904-791-8131

**Electronic Remittance Advice**
1-904-791-6865

**Direct Data Entry (DDE) Support**
1-904-791-8131

**PC-ACE Support**
1-904-355-0313

**Testing**
1-904-791-6865

**Help Desk (Confirmation/Transmission)**
1-904-905-8880

## Medicare Websites

### *PROVIDERS*

**Florida Medicare Contractor**
***www.floridamedicare.com***
**Centers for Medicare & Medicaid Services**
***www.cms.hhs.gov***

### *BENEFICIARIES*

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

## Other Important Addresses

### *REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY*

**Home Health Agency Claims**
**Hospice Claims**
Palmetto Goverment Benefit Administrators – Gulf Coast
34650 US Highway 19 North, Suite 202
Palm Harbour, FL 34684-2156

### *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**
Palmetto Goverment Benefit Administrators
P. O. Box 100141
Columbia, SC 29202-3141

# MEDICARE A BULLETIN

FIRST COAST SERVICE OPTIONS, INC. ❖ P.O. BOX 2078 ❖ JACKSONVILLE, FL 32231-0048

*** ATTENTION BILLING MANAGER ***