MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff.

Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *www.fcso.com.*

Routing Suggestions :

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

Table of Contents

Medicare A Bulletin

Vol. 10, No. 10
October 2008

Publication Staff

Millie C. Pérez
Terri Drury
Mark Willett
Betty Alix

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

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

Medicare Publications
1-904-361-0723

About the *Medicare A Bulletin*

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

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

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy (please see the hardcopy registration form published in the June 2007 *Medicare A Bulletin*, page 4). Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

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

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

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

What is in the *Bulletin*?

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

- Some issues of the publication may start with an important message from our contractor medical director.
- Following are sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines 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 new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin represents formal notice of coverage policies

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

Do you have comments?

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

Medicare Publications
1-904-361-0723

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

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

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

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

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

GENERAL INFORMATION

The ICD-10 Clinical Modification/Procedure Coding System—the next generation of coding

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

Provider types affected

This article is informational only for all physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This special edition article (SE0832) outlines general information for providers detailing the International Classification of Diseases, 10th Edition (ICD-10) clinical modification/procedure coding system (CM/PCS). Compared to the current ICD-9 coding system, ICD-10 offers more detailed information and the ability to expand specificity and clinical information in order to capture advancements in clinical medicine. Providers may want to become familiar with the new coding system.

The system is not yet implemented in the Medicare fee-for-service (FFS) claim processes so no action is needed at this time.

Background

The following countries already use ICD-10 coding system:

- United Kingdom (1995)
- France (1997)
- Australia (1998)
- Germany (2000)
- Canada (2001)

ICD-10-CM/PCS consists of two parts:

- **ICD-10-CM –** The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM).
- **ICD-10-PCS –** The procedure coding system was developed by CMS for use in the U.S. for inpatient hospital settings **only**. The new procedure coding system uses seven alpha or numeric digits while the ICD-9-CM coding system uses three or four numeric digits.

ICD-10-CM/PCS

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients
  - Designing payment systems
  - Processing claims
  - Making clinical decisions
  - Tracking public health
  - Identifying fraud and abuse
  - Conducting research.

Structural differences between the two coding systems

1. **Diagnoses codes**

   ICD-9-CM diagnoses codes are **three – five** digits in length with the first digit being alpha (E or V) or numeric and digits **two – five** being numeric. For example:

496	Chronic airway obstruction not elsewhere classified (NEC)
511.9	Unspecified pleural effusion
V02.61	Hepatitis B carrier.

   ICD-10-CM diagnoses are **three to seven** digits in length with the first digit being alpha, digits **two and three** being numeric and digits **four to seven** are alpha or numeric. The alpha digits are not case sensitive. For example:

A66	Yaws
A69.21	Meningitis due to Lyme disease
S52.131a	Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. **Procedure codes**

   ICD-9-CM procedures are **three to four** digits in length and all digits are numeric. For example:

The ICD-10 Clinical Modification/Procedure Coding System—The next generation of coding (continued)

43.5 Partial gastrectomy with anastomosis to esophagus

44.42 Suture of duodenal ulcer site.

ICD-10-PCS procedures are **seven** digits in length with each of the seven digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

0FB03ZX Excision of liver, percutaneous approach, diagnostic

0DQ107Z Repair, esophagus, upper, open with autograft.

Note: ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments' usage of *Current Procedural Terminology* (*CPT*) codes on Medicare FFS claims as *CPT* use will continue.

Additional information

The Centers for Medicare & Medicaid Services (CMS) has developed a dedicated Web page for ICD-10 information. That page is on the CMS Web site at *http://www.cms.hhs.gov/ICD10*.

Details on the ICD-10-PCS coding system, mappings, and a related training manual may be found on the CMS Web site at *http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage*.

The ICD-10 notice of proposed rulemaking is available on the Internet at *http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf*.

Details on the ICD-10-CM coding system, mappings, and guidelines may be found on the Internet at *http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm* and also on the CMS Web site at *http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp#TopOfPage*.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Note: The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 Web page also has links to these resources in the Related Links Outside of CMS at the bottom of the page.

MLN Matters Number: SE0832
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 SE00832

ICD-10-CM/PCS national provider conference call for Part A and Part B providers

Medicare Part A providers (except hospitals) and Part B providers may now register for the Centers for Medicare & Medicaid Services ICD-10-CM/PCS national provider conference call that will be conducted on November 12, 2008 from 12:30 p.m. – 2:30 p.m. EST.

To register for this call, go to *http://www.cms.hhs.gov/icd10/Downloads/ICD10_otherproviders.pdf*.

To find additional information about this conference call and to access the ICD-10 overview presentation that will be discussed during the call, go to *http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp*. ❖

Source: CMS PERL 200810-27

ICD-10 clinical modification/procedure coding system bookmark

The ICD-10-clinical modification/procedure coding system (CM/PCS) bookmark is now available from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*. This bookmark explains the ICD-10-CM and ICD-10-PSC, including the benefits of adopting the system, recommended steps to be taken in order to plan and prepare for implementation of the system, and where additional information about the system may be found.

To place your order, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*, scroll down to Related Links Inside CMS and select MLN Product Ordering Page. If you have problems accessing this hyperlink, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200810-19

ICD-10-clinical modification/procedure coding system fact sheet

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

Source: CMS PERL 200810-27

Medicare publishes billing edits to reduce payment errors

The Centers for Medicare & Medicaid Services (CMS) recently announced that beginning October 1, 2008, it will publish most of the edits utilized in its medically unlikely edit (MUE) program to improve the accuracy of claims payments.

"It is always our aim to ensure that CMS pays for appropriate services, at the same time protecting the Medicare trust funds and the American taxpayer," said CMS acting Administrator Kerry Weems. "This program is going to help us dramatically reduce costly payment errors."

CMS established the MUE program to reduce payment errors for Medicare Part B claims.

Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims.

These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using *CPT*/HCPCS codes along with the number of times (i.e., units of service) that the service is provided.

Prior studies, including one by the U.S Department of Health & Human Services Office of the Inspector General in May 2006, identified significant Medicare overpayments because provider or supplier claims sometimes report services with too many units of service. These errors may be caused by numerous factors, including clerical errors and coding errors.

CMS first implemented the MUE program January 1, 2007, with edits for about 2,600 HCPCS/*CPT* codes. There have been quarterly updates adding additional codes. The October 1, 2008, version of MUE will contain edits for about 9,700 *CPT*/HCPCS codes that have been assigned unit values for MUEs. MUEs are cumulative for each quarter. However, CMS will not publish all MUEs on October 1, 2008. CMS has not yet determined if there have been any savings in the MUE program since it was implemented.

The edits were developed by CMS with the cooperation and participation of national health care organizations representing physicians, hospitals, nonphysician practitioners, laboratories, and durable medical equipment suppliers. CMS also utilized claims data in its analysis of MUE.

The edits may be found on the CMS Web site at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage*.

At the start of each calendar quarter, CMS will publish most MUEs active for that quarter.

Although the October 1, 2008, publication will contain most MUEs, additional ones will be published on January 1, 2009. CMS is not able to publish all active MUEs because some are primarily designed to detect and deter questionable payments, rather than billing errors.

Publishing those MUEs would diminish their effectiveness. ❖

Source: CMS PERL 200810-08

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Reasonable charge update for 2009 for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses

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

Provider types affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis equipment, and certain intraocular lenses.

What you need to know

Change request (CR) 6221, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2009. CR 6221 also announces that the 2009 inflation-indexed charge (IIC) update factor is 5.0 percent.

Background

Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

For calendar year 2009, Medicare will continue to pay for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses on a reasonable charge basis.

In addition, please note that:

1. Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician's office.
2. You should use the Q-codes for splints and casts, when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

The 2009 payment limits for splints and casts will be based on the 2008 limits that were announced in CR 5740 last year, increased by 5.0 percent (the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2008). (The *MLN Matters* article related to CR 5740 may be viewed on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5740.pdf*.)

CR 6221 instructs your carrier or MAC to:

1. Compute 2009 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular lenses implanted in a physician's office) using actual charge data from July 1, 2007, through June 30, 2008.
2. Compute 2009 IIC amounts for these codes that were not paid using gap-filled payment amounts in 2008.

The 2009 IIC update factor is 5.0 percent.

For codes identified in the following four tables, CR 6221 instructs DME MACs to compute 2009 customary and prevailing charges using actual charge data from July 1, 2007, through June 30, 2008; and will compute 2009 IIC amounts for the codes that were not paid using gap-filled amounts in 2008.

Table 1 – Dialysis supplies billed with modifier AX

A4215	A4216	A4217	A4244	A4245	A4246	A4247	A4248
A4450	A4452	A4651	A4652	A4657	A4660	A4663	A4670
A4927	A4928	A4930	A4931	A6216	A6250	A6260	A6402

Table 2 – Dialysis supplies billed without modifier AX

A4653	A4671	A4672	A4673	A4674	A4680	A4690	A4706
A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722
A4723	A4724	A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766	A4770	A4771
A4772	A4773	A4774	A4802	A4860	A4870	A4890	A4911
A4918	A4929	E1634					

Table 3 – Dialysis equipment billed with modifier AX

E0210NU	E1632	E1637	E1639

Reasonable charge update for 2009 for splints, casts, dialysis supplies, dialysis equipment... (continued)

Table 4 – Dialysis equipment billed without modifier AX

E1500	E1510	E1520	E1530	E1540	E1550	E1560	E1570
E1575	E1580	E1590	E1592	E1594	E1600	E1610	E1615
E1620	E1625	E1630	E1635	E1636			

Your contractors will make payment for splints and casts furnished in 2009 based on the lower of the actual charge or the payment limits established for these codes. They will use the 2009 reasonable charges or the attached 2009 splints and casts payment limits to pay claims for items furnished from January 1, 2009, through December 31, 2009. Please refer to Attachment A, at the end of this article for a detailed list of the applicable HCPCS codes and 2009 payment limits.

Additional information

Detailed instructions for calculating:

- Reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments).
- Customary and prevailing charges are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge).
- The IIC are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

The *Medicare Claims Processing Manual* is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

For complete details regarding this CR please see the official instruction (CR 6221) issued to your Medicare FI, carrier, MAC, or DME MAC. That instruction may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1613CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6221
Related Change Request (CR) Number: 6221
Related CR Release Date: October 3, 2008
Related CR Transmittal Number: R1613CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1613, CR 6221

Attachment A

HCPCS Code	Payment Limit
A4565	$7.75
Q4001	$44.11
Q4002	$166.75
Q4003	$31.69
Q4004	$109.71
Q4005	$11.68
Q4006	$26.33
Q4007	$5.86
Q4008	$13.17
Q4009	$7.80
Q4010	$17.56
Q4011	$3.90
Q4012	$8.78
Q4013	$14.20
Q4014	$23.95
Q4015	$7.10

HCPCS Code	Payment Limit
Q4016	$11.97
Q4017	$8.21
Q4018	$13.09
Q4019	$4.11
Q4020	$6.55
Q4021	$6.07
Q4022	$10.96
Q4023	$3.06
Q4024	$5.48
Q4025	$34.07
Q4026	$106.37
Q4027	$17.04
Q4028	$53.19
Q4029	$26.05
Q4030	$68.58
Q4031	$13.03
Q4032	$34.28

HCPCS Code	Payment Limit
Q4033	$24.30
Q4034	$60.44
Q4035	$12.15
Q4036	$30.23
Q4037	$14.83
Q4038	$37.14
Q4039	$7.43
Q4040	$18.56
Q4041	$18.02
Q4042	$30.77
Q4043	$9.02
Q4044	$15.39
Q4045	$10.46
Q4046	$16.83
Q4047	$5.22
Q4048	$8.42
Q4049	$1.91

Medicare solicits nominees for advisory panel

The Centers for Medicare & Medicaid Services (CMS) is soliciting nominations for individuals to serve on the Program Advisory and Oversight Committee (PAOC) that advises CMS on various issues relating to the competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

The PAOC was initially established in 2004, as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), to advise CMS on the design and implementation of a competitive bidding program for DMEPOS that would build on the successes of two pilot projects that had shown that competitive bidding could reduce prices of DMEPOS, without adversely affecting beneficiary access or compromising quality.

Because the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delayed implementation of and made certain changes to the competitive bidding program, and extended the PAOC for two years through December 31, 2011, CMS is ending the term of service for current PAOC members.

The PAOC will be comprised of 10 and 12 members from the following broad categories:

- Beneficiary/consumer representatives
- Physicians and other practitioners
- Suppliers
- Professional standards organizations
- Financial standards specialists (that is, economist/ certified public accountant)
- Association representatives

CMS may consider nominees for additional categories if it finds that their expertise will help to ensure the successful implementation of the program nominations were due to CMS by November 3, 2008. For more information, please see the CMS Web site at *http://www.cms.hhs.gov/center/dme.asp*.

To read the CMS press release issued on October 1, 2008, access this link *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200810-07

CMS provides guidance on DMEPOS accreditation for pharmacy suppliers

On September 3, 2008, the Centers for Medicare & Medicaid Services (CMS) announced a list of providers that were exempt from meeting the quality standards for durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) accreditation.

CMS would like to clarify that pharmacists and pharmacies were not included in this provider exemption; therefore, they do need to obtain accreditation. For example, if a pharmacy is providing DMEPOS supplies to Medicare beneficiaries, such as diabetic supplies and enteral/parenteral nutrition, they would need to be accredited by the September 30, 2009 deadline.

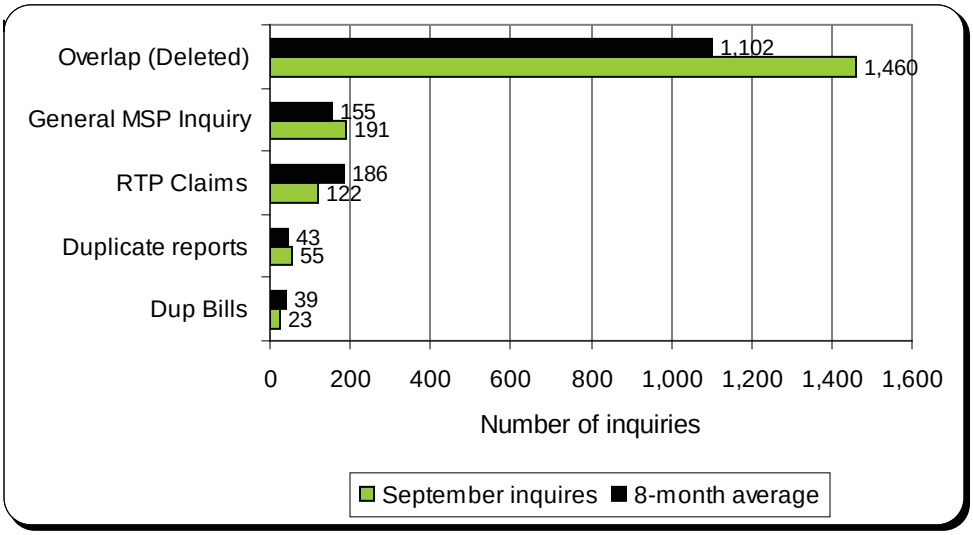
For more information about DMEPOS accreditation, please visit the Web page at *http://www.cms.hhs.gov/medicareprovidersupenroll/*. ❖

Source: CMS PERL 200810-10

Top inquiries for September 2008

This chart demonstrates how September's inquiries compare to the preceding eight months. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our Web site.

The five inquiry topics received most frequently by the Part A provider contact center during September 2008 are:



Clarification of Medicare payment for routine costs in a clinical trial

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

Provider types affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries in clinical trials.

Provider action needed

This special edition article provides clarification regarding Medicare payment of routine costs associated with clinical trials. Be sure your billing staff is aware of this information.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds providers that the policies for payment of the routine costs of the clinical trial are outlined in Chapter 16, Section 40 of the *Medicare Benefit Policy Manual*. The policy in the manual states:

> **40 No Legal Obligation to Pay for or Provide Services**
>
> Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free X-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

Key points of special edition article SE0822

There are three concerns addressed in this article regarding "Payment for Routine Costs in a Clinical Trial" and they are addressed in the following questions and answers:

Question: If a research sponsor says in writing that they will pay for routine costs if there is no reimbursement from any insurance company (including Medicare), does that fall into the "free of charge" category?

Answer: If the routine costs of the clinical trial are furnished gratuitously (i.e., without regard to the beneficiary's ability to pay and without expectation of payment from any other source), then Medicare payment cannot be made and the beneficiary cannot be charged. If private insurers deny the routine costs and the provider of services does not pursue the non-Medicare patients for payment after the denials (even though the non-Medicare patient has the ability to pay), Medicare payment cannot be made and the beneficiary cannot be charged for the routine costs.

Question: If the research sponsor pays for the routine costs provided to an indigent non-Medicare patient (the provider has determined that the patient is indigent due to a valid financial hardship) may Medicare payment be made for Medicare beneficiaries?

Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf*, "nothing in the Centers for Medicare & Medicaid Services (CMS) regulations or program instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a federal health care program – a highly unlikely circumstance.

Thus, the provider of services should bill the beneficiary for co-payments and deductible, but may waive that payment for beneficiaries who have a valid financial hardship.

Question: May a research sponsor pay Medicare copays for beneficiaries in a clinical trial.

Answer: If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a federal health care program. The citations include 42 U.S.C. 1320a-7(a)(i)(6); OIG Special Advisory Bulletin on Offering Gifts to Beneficiaries (*http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf*) and OIG Special Fraud Alert on Routine Waivers of Copayments and Deductibles (*http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html*).

Clarification of Medicare payment for routine costs in a clinical trial (continued)

Additional information

Chapter 16, Section 40 of the *Medicare Benefit Policy Manual* is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: SE0822
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 SE0822

Availability of an interim study of alternative MPFS payment localities

Medicare is statutorily required to adjust payments for Medicare physician fee schedule (MPFS) services, to account for differences in costs due to geographic location. There are currently 89 localities that have not been revised since 1997. In the calendar year 2009 physician fee schedule notice of proposed rulemaking released on June 30, 2008, the Centers for Medicare & Medicaid Services (CMS) indicated they would post a preliminary study of several options for revising the payment localities on its Web site. The report titled, *Review of Alternative GPCI Payment Locality Structures*, produced by Acumen LLC under contract to CMS, may be found at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/ReviewOfAltGPCIs.pdf*.

Our study of possible alternative payment locality configurations is in the early stages of development. At this time, CMS is not proposing to make any changes to the payment localities. CMS encouraged interested parties to submit comments on the options presented in the report, as well as suggestions for other options. These comments will be considered in the development of possible future notice and comment rulemaking. When CMS is ready to propose any changes to the locality configuration, they will provide extensive opportunities for public comment (for example, a town hall meeting or open door forum) on specific proposals, before implementing any change.

Note: The address for sending comments has been corrected, and the comment period has also been extended. ❖

Source: CMS PERL 200810-22

CMS enhances program integrity efforts to fight Medicare fraud, waste and abuse

The Centers for Medicare & Medicaid Services (CMS) recently announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers, consolidating its fraud detection efforts, strengthening its oversight of medical equipment suppliers, and home health agencies, and launching the national recovery audit contractor (RAC) program.

The new national RACs may be found at *http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf*.

For more information, visit the CMS RAC Web site at *http://www.cms.hhs.gov/RAC/*.

You may also click on either the CMS press release issued October 6, 2008, or the RAC fact sheet, both of which are also available at *http://www.cms.hhs.gov/RAC/* in the Related Links inside CMS section. ❖

Source: CMS PERL 200810-20

Incorporation of recent regulatory revisions into Chapter 10 of the Program Integrity Manual

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6178 which incorporates recent regulatory changes into the *Medicare Program Integrity Manual* (PIM), Chapter 10 (Healthcare Provider/Supplier Enrollment).

Background

The *Medicare Program IntegrityManual* (Chapter 10) specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program.

CR 6178 revises Chapter 10 (Healthcare Provider/Supplier Enrollment) of the *Medicare Program Integrity Manual* and incorporates non-appeals related provisions contained in "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)" which was published in the *Federal Register* on June 27, 2008. This CR instructs contractors to:

- Establish an enrollment bar for those providers and suppliers whose billing privileges are revoked. The enrollment bar will require that providers and suppliers whose billing privileges are revoked to wait from one to three years before reapplying to participate in the Medicare program.
- Require providers and supplier to receive payments by electronic funds transfer (EFT) when enrolling, making a change to their enrollment information, or during a revalidation process. In addition, providers or suppliers must continue to receive payment via EFT when Medicare contractor transition occurs and the provider or supplier was previously receiving payment via EFT.
- Allow Medicare contractors to reject an enrollment application when a provider or supplier fails to provide missing information/documentation within 30 days of a contractor's request for additional information (the previous standard was 60 days).
- Establish a new revocation reason for services that could not be provided (e.g., physician billing for services within in the United States when the physician was living outside of the country).

Additional information

The official instruction, CR 6178, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R269PI.pdf*.

The revised Chapter 10 of the *Medicare Program Integrity Manual (PIM)* is attached to CR 6178.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6178
Related Change Request (CR) Number: 6178
Related CR Release Date: September 19, 2008
Related CR Transmittal Number: R269PI
Effective Date: October 20, 2008
Implementation Date: October 20, 2008

Source: CMS Pub. 100-08, Transmittal 269, CR 6178

Notice of interest rate for Medicare overpayments and underpayments

Medicare regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been changed to **11.375 percent**, **effective October 22, 2008.** The PCR will remain in effect until a new rate change is published. Below is a list of previous interest rates.

Period	Interest rate
July 24, 2008 – October 21, 2008	11.125%
April 18, 2008 – July 23, 2008	11.375%
January 18, 2008 – April 17, 2008	12.125%
October 19, 2007 – January 17, 2007	12.5%
July 20, 2007 – October 18, 2007	12.625%
April 20, 2007 – July 19, 2007	12.375%
January 19, 2007 – April 19, 2007	12.5%. ❖

Source: CMS Pub. 100-06, Transmittal 142, CR 6238

Influenza pandemic emergency—the Medicare program prepares

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

Provider types affected

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

Impact on providers

This article is informational only and is alerting providers that the Centers for Medicare & Medicaid Services (CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

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

Decision to implement would occur if:

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

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

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

Dedicated CMS Web page now available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp*.

That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional information

Additional CMS influenza pandemic policy documents include:

- CR 6164 may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf*.
- CR 6174, which may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R390OTN.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

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

Source: CMS Special Edition *MLN Matters* Article SE0836

October flu shot reminder

Flu season is upon us. Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies. And don't forget, health care personnel can spread the highly contagious flu virus to patients.

Protect yourself. Don't get the flu. Don't give the flu. Get your flu shot.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug.

For information about Medicare coverage of the influenza virus vaccine and its administration, as well as related educational resources for health care professionals, please go to the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf*. ❖

Source: CMS PERL 200810-13 and 200810-03

Community pan-flu preparedness—a checklist of key legal issues for providers

The Centers for Medicare & Medicaid Services (CMS) wants to alert providers to a valuable resource in the preparation for a potential pandemic influenza.

Community Pan-Flu Preparedness: A Checklist of Key Legal Issues for Healthcare Providers, is a scalable tool designed to assist providers along the continuum of care, as well as the broader health care and public health communities, in taking concrete steps to prepare for a pandemic influenza. The C*hecklist* was informed by a public interest dialogue session convened by the American Health Lawyers Association (AHLA), the Office of Inspector General of the U.S. Department of Health & Human Services, and the U.S. Centers for Disease Control and Prevention.

Participants from federal and state agencies, the provider and payer communities, academia, and other stakeholders discussed the role of the health care sector in community pan-flu preparedness. They also shared their best thinking regarding the challenges to pan-flu preparedness and practical solutions to such challenges. These ideas and recommendations were incorporated into the *Checklist* in order to make the resource as practical and relevant as possible.

CMS encourages hospitals and other health care providers to review the *Checklist* as they consider the legal impediments and implementation challenges to community pan-flu preparedness and practical solutions to such challenges.

This publication may be found at *http://www.healthlawyers.org/panfluchecklist*.

On October 22, 2008, AHLA also sponsored a teleconference entitled "*The Sneeze Heard 'Round the World: Pandemic Influenza Preparedness Strategies to Adopt Now***."** The teleconference focused on the considerations unique to preparedness planning for pandemic influenzas, including protection of employees and maintaining operations, implementation of altered clinical pathways, and strategies for successful public health and provider coordination that need to be addressed at the present time to ensure an adequate level of preparedness. One of the country's leading experts, Dr. Michael T. Osterholm, and three experts in the emerging specialty of emergency preparedness law will discuss practical preparedness steps that health care entities, providers and payers can implement now. To learn more about the teleconference, go to *http://www.healthlawyers.org/pi/teleconference*. ❖

Source: CMS PERL 200810-24

Influenza pandemic emergency—policies concerning the Medicare program

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded *MLN Matters* article MM6164 for change request 6164 on October 20, 2008. *MLN Matters* article MM6164 was replaced by special edition article SE0836, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0836.pdf*.

The special edition article SE0836 is being published in this issue of the *Medicare A Bulletin* on page 13**.**

MLN Matters Number: MM6164 Rescinded
Related Change Request (CR) Number: 6164
Related CR Release Date: September 26, 2008
Related CR Transmittal Number: R379OTN
Effective Date: October 27, 2008 (for preparedness)

Source: CMS Pub. 100-20, Transmittal 379, CR 6164

AMBULANCE SERVICES

Medicare payment for air ambulance services

Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008

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

Provider types affected

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for air ambulance services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6214, which alerts providers to the fact that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.

Be aware that upon the implementation date of January 5, 2009, in addition to the successful installation of the revised calendar year (CY) 2008 ZIP code file, your Medicare contractor will mass-adjust all air ambulance claims with dates of service on or after July 1, 2008, through December 31, 2008, which were previously paid under an urban ZIP code that was considered rural on December 31, 2006. In addition, the revised ZIP code file will be used to process such claims that were not already processed.

Key points of change request 6214

Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) further amends the designation of rural areas for air ambulance services.

- The statute specifies that any area that was designated as a rural area, as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.
- Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, CMS has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective July 1, 2008.
- Your Medicare contractor will process air ambulance transport and mileage claims (i.e., A0430, A0431, A0435, A0436), in accordance with these revised designations.

Background

The ambulance fee schedule was implemented in April 2002 based on a final rule published in the *Federal Register* (67 Fed. Reg. 9100 (February 27, 2002)). The elements of this final rule allowed for payment for various ground ambulance services and rotary and fixed wing air ambulance services under a fee schedule. The payment for these services is based on the type of service provided and on the geographical points of pick up. The final rule also establishes increased payment for services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance.

When the fee schedule was implemented, a rural area was defined as one that was outside any area defined by the Office of Management and Budget (OMB) as a metropolitan statistical area, (MSA) or a New England county metropolitan area (NECMA). The definition of "rural" also included the Goldsmith modification. The Goldsmith modification was developed because of the need to identify small towns and rural areas within large metropolitan counties. Some of these communities were isolated from central areas with health services because of distance or other physical features. The urban and rural areas were identified for payment purposes by a nexus of the ZIP code file and the ambulance fee schedule. The ZIP code file is updated quarterly.

Another final rule published in 71 *Federal Register* 69713 (December 1, 2006), revised the geographic designations for urban and rural areas as set forth in OMB's core-based statistical areas (CBSAs) standard. It added the definition of ''urban area'' as defined by the Executive OMB. In addition, it removed the definition of "Goldsmith modification" and amended the definition of ''rural area'' to include areas determined to be rural under the most recent version of the Goldsmith modification. Updating the MSA definition to conform with OMB's CBSA-based geographic area designations, coupled with updating the Goldsmith Modification (that is, using the current rural urban commuting areas (RUCAs) version, as discussed in Section III.B.1.b of the final rule), more accurately reflected the contemporary urban and rural nature of areas across the country for ambulance payment purposes and made ambulance fee schedule payments more accurate. These changes became effective January 1, 2007.

Additional information

To see the official instruction (CR6214) issued to your Medicare carrier, FI or A/B MAC visit the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R387OTN.pdf*.

Medicare payment for air ambulance services (continued)

If you have questions, please contact your Medicare A/B MAC, FI or carrier 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 888-664-4112.

MLN Matters Number: MM6214
Related Change Request (CR) Number: 6214
Related CR Release Date: October 17, 2008
Related CR Transmittal Number: R387OTN
Effective Date: July 1, 2008
Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 387

Ambulance inflation factor for calendar year 2009

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

Provider types affected

Providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What you need to know

Change request (CR) 6113, from which this article is taken, provides the ambulance inflation factor (AIF) for calendar year (CY) 2009. The AIF for CY 2009 is five percent.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2009 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

CR 6113, from which this article is taken furnishes the CY 2009 AIF, which will be 5.0 percent. The following table displays the AIF for CY 2009 and for the previous six years.

Ambulance inflation factor by CY	
2009	5.0%
2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) is subject to a "floor amount."

Payment will not be less than this "floor amount," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

Note: For ground ambulance trips of over 50 miles that you furnish on or after July 1, 2004, and before January 1, 2009, (regardless of where the transportation originates) a 25 percent bonus "per mile" payment will be added to the existing "per mile" reimbursement rate for all miles above the initial 50 miles. This 25 percent increase in the "per mile" payment rate for trips of 51 miles or greater will stop on December 31, 2008, and effective for dates of service of January 1, 2009, and later, services paid under the ambulance fee schedule will not include this temporary increase.

To read more about this temporary 25 percent "per mile" rate increase for ambulance trips of 51 miles or greater, you might want to read MLN Matters article MM3099 (MMA-Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003) released on June 25, 2004. You may find this article on the Centers for Medicare & Medicaid (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3099.pdf*.

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than

Ambulance inflation factor for calendar year 2009 (continued)

the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate. For CY 2009, this blend is 20 percent regional ground base rate and 80 percent national ground base rate. Part B coinsurance and deductible requirements apply.

Additional Information

CR 6113, the official instruction issued to your Medicare contractor, is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1607CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6113
Related Change Request (CR) Number: 6113
Related CR Release Date: October 3, 2008
Related CR Transmittal Number: R1607CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1607, CR 6113

NATIONAL PROVIDER IDENTIFIER

NPPES—keeping it safe and keeping it updated

This message is for health care providers, particularly physicians and other practitioners, who have obtained national provider identifiers (NPIs) and have records in the national plan and provider enumeration system (NPPES). The Centers for Medicare & Medicaid Services (CMS) recommends that each health care provider, including individual physicians and nonphysician practitioners (NPPs) do all the following:

- Know and maintain their NPPES user IDs and passwords.
- Reset their NPPES passwords at least once a year. See the NPPES Application Help page regarding the "Change Password" rules. Those rules indicate the length, format, content and requirements of NPPES passwords.
- Review their NPPES records in order to ensure that the information reflects current and correct information.

Maintaining NPPES account information for safety and accessibility

Health care providers, including physicians and NPPs, should maintain their own NPPES account information (i.e., user ID, password, and secret question/answer) for safety and accessibility purposes.

Viewing NPPES information

Health care providers, including physicians and NPPs, may view their NPPES information in one of two ways:

1. By accessing the NPPES record at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.

   Note: If the health care provider has forgotten the password, enter the user ID and click the "Reset Forgotten Password" button to navigate to the Reset Password Page. If the health care provider enters an incorrect user ID and password combination three times, the user ID will be disabled. Please contact the NPI enumerator at 1-800-465-3203 if the account is disabled or if the health care provider has forgotten the user ID.

2. By accessing the NPI registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*. The NPI registry gives the health care provider an online view of Freedom of Information Act (FOIA)-disclosable NPPES data.

   The health care provider can search for its information using the name or NPI as the criterion.

NPPES—keeping it safe and keeping it updated (continued)

Updating NPPES information

Health care providers, including physicians and NPPs, can correct, add, or delete information in their NPPES records by accessing their NPPES records at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.

Note: Required information cannot be deleted from an NPPES record; however, required information may be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the Web, thus requiring the change/update to be made via paper application. The paper NPI application/update form may be downloaded and printed at *http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf*.

Additional information

Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Having trouble viewing any of the URLs in this message? If you are having trouble viewing any of the URLs in this message, try to cut and paste them into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available on the CMS Web site by clicking "CMS Communications" in the left column of the *https://www.cms.hhs.gov/NationalProvIdentStand*. ❖

Source: CMS Provider Education Resource 200810-26

Reporting national provider identifier for secondary providers

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 October 19, 2008, to reflect changes to change request (CR) 6048, which CMS revised on October 15, 2008 to include the fiscal intermediary share system (FISS) in the business requirements. The FISS implementation date was also added. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. All other information remains the same. The *MLN Matters* article MM6048 was previous published in the September 2008 *Medicare A Bulletin* (pages 20-21).

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6093 and outlines the need to use national provider identifiers (NPIs) to identify secondary providers in Medicare claims beginning May 23, 2008.

Background

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

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

Medicare claims always identify primary providers. Primary providers are the billing and pay-to providers and, for non-institutional and non-pharmacy claims, the rendering provider.

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

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

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

Key points of change request 6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), **that identifier must be an NPI.**

Reporting national provider identifier for secondary providers (continued)

- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) **does not furnish** its NPI at the time of the order/, referral, purchase, prescription, or time of service, **you as the billing provider need to know that NPI in order to use it in your claim.**
- You may use the NPI registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the implementation guides for the X12N claims transactions permit the reporting of the social security number (SSN) for some secondary providers if there is no NPI, the Centers for Medicare & Medicaid Services (CMS) does not believe you will be successful in having secondary providers disclose their SSNs.
- If you are **unable to obtain the NPI of the entity** to be identified as the **service facility provider, or if that entity has not obtained an NPI, no identifier is to be reported in that loop.**
- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, **you (the billing provider) must use your NPI as the identifier for that secondary provider.**
- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional information

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

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

The toll-free number for First Coast Service Options Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6093 – Revised
Related Change Request (CR) Number: 6093
Related CR Release Date: October 15, 2008
Related CR Transmittal Number: R270PI
Effective Date: May 23, 2008
Implementation Date: September 26, 2008
FISS Implementation Date: November 3, 2008

Source: CMS Pub. 100-08, Transmittal 270, CR 6093

NPI registry update

The national provider identifier (NPI) registry option to search by "Doing Business As"(DBA) name has been temporarily removed from the NPI registry search page while CMS makes enhancements to the system. The DBA search option was expected to be available by Friday, October 10, 2008.

For more information

Providers may apply for an NPI online at *https://nppes.cms.hhs.gov* or may call the NPI enumerator to request a paper application at 1-800-465-3203.

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *http://www.cms.hhs.gov/NationalProvIdentStand/* CMS Web page. ❖

Source: CMS PERL 200809-41

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL COVERAGE

Laboratory national coverage determination edit software for October 2008

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), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 6213 which announces the changes that will be included in the October 2008 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in July 2008. CR 6213 incorporates all changes from July 2008 to the present.

Background

The national coverage determination (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Section 120.2 (see *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6213 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for October 2008 as described below. These changes become effective for services furnished on or after October 1, 2008.

For bacterial urine culture:

- Add ICD-9-CM diagnosis codes 038.12, 599.70, 599.71, 599.72, 780.60, 780.61, 780.62, 780.63, 780.64, 780.65, 788.91, and 788.99 to the list of ICD-9-CM diagnosis codes covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Delete ICD-9-CM diagnosis codes 599.7, 780.6, and 788.9 from the list of ICD-9-CM diagnosis codes covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the urine culture, bacterial (190.12) NCD.

For HIV testing:

- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the HIV testing (prognosis including monitoring (190.13)) NCD.
- Add ICD-9-CM diagnosis codes 078.12, 136.21, 136.29, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM diagnosis codes covered by Medicare for the HIV testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM diagnosis codes 136.2 and 780.6 from the list of ICD-9-CM diagnosis codes covered by Medicare for the HIV testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the HIV testing (diagnosis) (190.14) NCD.

For blood counts:

- Add ICD-9-CM diagnosis codes 078.12, V45.11, V45.12, V49.83, V51.0, V51.8, V61.01, V61.02, V61.03, V61.04, V61.05, V61.06, V61.09, V62.21, V62.22, V62.29 and V72.42 to the list of ICD-9-CM diagnosis codes that do not support medical necessity for the blood counts (190.15) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the blood counts (190.15) NCD.
- Delete ICD-9-CM diagnosis codes V45.1, V51, V61.0, and V62.2 from the list of ICD-9-CM diagnosis codes that do not support medical necessity for the blood counts (190.15) NCD

For partial thromboplastin time (PTT):

- Add ICD-9-CM diagnosis codes 275.5, 238.77, 571.42, 599.70, 599.71, 599.72, and 611.89 to the list of ICD-9-CM diagnosis codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Delete ICD-9-CM diagnosis codes 599.7 and 611.8 from the list of ICD-9-CM diagnosis codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

For prothrombin time (PT):

- Add ICD-9-CM diagnosis codes 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 511.81, 511.89, 571.42, 599.70, 599.71, 599.72, 611.89, and 999.89 to the list of ICD-9-CM diagnosis codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

Laboratory national coverage determination edit software for October 2008 (continued)

- Delete ICD-9-CM diagnosis codes 511.8, 599.7, 611.8, and 999.8 from the list of ICD-9-CM diagnosis codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the prothrombin time (PT) (190.17) NCD.

For serum iron studies:
- Add ICD-9-CM diagnosis codes 199.2, 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.60, 209.61, 209.62, 209.63, 209.64, 209.65, 209.66, 209.67, 209.69, 209.30, 238.77, 571.42, 999.89, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM diagnosis codes covered by Medicare for the serum iron studies (190.18) NCD.
- Delete ICD-9-CM diagnosis codes 999.8 and V15.2 from the list of ICD-9-CM diagnosis codes covered by Medicare for the serum iron studies (190.18) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the serum iron studies (190.18) NCD.

For collagen crosslinks:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the collagen crosslinks, any method (190.19) NCD.

For blood glucose testing:
- Add ICD-9-CM diagnosis codes 038.12, 707.20, 707.21, 707.22, 707.23, 707.24, 707.25, 780.72, V23.85, and V23.86 to the list of ICD-9-CM diagnosis codes covered by Medicare for the blood glucose testing (190.20) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the blood glucose testing (190.20) NCD.

For Glycated Hemoglobin/Glycated Protein:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

For thyroid testing:
- Add ICD-9-CM codes 275.5, 780.72, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM diagnosis codes covered by Medicare for the thyroid testing (190.22) NCD.
- Delete ICD-9-CM diagnosis code 780.6 from the list of ICD-9-CM diagnosis codes covered by Medicare for the thyroid testing (190.22) NCD.
- Delete ICD-9-CM diagnosis codes V28.8.and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the thyroid testing (190.22) NCD.

For lipid testing:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the lipids testing (190.23) NCD.

For digoxin therapeutic drug assay:
- Add ICD-9-CM diagnosis codes 275.5, 339.3, and 780.72 to the list of ICD-9-CM diagnosis codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the digoxin therapeutic drug assay (190.24) NCD.

For alpha-fetoprotein:
- Add ICD-9-CM diagnosis codes 571.42, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM diagnosis codes covered by Medicare for the alpha-fetoprotein (190.25) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the alpha-fetoprotein (190.25) NCD.

For carcinoembryonic antigen:
- Add ICD-9-CM diagnosis codes 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM diagnosis codes covered by Medicare for the carcinoembryonic antigen (190.26) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the carcinoembryonic antigen (190.26) NCD.

For human chorionic gonadotropin:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the human chorionic gonadotropin (190.27) NCD.

For tumor antigen by immunoassay-CA125:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the tumor antigen by immunoassay-CA125 (190.28) NCD.

For tumor antigen by immunoassay-CA15-3/CA27.29:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the tumor antigen by immunoassay-CA15-3/CA27.29 (190.29) NCD.

For tumor antigen by immunoassay-CA19-9:
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the tumor antigen by immunoassay-CA19-9 (190.30) NCD.

Laboratory national coverage determination edit software for October 2008 (continued)

For prostate specific antigen:

- Add ICD-9-CM diagnosis codes 599.70, 599.71, and 599.72 to the list of ICD-9-CM diagnosis codes covered by Medicare for the prostate specific antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM diagnosis code 599.7 from the list of codes covered by Medicare for the prostate specific antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the PSA (190.31) NCD.

For gamma glutamyl transferase:

- Add ICD-9-CM diagnosis codes 275.5, 038.12, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 558.41, 558.42, and 571.42 to the list of ICD-9-CM diagnosis codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the gamma glutamyl transferase (190.32) NCD.

For hepatitis panel/acute hepatitis panel:

- Add ICD-9-CM code 780.72 to the list of ICD-9-CM diagnosis codes covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.
- Hepatitis panel (190.33) NCD.

For fecal occult blood test:

- Add ICD-9-CM codes 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 530.13, 558.41, 558.42, 569.44, 571.42, and 780.72 to the list of ICD-9-CM diagnosis codes covered by Medicare for the fecal occult blood test (FOBT) (190.34) NCD.
- Delete ICD-9-CM diagnosis codes V28.8 and V68.0 from the list of ICD-9-CM diagnosis codes denied by Medicare for the FOBT (190.34) NCD.

For All 23 NCDs (190.12-190.34):

- Add ICD-9-CM diagnosis codes V28.81, V28.82, V28.89, V68.01, and V68.09 to the list of denied ICD-9-CM diagnosis codes for all 23 lab NCDs.

Additional Information

The official instruction, CR 6213, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1606CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6213
Related Change Request (CR) Number: 6213
Related CR Release Date: October 2, 2008
Related CR Transmittal Number: R1606CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1606, CR 6213

Continuous positive airway pressure therapy for obstructive sleep apnea

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 October 16, 2008, to reflect changes to change request (CR) 6048, which CMS revised on October 15, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. In addition, some language in item 3 was clarified. All other information remains the same. The previous revision to *MLN Matters* article MM6048 was published in the September 2008 *Medicare A Bulletin* (pages 49-50).

Provider types affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or durable medical equipment [DME] MACs) for obstructive sleep apnea (OSA)-related services provided to Medicare beneficiaries.

Impact on providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of continuous positive airway pressure (CPAP) therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of change request (CR) 6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 national coverage determination (NCD) for CPAP therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with Section 240.4 of the Medicare NCD Manual (see the Additional Information section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR 6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf*.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key points of change request 6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

   Note: DME prosthetics, orthotics, and supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively [42 CFR 424.57(c)(12)]. Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges [(42 CFR 424.57(d)].

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:

   - Polysomnography (PSG) performed in a sleep laboratory.
   - Unattended home sleep monitoring device of type II.
   - Unattended home sleep monitoring device of type III.
   - Unattended home sleep monitoring device of type IV, measuring at least three channels.

   Note: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the apnea-hypopnea index (AHI) or respiratory distress index (RDI) are met:

   - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
   - AHI or RDI greater than or equal to five and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

   As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep

Continuous positive airway pressure therapy for obstructive sleep apnea (continued)

test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for type IV devices measuring three or more channels that do not measure AHI or RDI directly.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or type II, type III, or a type IV HST measuring at least three channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *National Coverage Determination Manual* revision attached to CR 6048. Medicare will process claims according to coverage with evidence development (CED)/clinical trials criteria at Section 310.1 of the *NCD Manual* and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available on the CMS Web site at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at Section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398 Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.
Short Descriptor: Home sleep test/type 2 Porta

G0399 Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
Short Descriptor: Home sleep test/type 3 Porta

G0400 Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
Short Descriptor: Home sleep test/type 4 Porta

Additional information

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R96NCD.pdf*.

If you have questions, please contact your Medicare A/B MAC, FI, carrier, 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 888-664-4112.

MLN Matters Number: MM6048 – Revised
Related Change Request (CR) Number: 6048
Related CR Release Date: October 15, 2008
Related CR Transmittal Number: R96NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site *http://www.fcso.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 LCDs and review guidelines are consistent with accepted standards of medical practice.

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

Additional Medical Information

Advance beneficiary notice

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

This Bulletin Should Be Shared with All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at no Cost from Our Provider Education Web site at *http://www.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

AJ0881: Erythropoiesis stimulating agents—revision to the LCD

LCD ID: L895

The local coverage determination (LCD) for erythropoiesis stimulating agents (ESAs) was last revised on October 1, 2008. Since that time, the LCD has been revised. A request was received to clarify the language surrounding the dosage and administration of erythropoiesis stimulating agents (ESAs) as it relates to chronic kidney disease (CKD) and to include the entire black box warning found on the product labeling for epoetin alfa and darbepoetin alfa, so the warnings for CKD and cancer indications are better defined. As a result of this request, the LCD has been revised to include the entire black box warning for ESAs, which clearly define the CKD warnings from the cancer warnings. In addition, the language surrounding the dosage and administration for CKD for ESAs was revised to read per the current approved Food and Drug Administration label.

This revision to the LCD is effective for services provided **on or after October 9, 2008.**

To better identify the dual diagnosis requirements for each HCPCS code in the LCD, the notations found under each list of ICD-9-CM codes have been moved to the top of each list of ICD-9-CM codes. The asterisks have been removed from diagnoses 285.21, 285.29 and 285.9 to lessen the confusion over which diagnosis codes require a dual diagnosis. As previously published, every claim submitted with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 requires a dual diagnosis. These notations at the top of the ICD-9-CM code lists group the appropriate anemia codes with the appropriate covered indication.

This revision to the LCD is effective for services provided **on or after April 7, 2008.**

First Coast Service Options Inc. (FCSO) LCDs and coding guidelines are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

ASKINSUB: Skin substitutes—revision to the LCD

LCD ID: L13688

The local coverage determination (LCD) for skin substitutes was last updated on January 1, 2007. Since that time, a reconsideration request was evaluated and the following revisions were made to the LCD:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for Apligraf®, removed the statement "The safe and effective use of Apligraf® has not been determined when used for treating diabetic foot ulcers that are less than 0.4 cm^2 or greater than 16.0 cm^2."
- Added "Dermal Regeneration Template (DRT)" to the product description of Integra® throughout the LCD where indicated.
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following diagnosis codes were added: For Apligraf® (J7340) and Oasis® Wound Matrix (J7341), ICD-9-CM codes 707.10, 707.11, 707.19, and 707.8 were added to the LCD. For Xenograft (J7343), ICD-9-CM codes 707.11, 707.19, and 707.8 were added to the LCD.

In addition, the "Sources of Information and Basis for Decision" section was updated.

Effective date

This revision to the LCD is effective for services provided **on or after October 30, 2008**.

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

AZEVALIN: Ibritumomab tiuxetan (Zevalin®) therapy—revision to the LCD

LCD ID: L13771

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin®) therapy was last revised on October 1, 2007. Since that time, the LCD has been revised based on a reconsideration request. The list of *CPT*/HCPCS codes that support medical necessity has been revised to now include *CPT* code *78802* (*Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agents(s); whole body, single day imaging*). Following the injection of In-111, a scan is performed to assess biodistribution. This only requires one day of imaging, and can be done over two or more days. The LCD will now allow for the one day of imaging or two or more days of imaging.

Effective date

This revision to the LCD is effective for services provided **on or after October 2, 2008**.

First Coast Service Options Inc. (FCSO) LCDs and coding guidelines are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

ADDITIONAL MEDICAL INFORMATION

AJ0881: Erythropoiesis stimulating agents—revision to the coding guidelines

LCD ID: L895

The "coding guidelines" attachment for erythropoiesis stimulating agents was last revised on April 7, 2008. Since that time, the "coding guidelines" attachment has been revised in conjunction with the Centers for Medicare & Medicaid Services (CMS) change request 6047, transmittal 1503, dated May 16, 2008, "Revisions to the billing requirements for end-stage renal disease (ESRD)-related epoetin alfa (EPO) and darbepoetin alfa (Aranesp®) administrations provided during unscheduled or emergency dialysis treatments in the outpatient hospital setting."

The following language has been added:

> Effective **October 1, 2008,** revenue code 045x will no longer be required in order to allow for EPO or Aranesp® payment related to an unscheduled or emergency dialysis treatment. Payment will only be made for ESRD related EPO or Aranesp (HCPCS code Q4081 or J0882) in the outpatient setting (13x or 85x) when HCPCS code G0257 appears on the claim for dates of service **on or after October 1, 2008**.

Effective date

This revision to the coding guidelines attachment is effective for claims processed **on or after October 6, 2008**, for services provided **on or after October 1, 2008**.

First Coast Service Options Inc. (FCSO) LCDs and coding guidelines are available through the CMS Medicare Coverage Database (List of LCDs for FCSO Inc. (00090, Intermediary). ❖

Final/active LCD list sorted by FCSO LCD number pages retired

The "Final/active LCD list sorted by FCSO LCD number" articles previously located on the Part A local coverage determination (LCD) page on the floridamedicare.com Web site was retired effective September 15, 2008. This document was replaced with links to pre-defined searches of the Medicare coverage database (MCD) on the Centers for Medicare & Medicaid Services (CMS) Web site.

For First Coast Service Options Inc. (FCSO) final/active Part A LCDs, from the floridamedicare.com site, select the Part A tab; from the Local Medical Coverage section, select "Final LCDs," and choose the link entitled "Final/Active LCD List sorted by LCD Title." Or, go directly to the CMS Web site at *http://www.cms.hhs.gov/mcd/results_index.asp?from2=results_index.asp&contractor=68&from='lmrpcontractor'&retired=&name=First%20Coast%20Service%20Options,%20Inc.%20(00090,%20FI)&letter_range=4&.*

A how-to guide for effectively locating LCDs on the CMS site, including other features available in the MCD, may also be found on the Part A Final LCDs Web page as well as the Help section at the top right of each page on the floridamedicare.com site. ❖

HOSPITAL SERVICES

Hospital outpatient department payment data for value-driven health care updated

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, President Bush directed the U.S. Department of Health & Human Services to make cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2006 and 2007 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

Earlier this year, Medicare updated the hospital information and moved it to the Hospital Compare Web site where it can be viewed along with hospital quality information. The Hospital Compare Website may be found at *www.medicare.gov*.

On October 17, 2008, Medicare posted an update to the hospital outpatient department data. ASC and physician payment data were updated earlier this year. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2007 data. The posting updates may be found at http://www.cms.hhs.gov/HealthCareConInit/. ❖

Source: CMS PERL 200810-26

Outlier payment billing under the hospital inpatient prospective payment system

Overview

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG, which reflects the patient's diagnosis and covered inpatient care at the time of admission. When the cost of care at discharge significantly exceeds the IPPS set rate, the hospital may be eligible for additional reimbursement commonly known as an outlier payment.

Outlier payment definition

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring **extraordinarily high costs.** To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers).

Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. Payments for eligible cases are then made based on **a marginal cost factor**, which is a percentage of the costs above the threshold.

Medicare law requires the Centers for Medicare & Medicaid Services (CMS) **to set aside between five to six percent of funds** under the IPPS to use to partially reimburse for outlier payments. Medicare reimburses for an outlier payment only if the hospital combined capital-related and operating cost for the discharge exceeds the cost outlier threshold. CMS publishes the outlier threshold in the annual IPPS final rule.

Beneficiary eligibility

Cost outlier payment is made for each day during the outlier period that the beneficiary has an available benefit day. The beneficiary's eligibility may be determined through the common working file (CWF). The CWF may be accessed through direct data entry (DDE) eligibility detail inquiry (ELGA) screen or through the interactive voice response (IVR) unit at the toll-free telephone number 1-877-602-8816.

Outlier billing requirements

The following codes must be used on the claims when submitting for a cost outlier:

Occurrence code

47 – first day inpatient cost outlier threshold is reached
A3 – benefits exhausted

Occurrence span code

70 – code and span of time indicating from/through dates during inlier stay

Condition code

61 – code indicating claim is a cost outlier
67 – beneficiary elects not to use lifetime reserve (LTR) days
68 – beneficiary elects to use LTR days

Educational Resources

First Coast Service Options Inc. (FCSO) has developed the following training courses and educational materials to assist hospital providers and their billing staffs with the coding of inpatient cost outlier claims. The following courses and educational materials are available through FCSO's Medicare training Web site:

- Coding inpatient cost outlier claims
- Determining Medicare Part A benefit period

Outlier payment billing under the hospital inpatient prospective payment system (continued)

- Ask the contractor (ACT) teleconference recorded on October 15, 2008:
  - Inpatient cost outlier claims – intermediary level presentation (10.15.08)
  - Cost outlier flowcharts (10.15.08)

How to register

Simply go to our Web site *http://www.fcso.com*, select Florida Providers, and click on the "Provider Outreach & Education" link located on the horizontal navigational bar. On the Quick Find menu, select "Online Learning."

Log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the appropriate course. If you are a first time user, set up an account using the instructions indicated on the page.

Reference materials

- The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412, and the specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86. These regulations are available at *http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html*, and http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1243p.pdf.
- The annual IPPS proposed and final rule, which includes statewide average cost-to-cost ratios (CCRs) in Tables 8A and 8B) may be reviewed and downloaded from the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1500f.pdf*.
- A detailed list of cost-to-charge ratios by provider and by federal fiscal year may be downloaded from the CMS Web site public use file at *http://www.cms.hhs.gov/AcuteInpatientPPS/*.
- Detailed explanations on the calculations of outlier payments, including examples, are available on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage*.

Inpatient hospital outlier payments information is also available in the CMS Internet-only manual Pub-100-04 (*Medicare Claim Processing Manual*), Section 20.1.2 (Outliers), and Section 20.7.4 (Cost Outliers Bills with Benefits Exhausted). Instructions for billing for outlier claims reside in the same manual under Chapter 25 (Completing and Processing the Form CMS-1450 Data Set) available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf* and *http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf*. ❖

Fiscal year 2009 inpatient prospective payment system, long term care hospital PPS, and inpatient psychiatric facility PPS changes

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 6189 which outlines changes for inpatient prospective payment system (IPPS) hospitals for fiscal year (FY) 2009. The policy changes for FY 2009 appeared in the *Federal Register* on August 19, 2008, and the final IPPS rates were available on the Centers for Medicare & Medicaid Services (CMS) Web site prior to October 1, 2008. CR 6189 also addresses changes to Medicare severity diagnosis related groups (MS-DRGs) and ICD-9-CM coding that affects long-term care hospital (LTCH) PPS, and inpatient psychiatric facility (IPF) PPS. The LTCH PPS rate changes occurred on July 1, 2008.

Background

CR 6189 announces changes for IPPS hospitals for FY 2009. The policy changes for FY 2009 appeared in the *Federal Register* on August 19, 2008, and the final IPPS rates were available on the CMS Web site prior to October 1, 2008. All items covered in CR 6189 are effective for hospital discharges occurring on or after October 1, 2008, unless otherwise noted.

Note: The final rule of August 19, 2008, did not include the implementation of public law 110-275, which extended the hospital reclassification provisions of section 508 and certain special exceptions through September 30, 2009.

Please refer to transmittal 1547, CR 6114, published on July 2, 2008, for LTCH policy changes. An *MLN Matters* article related to that transmittal is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6114.pdf*.

The IPF PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2008. IPF PPS rate changes occurred on July 1, 2008. Refer to transmittal 1543, CR 6077, published on June 27, 2008 for IPF PPS policy changes. An *MLN Matters* article related to that transmittal is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMAttersArticles/downloads/MM6077.pdf*.

The changes conveyed in CR 6189 follow.

ICD-9-CM changes

The ICD-9-CM coding changes are effective October 1, 2008. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 1, 2008, *Federal Register*. The ICD-9-CM codes

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f. The August 1, 2008, *Federal Register* notice is available on the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf*.

Software updates

The LTCH PRICER has been updated with the MS-LTC-DRG table and weights.

A new MS-DRG GROUPER software package, version 26.0, is effective for discharges on or after October 1, 2008. The GROUPER 26.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare code editor (MCE), version 25.0, uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2008.

The IPPS PRICER FY 08 used for discharges occurring on or after October 1, 2007, through September 30, 2008, incorporates a correction to Puerto-Rico rates. All IPPS Puerto Rico claims with discharges on or after October 1, 2007, through September 30, 2008, will be reprocessed by Medicare using the corrected rates, which are as follows:

- **Wage index (**WI) > 1 = labor share (LS) = $1,471.10 non-labor share (NLS) = $901.64
- WI < 1 = LS = $1,392.80 NLS = $979.94
- The revised FY 2008 Puerto Rico capital rate is $202.89.

An IPPS PRICER FY 09 will be used for discharges occurring on or after October 1, 2008. The FY 09 IPPS PRICER package processes bills with discharge dates on or after October 1, 2003.

Rates

Standardized amount update factor	1.036, but 1.016 for hospitals that do not submit quality data.
Hospital specific update factor	1.036, but 1.016 for hospitals that do not submit quality data.
Common fixed loss cost outlier threshold	$20.045.00
Federal capital rate	$424.17
Puerto Rico capital rate	$198.77
Outlier offset-operating national	0.948996
Outlier offset-operating Puerto Rico	0.954304
IME formula	1.35 x [(1 + resident-to-bed ratio).^{405}-1]
MDH/SCH budget neutrality factor	0.998795

Operating B – Rates with full market basket and wage index greater than 1

	Labor share	**Non-labor share**
National	3,574.50	1,553.91
PR national	3,574.50	1,553.91
PR specific	1,507.82	924.15

Rates with reduced market basket and wage index greater than 1

	Labor share	**Non-labor share**
National	3,505.49	1,523.91
PR national	3,574.50	1,553.91
PR specific	1,507.83	924.15

Rates w/ reduced market basket & wage index greater than 1

Nada	**Labor share**	**Non-labor share**
National	3,505.49	1,523.91
PR national	3,574.50	1,553.91
PR specific	1,507.83	924.15

Rates with reduced **market basket** & **wage index** less than 1

	Labor share	**Non-labor share**
National	3,118.23	1,911.17
PR national	3,179.61	1,948.80
PR specific	1,427.57	1,004.40

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

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

Area	COLA factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and county of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and county of Kalawao	1.25

Postacute transfer policy

The DRGs determined in the post acute care policy have been modified due to changes made to the MS-DRG system. All post acute transfer MS-DRGs for FY 2009 are listed in Table 5 of the IPPS final rule, which is available on the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1203f_2.pdf*.

New technology add-on payment

Effective for discharges on or after October 1, 2008, the new technology add-on payment for FY 2009 will be triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and diagnosis code reflecting clinical trial – V70.7 (Examination of participant in clinical trial). If the criteria are met, Medicare will make a maximum add-on payment of up to $53,000 (that is, 50 percent of the estimated operating costs of the device) per case for cases that involve this technology. If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of 50 percent of the costs of the new medical service or technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

State rural floor budget neutrality adjustment factors

The inclusion of the new PRICER table (see attachment C of CR 6189), "State Rural Floor Budget Neutrality Adjustment Factors", is due to new regulations for the wage index, at 42 CFR 412.64(e)(4), that were implemented in the FY 2009 IPPS final rule (73 FR 48570).

The table in Attachment C of CR 6189 lists the blended overall rural floor budget neutral factors that are to be applied onto the wage index based on the provider's geographic state location. Attachment C is available at the end of this article. The wage table loaded for the FY 2009 PRICER contains wage index values **prior** to the application of the blended overall rural floor budget neutrality factors. PRICER is applying the budget neutrality factors from Attachment C to the wage index within the PRICER payment logic. The wage index tables printed in the FY 2009 *Federal Register* final rule notice already have the blended overall rural floor budget neutrality factors applied. To confirm the wage index PRICER uses in calculating payments with the wage index printed in the *Federal Register*, you must take the wage index from PRICER and multiply it by the appropriate factor from Attachment C.

Hospital-acquired conditions (HAC) and present on admission (POA) indicator reporting

The Deficit Reduction Act of 2005 (DRA) requires a payment adjustment in Medicare DRG payment for certain hospital-acquired conditions. CMS has titled the program, "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."

Hospital-acquired conditions:

- Are high cost or high volume or both.
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis.
- Could reasonably have been prevented through the application of evidence-based guidelines.

Section 5001(c) of the DRA required the Secretary of the Department of Health & Human Services to identify, by October 1, 2007, at least two conditions that for discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though the secondary diagnosis were not present.

Version 26.0 of the GROUPER will include logic to determine the appropriate MS-DRG based on the HAC and POA logic. The hospital-acquired conditions payment provision applies only to IPPS hospitals. At this time, the following hospitals are **exempt** from the HAC payment provision:

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

- Critical access hospitals (CAHs)
- Long-term care hospitals (LTCHs)
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient facilities
- Inpatient rehabilitation facilities (IRFs)
- Psychiatric hospitals

The current proposed list of impacted HACs is in the following table:

Hospital-acquired condition	**Complicating condition (CC) or major complicating condition (MCC)** (ICD-9-CM Codes)
Foreign object retained after surgery	998.4 (CC) 998.7 (CC)
Air embolism	999.1 (MCC)
Blood incompatibility	999.6 (CC)
Stage III & IV pressure ulcers	707.23 (MCC) 707.24 (MCC)
Falls and trauma • Fractures • Dislocations • Intracranial injuries • Crushing injuries • Burns • Electric shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994
Catheter-associated urinary tract infection (UTI)	996.64 CC Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)
Vascular catheter-associated infection	999.31 (CC)
Manifestations of poor glycemic control	250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	519.2 (MCC) and any one of the following procedures: 36.10-36.19
Surgical site infection following certain orthopedic procedures	996.67 (CC) 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23, 81.24, 81.31-81.38, 81.83, or 81.85.
Surgical site infection following bariatric surgery for obesity	Principal diagnosis of 278.01, 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) and one of the following procedure codes: 00.85-00.87, 81.51-81.52, and 81.54.

For more information on HAC POA, see on the CMS Web site *http://www.cms.hhs.gov/HospitalAcqCond/.*

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider specific information

Tables 8a and 8b of section VI of the addendum to the PPS final rule contain the FY 2009 statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI or A/B MAC is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.196 and the capital ceiling is 0.145.

CBSA designations

Attachment A of CR 6189 shows the IPPS providers that will be receiving a "special" wage index for FY 2009 (i.e., receives an out-commuting adjustment under section 505 of the MMA). For any provider with a special wage index from FY 2008, FIs and A/B MACs shall remove that special wage index, by entering zeros in the field unless they receive a new special wage index as listed in Attachment A of CR 6189 is duplicated at the end of this article and is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf*.

Low volume hospitals

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

Hospital quality initiative

The FIs and A/B MACs will also identify each hospital that meets the criteria for higher payments per MMA Quality standards. The hospitals that will receive the quality initiative bonus are listed on the Internet at *http://www.qualitynet.org/pqri*.

This Web site is expected to be updated in September 2009. Attachment B of CR 6189 includes the list of providers that did not meet the criteria for FY 09 and which will not receive the two percent annual payment update for FY 2009. (CR 6189 is included at the end of this article and is available on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf*.)

Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website and FIs and A/B MACs will update their records accordingly.

FIs and A/B MACs will identify new hospitals to the quality improvement organizations (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting.

This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the hospital quality initiative.

Capital IPPS adjustment for indirect medical education

As established in the FY 2008 IPPS final rule with comment period (72 FR 47401), in accordance with the regulations at Section 412.322(c), for discharges occurring during FY 2009, the capital indirect medical education (IME) adjustment factor equals one-half the current adjustment (that is the amount computed under Section 412.322(b)). This 50 percent reduction in the capital IME adjustment factor is reflected in the PRICER.

Re-basing of sole community hospitals

Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110-275) provides an option to sole community hospital (SCHs) that would allow them to rebase their hospital specific rates using data from their FY 2006 cost report (cost reporting periods beginning on or after October 1, 2005, and on or before September 30, 2006) if this results in a payment increase. If the FY 2006 cost report data amount is used, it would be effective for the SCH's cost reporting periods beginning on or after January 1, 2009.

The inpatient psychiatric facility PPS update

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2009 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs for which the IPF PPS provides an adjustment. **This table is only a listing of FY 2009 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs.** When coded as a principal diagnosis, these codes receive the correlating DRG adjustment.

Diagnosis code	Description	MS-DRG
046.11	Variant Creutzfeldt-Jakob disease	056, 057
046.19	Other and unspecified Creutzfeldt-Jakob disease	056, 057
046.71	Gerstman-Sträussler-Scheinker syndrome	056, 057
046.72	Fatal familial insomnia	056, 057
046.79	Other and unspecified prion disease of central nervous system	056, 057

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

For FY 2009, the diagnosis code of 046.1 (Jakob-Creutzfeldt [MS-DRG 056, 057]) is invalid and no longer applicable for the DRG adjustment.

Since CMS does not plan to update the regression analysis until it analyzes IPF PPS data, the MS-DRG adjustment factors, shown in the following table, are effective October 1, 2008, and will continue to be paid for RY 2009.

MS-DRG	MS-DRG descriptions	Adjustment factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnoses of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neuroses	0.99
882	Neuroses except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity adjustment update

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

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

The IPF PPS uses the MS-DRG coding system, in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is using the FY 2009 GROUPER, version 26.0 which is effective for discharges occurring on or after October 1, 2008.

CR 6189 contains three tables that list the FY 2009 new, revised and invalid ICD-9-CM diagnosis codes, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2009 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

Additional information

The official instruction, CR 6189, issued to your FI or A/B MAC regarding this change is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1610CP.pdf*.

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

The toll-free number for First Coast Service Options Inc. Medicare Part A Customer Service Center is 888-664-4112.

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Attachment A

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
010008	1	0.7792
010015	1	0.7664
010021	1	0.7670
010027	1	0.7644
010032	1	0.7943
010038	1	0.8025
010040	1	0.8022
010045	1	0.7840
010046	1	0.8022
010047	1	0.7745
010049	1	0.7644
010078	1	0.8025
010091	1	0.7664
010109	1	0.8023
010110	1	0.7833
010125	1	0.8094
010128	1	0.7664
010129	1	0.7752
010138	1	0.7684
010146	1	0.8025
010150	2	0.8464
020008	2	1.2554
030067	1	0.9122
040047	1	0.7762
040067	1	0.7652
040081	1	0.8002
050002	1	1.5640
050007	1	1.5211
050009	1	1.4125
050013	1	1.4125
050043	1	1.5640
050069	1	1.1985
050070	1	1.5211
050075	1	1.5640
050084	1	1.2104
050089	1	1.1983
050090	1	1.5282
050099	1	1.1983
050113	1	1.5211
050129	1	1.1983
050136	1	1.5282
050140	1	1.1983

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
050167	1	1.2104
050168	1	1.1985
050173	1	1.1985
050174	1	1.5282
050193	1	1.1985
050194	1	1.5954
050195	1	1.5640
050211	1	1.5640
050224	1	1.1985
050226	1	1.1985
050230	1	1.1985
050242	1	1.5954
050245	1	1.1983
050264	1	1.5640
050272	1	1.1983
050279	1	1.1983
050283	1	1.5640
050289	1	1.5211
050291	1	1.5282
050298	1	1.1983
050300	1	1.1983
050305	1	1.5640
050313	1	1.2104
050320	1	1.5640
050325	1	1.2005
050327	1	1.1983
050336	1	1.2104
050348	1	1.1985
050366	1	1.1987
050385	1	1.5282
050426	1	1.1985
050444	1	1.2288
050488	1	1.5640
050512	1	1.5640
050517	1	1.1983
050526	1	1.1985
050543	1	1.1985
050547	1	1.5282
050548	1	1.1985
050549	2	1.4681
050551	1	1.1985
050567	1	1.1985

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
050570	1	1.1985
050580	1	1.1985
050584	1	1.1983
050586	1	1.1983
050589	1	1.1985
050603	1	1.1985
050609	1	1.1985
050667	1	1.4125
050678	1	1.1985
050690	1	1.5282
050693	1	1.1985
050714	1	1.5954
050720	1	1.1985
050744	1	1.1985
050745	1	1.1985
050746	1	1.1985
050747	1	1.1985
050748	1	1.2104
050754	1	1.5211
050758	1	1.1983
060010	1	0.9722
060030	1	0.9722
060075	2	1.1062
060119	1	0.9722
070001	2	1.2600
070005	2	1.2600
070006	2	1.3003
070010	1	1.2869
070016	2	1.2600
070017	2	1.2600
070018	2	1.3003
070019	2	1.2600
070022	2	1.2600
070028	1	1.2869
070031	2	1.2600
070033	1	1.2869
070034	2	1.3003
070039	2	1.2600
090003	1	1.0684
090005	1	1.0684
090006	1	1.0684
090008	1	1.0684
100290	1	0.8954

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
110100	1	0.8604
110101	1	0.7881
110142	1	0.7999
110190	1	0.8055
110205	1	0.8321
130024	1	0.8243
130066	1	0.9470
140001	1	0.8767
140026	1	0.8713
140116	1	1.0289
140161	1	0.8566
140176	1	1.0289
140234	1	0.8713
150022	1	0.8623
150034	2	1.0274
150072	1	0.8570
160013	1	0.9133
160030	1	0.9412
160032	1	0.9189
160040	2	0.8954
160064	2	1.0364
160067	2	0.8954
160080	1	0.9020
170150	1	0.8221
180064	1	0.8213
180070	1	0.8139
180079	1	0.8158
190034	1	0.7845
190044	1	0.7917
190050	1	0.7700
190053	1	0.7757
190054	1	0.7741
190078	1	0.7843
190099	1	0.7845
190116	1	0.7741
190133	1	0.7758
190140	1	0.7691
190145	1	0.7746
190190	1	0.7731
190218	2	0.8519
190246	1	0.7731
190277	1	0.8043
200032	1	0.8943

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
220002	1	1.1359
220011	1	1.1359
220046	2	1.1366
220049	1	1.1359
220063	1	1.1359
220070	1	1.1359
220082	1	1.1359
220084	1	1.1359
220098	1	1.1359
220101	1	1.1359
220105	1	1.1359
220171	1	1.1359
220175	1	1.1359
230003	2	1.0355
230004	2	1.0355
230005	1	0.9336
230013	2	1.0769
230019	2	1.0769
230020	2	1.0163
230024	2	1.0163
230029	2	1.0769
230036	2	1.0769
230038	2	1.0355
230053	2	1.0163
230059	2	1.0355
230066	2	1.0355
230071	2	1.0769
230072	2	1.0355
230075	1	1.0048
230089	2	1.0163
230093	1	0.8921
230097	2	1.0355
230104	2	1.0163
230106	2	1.0355
230119	2	1.0163
230130	2	1.0769
230135	2	1.0163
230146	2	1.0163
230151	2	1.0769
230165	2	1.0163
230174	2	1.0355
230176	2	1.0163
230207	2	1.0769
230217	1	1.0048
230223	2	1.0769
230236	2	1.0355
230254	2	1.0769
230269	2	1.0769
230270	2	1.0163
230273	2	1.0163
230277	2	1.0769
240018	1	0.9891
240044	1	0.9711
240117	1	0.9613
240211	1	0.9898
250002	2	0.8418
250078	2	0.8217
250122	2	0.8418
250128	1	0.8071
250162	1	0.8879
260059	1	0.8492
260064	1	0.8504
260097	1	0.8715
260116	1	0.8502
260163	1	0.8502
270002	2	0.8738
270012	2	0.8738
270023	2	0.9011
270032	2	0.9011
270057	2	0.9011
280077	1	0.8808
280123	1	0.8851
310021	2	1.2762
310028	2	1.2762
310050	2	1.2762
310051	2	1.2762
310060	2	1.2762
310115	2	1.2762
310120	2	1.2762
320011	1	0.9171
320018	1	0.8858
320085	1	0.8858
330010	1	0.8330
330023	2	1.3003
330027	1	1.2809
330033	1	0.8486

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
330047	1	0.8330
330049	2	1.2791
330067	2	1.3003
330106	2	1.4928
330126	2	1.2791
330132	1	0.8394
330135	2	1.2791
330144	1	0.8319
330151	1	0.8319
330167	1	1.2809
330175	1	0.8523
330181	1	1.2809
330182	1	1.2809
330198	1	1.2809
330205	2	1.2791
330225	1	1.2809
330259	1	1.2809
330264	2	1.2686
330276	1	0.8299
330331	1	1.2809
330332	1	1.2809
330372	1	1.2809
340002	2	0.9431
340020	1	0.8756
340024	1	0.8777
340037	1	0.8762
340038	1	0.8853
340104	1	0.8762
340133	1	0.8860
340151	1	0.8652
350002	2	0.8229
350003	2	0.8229
350006	2	0.8229
350015	2	0.8229
350017	2	0.8229
350019	2	0.7944
350030	2	0.8229
360002	1	0.8711
360040	1	0.8957
360044	1	0.8697
360070	1	0.8824
360071	1	0.8605
360084	1	0.8824
360100	1	0.8824
360131	1	0.8824
360151	1	0.8824
360156	1	0.8689
370023	1	0.8030
370065	1	0.8036
370072	1	0.8198
370083	1	0.7991
370100	1	0.8040
370156	1	0.8061
370169	1	0.8103
370214	1	0.8061
380090	2	1.2797
390001	2	0.9642
390003	2	0.9642
390008	1	0.8393
390045	2	0.9642
390052	1	0.8380
390056	1	0.8369
390072	2	0.9642
390095	2	0.9642
390117	1	0.8335
390119	2	0.9642
390122	1	0.8386
390125	1	0.8355
390137	2	0.9642
390146	1	0.8355
390150	1	0.8364
390169	2	0.9642
390185	2	0.9797
390192	2	0.9642
390201	1	0.9503
390236	1	0.8336
390237	2	0.9642
390270	2	0.9797
390316	1	0.9492
420002	1	0.9535
420019	1	0.8746
420027	1	0.9805
420043	1	0.8745
420053	1	0.8623
420054	1	0.8590
420082	1	0.9569
430005	2	0.9467
430008	2	0.9373

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider number	Value to enter in special pay indicator	Value to enter in special wage index
430013	2	0.9373
430015	2	0.9344
430048	2	0.9344
430060	2	0.9344
430064	2	0.9344
430094	1	0.8525
440007	1	0.8162
440012	1	0.7952
440016	1	0.8087
440017	1	0.7952
440031	1	0.7962
440033	1	0.7970
440047	1	0.8281
440050	1	0.7952
440051	1	0.8025
440057	1	0.7964
440070	1	0.8052
440081	1	0.7995
440084	1	0.7968
440109	1	0.8013
440115	1	0.8281
440137	1	0.8681
440174	1	0.8255
440176	1	0.7952
440180	1	0.7970
440181	1	0.8308
440182	1	0.8087
450032	1	0.8378
450059	1	0.8992
450072	2	0.9890
450090	1	0.8774
450144	1	0.8683
450163	1	0.8178
450192	1	0.8395
450194	1	0.8337
450210	1	0.8275
450236	1	0.8513
450270	1	0.8395
450370	1	0.8359
450438	1	0.8359
450451	1	0.8660
450460	1	0.8177
450497	1	0.8499
450539	1	0.8191
450573	1	0.8250
450591	2	0.9890
450615	1	0.8157
450641	1	0.8499
450698	1	0.8251
450755	1	0.8400
450838	1	0.8250
450884	1	0.8716
450888	1	0.9674
460017	1	0.8746
470003	2	1.1366
490001	2	0.8651
490084	1	0.8219
490110	1	0.8277
500019	1	1.0273
500041	1	1.1431
510012	1	0.7744
520035	1	0.9477
520044	1	0.9477
520057	1	0.9594
520095	1	0.9594
530008	2	0.9271
530010	2	0.9271
530015	2	1.0353
670015	1	0.9674
670023	1	0.9674

Attachment B

Provider ID	Provider name
30073	Tuba City Regional Health Care Corporation
30074	Sells Indian Health Service Hospital
30077	San Carlos Hospital
30113	Whiteriver Phs Indian Hospital
50018	Pacific Alliance Medical Center
50091	Community And Mission Hospital Of Huntington Park
50257	Good Samaritan Hospital
50320	Alameda County Medical Center
50325	Tuolumne General Medical Facility
50377	Chowchilla District Mem Hospital
50378	Pacifica Hospital Of The Valley

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider ID	Provider name
50430	Modoc Medical Center
50456	South Bay Community Hospital, L P
50545	Lanterman Developmental Center
50546	Porterville Developmental Center
50548	Fairview Developmental Center
50578	Martin Luther King, Jr – Harbor Hospital
50662	Agnews State Hospital
50668	Laguna Honda Hospital & Rehabilitation Center
50698	San Diego Hospice & Palliative Care Acute Care Cen
50708	Fresno Surgical Hospital
50758	Montclair Hospital Medical Center
70038	Connecticut Hospice Inc.
90008	United Medical Center
100108	Trinity Community Hospital
100134	Ed Fraser Memorial Hospital
100279	Gulf Coast Hospital
100298	Florida State Hospital Unit 31 Med
120004	Wahiawa General Hospital
140033	Vista Medical Center West
140094	St Mary & Elizabeth Med Ctr-Claremont Campus
140205	Swedish American Medical Center Belvidere
150164	Monroe Hospital
170150	South Central Ks Regional Med Center
190037	South Cameron Memorial Hospital
190151	Richardson Medical Center
190267	Fairway Medical Center
220153	Soldiers Home Of Holyoke
220154	Soldiers Home In Massachusetts
220172	University Health Services
230135	Henry Ford Cottage Hospital
230144	Forest Health Medical Center
250023	Pearl River County Hospital
250051	Kilmichael Hospital
250060	Jefferson County Hospital
250079	Sharkey Issaquena Community Hospital
250125	Gulf Coast Medical Center

Provider ID	Provider name
250127	Choctaw Health Center
250151	Alliance Health Center
250152	Mississippi Methodist Rehab Ctr
280119	P H S Indian Hospital
280127	Lincoln Surgical Hospital
290002	South Lyon Medical Center
290020	Primecare Nevada, Inc., Dba Nye Regional Medical Center
290027	Grover C Dils Medical Center
290042	Harmon Medical And Rehabilitation Hospital
290053	St Rose Dominican Hospital-San Martin
320030	Artesia General Hospital
330029	Sheehan Memorial Hospital
330094	Columbia Memorial Hospital
330406	Sunnyview Hospital And Rehabilitation Center
330407	Eddy Cohoes Rehabilitation Center
340104	Crawley Memorial Hospital
340137	Broughton Hospital-Medical Unit
340138	Central Regional Hospital
340168	Wilmington Treatment Center
350064	Us Public Health Service Indian Hospital
360187	Springfield Regional Medical Center
360247	Woods At Parkside,The
360258	Barix Clinics Of Ohio, Llc
360274	Medical Center At Elizabeth Place
360276	Hmhp St Elizabeth Boardman Health Center
370169	Community Hospital Lakeview
370171	W W Hastings Indian Hospital
370199	Lakeside Women's Hospital
370214	Lindsay Municipal Hospital
370220	Orthopedic Hospital
390112	Windber Hospital
390176	Commonwealth Medical Center
390312	Cancer Treatment Centers Of America
390317	Dsi Of Bucks County
430081	Pine Ridge Ihs Hospital
430093	Same Day Surgery Center Llc

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

Provider ID	Provider name
440223	Baptist Womens Treatment Ctr Murfreesboro
440224	Baptist Women's Treatment Center
450162	Highland Community Hospital
450270	Lake Whitney Medical Center
450330	Oakbend Medical Center
450379	R.H.D. Memorial Medical Center
450446	Riverside General Hospital
450683	Renaissance Hospital Terrell
450758	Healthsouth Dallas Rehab Hospital
450839	Shelby Regional Medical Center
460018	Kane County Hospital
460035	Beaver Valley Hospital
490104	Hiram W Davis Medical Center
490105	Southwestern Virginia Mental Health Institute
490108	Central Virginia Training Center
490129	Capital Hospice – Halquist Memorial Inpatient Center
490134	Piedmont Geriatric Hospital
490135	Catawba Hospital
500143	Prov St Peter Chemical Dependency Center
520203	Select Specialty Hospital - Madison
670007	Beaumont Bone & Joint Institute
670010	Denton Rehabilitation Hospital L.P.
670017	Healthsouth Rehabilitation Hospital
670018	Doctors Diagnostic Hospital
670021	Innova Hospital San Antonio
670027	Apex Hospital – Tmc

Attachment C

State Code	Factor	State Code	State Name
01	0.9968	01	Alabama
02	0.9951	02	Alaska
03	0.9968	03	Arizona
04	0.9968	04	Arkansas
05	0.9931	05	California
06	0.9962	06	Colorado
07	0.9900	07	Connecticut
08	0.9968	08	Delaware
09	0.9968	09	District of Co
10	0.9964	10	Florida
11	0.9968	11	Georgia
12	0.9968	12	Hawaii
13	0.9968	13	Idaho
14	0.9968	14	Illinois
15	0.9967	15	Indiana
16	0.9944	16	Iowa
17	0.9968	17	Kansas
18	0.9968	18	Kentucky
19	0.9967	19	Louisiana
20	0.9968	20	Maine
21	1.0000	21	Maryland
22	0.9968	22	Massachusetts
23	0.9968	23	Michigan
24	0.9968	24	Minnesota
25	0.9968	25	Mississippi
26	0.9968	26	Missouri
27	0.9968	27	Montana
28	0.9968	28	Nebraska
29	0.9968	29	Nevada
30	0.9924	30	New Hampshire
31	0.9946	31	New Jersey
32	0.9966	32	New Mexico
33	0.9968	33	New York
34	0.9968	34	North Carolina
35	0.9968	35	North Dakota
36	0.9966	36	Ohio
37	0.9968	37	Oklahoma
38	0.9954	38	Oregon
39	0.9968	39	Pennsylvania
40	0.9968	40	Puerto Rico
41	0.9968	41	Rhode Island
42	0.9964	42	S Carolina
43	0.9968	43	South Dakota
44	0.9963	44	Tennessee
45	0.9968	45	Texas
46	0.9968	46	Utah
47	0.9968	47	Vermont
48	1.0000	48	Virgin Islands
49	0.9968	49	Virginia
50	0.9964	50	Washington

Fiscal year 2009 IPPS, long term care hospital PPS, and inpatient psychiatric facility PPS changes (continued)

State Code	Factor	State Code	State Name
51	0.9964	51	West Virginia
52	0.9966	52	Wisconsin
53	0.9968	53	Wyoming
55	0.9931	55	California
56	1.0000	56	Canada
59	1.0000	59	Mexico
64	1.0000	64	American Samoa
65	1.0000	65	Guam
66	1.0000	66	Marianas Islands
67	0.9968	67	Texas
68	0.9964	68	Florida
69	0.9964	69	Florida
70	0.9968	70	Kansas
71	0.9967	71	Louisiana
72	0.9966	72	Ohio
73	0.9968	73	Pennsylvania
74	0.9968	74	Texas
75	0.9931	75	California
76	0.9944	76	Iowa
77	0.9968	77	Minnesota
78	0.9968	78	Illinois
80	1.0000	80	Maryland

MLN Matters Number: MM6189
Related Change Request (CR) Number: 6189
Related CR Release Date: October 3, 2008
Related CR Transmittal Number: R1610CP
Effective Date: Discharges on or after October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1610, CR 6189

ESRD Services

CMS issues new resources on ESRD conditions for coverage

Frequently asked questions

Thank you to all of our colleagues in the renal care community who submitted questions to the Centers for Medicare & Medicaid Services (CMS) about our recently released end-stage renal disease (ESRD) conditions for coverage final rule. In response to these inquiries, we have already provided many of you with individual responses to your questions; however, to share the benefit of these questions with the entire community, CMS has developed a "frequently asked questions" (FAQ) document that condenses many of the questions we received from you. The FAQs are available online on the CMS Web site at *http://www.cms.hhs.gov/center/esrd.asp*.

To view them, go to *http://www.cms.hhs.gov/CFCsAndCoPs/downloads/FAQsESRDRolloutFINAL082808.pdf*.

Crosswalk: Former conditions versus revised conditions

As another tool to help you understand the new conditions for coverage, CMS has developed a crosswalk that compares the former conditions to the final revised conditions, which were issued in the *Federal Register* on April 15, 2008. The crosswalk will help you navigate the new organization structure of the condition as well as some revised provisions of the conditions themselves. To access the crosswalk, go to *http://www.cms.hhs.gov/CFCsAndCoPs/downloads/ESRDConditionsCrosswalkFINAL080408.pdf*.

CMS hopes you find these tools helpful as you work to implement the revised conditions. For more information, please visit us online on the CMS Web site at *http://www.cms.hhs.gov/CFCsAndCoPs/13_ESRD.asp*. ❖

Source: CMS PERL 200810-12

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Provider, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

SKILLED NURSING FACILITY SERVICES

2009 annual update of HCPCS codes for skilled nursing facility consolidated billing

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

Provider types affected

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

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6220 which provides the 2009 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) and how the updates affect edits in Medicare claims processing systems.

CAUTION – what you need to know

Physicians and providers are advised that, by the first week in December 2008, new code files will be posted on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

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

GO – what you need to do

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

Background

Medicare claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs). (This manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.)

These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 6220, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1608CP.pdf* on the CMS website. If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6220
Related Change Request (CR) Number: 6220
Related CR Release Date: October 3, 2008
Related CR Transmittal Number: R1608CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1608, CR 6220

Medicare Part A skilled nursing facility prospective payment system PRICER update for fiscal year 2009

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

Provider types affected

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

Impact on providers

This article is a reminder that the SNF PPS rates are updated annually.

Background

Annual updates to the PPS rates are required by Section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for fiscal year (FY) 2009 and those rates will be effective as of October 1, 2008. The rates will be published in the *Federal Register* before that date.

Key points of change request 6193

- The FY 2009 SNF payment rates will be effective October 1, 2008, through September 30, 2009.
- The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS (acquired immunization deficiency syndrome).
- The statute mandates an update to the federal rates using the latest SNF full market basket.

Additional information

To see the official instruction (CR 6193) issued to your Medicare A/B MACs and carriers visit the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1600CP.pdf*.

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

The toll-free number for First Coast Service Options Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6193
Related Change Request (CR) Number: 6193
Related CR Release Date: September 19, 2008
Related CR Transmittal Number: R1600CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1600, CR 6193,

SNF PPS PC PRICER software release for fiscal year 2009

The Centers for Medicare & Medicaid Services (CMS) has released the SNF PPS PC PRICER software for fiscal year (FY) 2009. If you use SNF PPS PC PRICER software, please go to the Web page at *http://www.cms.hhs.gov/PCPricer/04_SNF.asp#TopOfPage* and download version FY 2009.0, posted on October 1, 2008. ❖

Source: CMS PERL 200810-06

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2008 update of the hospital outpatient prospective payment system

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

Provider types affected

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

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6196 which describes changes to, and billing instructions for various payment policies implemented in the October 2008 outpatient prospective payment system (OPPS) update.

CAUTION – what you need to know

The October 2008 integrated code editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this notification. October 2008 revisions to I/OCE data files, instructions, and specifications are provided in change request (CR) 6186, October 2008 I/OCE specifications version 9.3.

GO – what you need to do

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

Background

This recurring update notification describes changes to, and billing instructions for various payment policies implemented in the October 2008 OPPS update. The October 2008 I/OCE and OPPS PRICER will reflect the HCPCS, APC, HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 6196.

October 2008 revisions to I/OCE data files, instructions, and specifications are provided in CR 6186, "October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3" which has a related *MLN Matters* article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6186.pdf*.

Key points of change request 6196

1. Revenue code reporting

Hospitals must continue to report HCPCS codes and charges with an appropriate uniform bill (UB) revenue code consistent with the National Uniform Billing Committee (NUBC) requirements. When reporting the appropriate revenue code for services, hospitals should choose the most precise revenue code, or subcode, if appropriate. As NUBC guidelines dictate, "It is recommended that providers use the more detailed subcategory when applicable/available rather than revenue codes that end in "0" (General) or "9" (Other)."

Hospitals are required to follow the Medicare cost apportionment regulations at 42 CFR 413.53(a)(1), which convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another department. In order to comply with the requirements of this regulation, hospitals must follow the Medicare reimbursement policies in the *Provider Reimbursement Manual I* (PRM-I), Section 2302.8 and PRM-II in order to ensure that their ancillary costs and charges are reported in the appropriate cost centers on the cost report. The PRM manuals are available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Manuals/PBM/list.asp*.

CMS relies on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies because the CMS uses a revenue code to cost center crosswalk to estimate the service costs that underpin OPPS payment rates. The current revenue code to cost center crosswalk that CMS uses for setting annual hospital outpatient payments may be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage*.

CMS always invites reviews of this crosswalk and welcomes comments. The accuracy of hospital outpatient payments for future years depends on hospitals appropriately implementing NUBC instructions and reporting appropriate revenue codes, and following all cost report instructions.

2. Payment for radiology services reported with modifier 52

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.6 to remove language incorrectly stating that payment is not reduced for radiology services reported with modifier 52 (reduced services). As indicated in Section 20.6.4 of the same manual, modifier 52 should be appended to procedures for which anesthesia is not planned that are discontinued after the patient is prepared and taken to the room where the procedure is to be performed. These procedures are paid at 50 percent of the full OPPS payment amount. The revised Section 20.6.6 of the *Medicare Claims Processing Manual* is attached to CR 6196.

October 2008 update of the hospital outpatient prospective payment system (continued)

3. Changes to procedure and device edits for October 2008

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits may be found under "2008 Device and Procedure Edits" on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

4. Billing for devices

CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 61.1 to clarify correct HCPCS coding and charge reporting for all devices that are used to perform procedures that require the use of devices where such codes exist and are designated with a status indicator of "N" (for packaged payment) or "H" (for pass-through device payment) in the OPPS Addendum B that applies to the date of service. If there are device HCPCS codes with status indicators other than "N" or "H" that describe devices that are used to perform the procedure or that are furnished because they are necessary for the function of an implanted device, hospitals should report the charges for those other devices on an uncoded revenue code line, but should not report the HCPCS codes for those items. Typically, payment for the costs of all internal and external components required for the function of a nonpass-through device is packaged into the APC payment for the associated procedure in which the device is used. Accurate reporting of HCPCS codes and charges for these internal and external device components is necessary so that the OPPS payment for the associated procedures will be correct in future years in which the claims are used to set the APC payment rates. The revised Section 61.1 of the *Medicare Claims Processing Manual* is attached to CR 6196.

5. Billing for medical and surgical supplies

When medical and surgical supplies described by HCPCS codes with status indicators other than "H" or "N" are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim. In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hypdrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

6. Billing for drugs, biologicals, and radiopharmaceuticals

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

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

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

a. Drugs and biologicals with payments based on average sales price effective October 1, 2008

In the calendar year (CY) 2008 OPPS final rule, it was stated that payments for separately payable 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

October 2008 update of the hospital outpatient prospective payment system (continued)

necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2008 release of the OPPS PRICER. The updated payment rates, effective October 1, 2008, will be included in the October 2008 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp on the CMS website shortly*.

b. Drugs and biologicals with OPPS pass-through status effective October 1, 2008
Three drugs have been granted OPPS pass-through status effective October 1, 2008, as noted in the following table.

Table 1 – Drugs granted pass-through status effective October 1, 2008

HCPCS code	Long descriptor	SI	APC
J9225	Histrelin implant (Vantas), 50 mg	G	1711
C9243*	Injection, bendamustine hcl, 1 mg	G	9243
C9359*	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc	G	9359

Note: Those HCPCS codes identified with an "*" indicate that they are new codes effective October 1, 2008.

c. New HCPCS codes for drugs and biologicals
There is one new drug HCPCS code for October 2008. HCPCS code C9244 (Injection, regadenoson, 0.4 mg) is assigned status indicator "K" and is assigned to APC 9244 effective October 1, 2008.

d. Updated payment rates for certain HCPCS codes effective January 1, 2008 through March 31, 2008
The payment rates for several HCPCS codes were incorrect in the January 2008 OPPS Pricer. The corrected payment rates are listed in Table 2 below and have been installed in the October 2008 OPPS PRICER, effective for services furnished on January 1, 2008 through implementation of the April 2008 update. If you have claims that were already processed for these HCPCS codes for services provided on or after January 1, 2008, and prior to April 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

Table 2 – Updated payment rates for certain HCPCS codes effective January 1, 2008 through March 31, 2008

HCPCS code	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J7324	0877	Orthovisc inj per dose	$169.10	$33.82
J9015	0807	Aldesleukin/single use vial	$757.34	$151.47
J9303	9235	Panitumumab injection	$82.86	$16.42

e. Updated payment rates for certain HCPCS codes effective April 1, 2008 through June 30, 2008
The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS PRICER. The corrected payment rates are listed in Table 3 below and have been installed in the October 2008 OPPS PRICER, effective for services furnished on April 1, 2008 through implementation of the July 2008 update. If you have claims that were already processed for these HCPCS codes for services provided on or after April 1, 2008, and prior to July 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

Table 3 – Updated payment rates for certain HCPCS codes effective April 1, 2008 through June 30, 2008

HCPCS code	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J7324	0877	Orthovisc inj per dose	$174.63	$34.93
J9303	9235	Panitumumab injection	$82.83	$16.29
Q4096	1213	VWF complex, not Humate-P	$0.65	$0.13

f. Updated payment rates for certain HCPCS codes effective July 1, 2008 through September 30, 2008
The payment rate for one HCPCS code was incorrect in the July 2008 OPPS PRICER. The corrected payment rate is listed in Table 4 below and has been installed in the October 2008 OPPS PRICER, effective for services furnished on July 1, 2008 through implementation of the October 2008 update. If you have claims that were already processed for this HCPCS code for services provided on or after July 1, 2008, and prior to October 1, 2008, your Medicare contractor will adjust the claims if you bring them to the attention of your contractor.

October 2008 update of the hospital outpatient prospective payment system (continued)

Table 4 – Updated payment rates for certain HCPCS codes effective July 1, 2008, through September 30, 2008

HCPCS code	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J7324	0877	Orthovisc inj per dose	$175.85	$35.17

g. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct reporting of units for drugs

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

i. Correct reporting of outpatient diagnostic nuclear medicine procedures when a radiolabeled product is provided in the inpatient setting

Effective January 1, 2008, under the OPPS, payment for diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures. In order to ensure that CMS captures appropriate diagnostic radiopharmaceutical costs for future rate setting purposes, CMS implemented nuclear medicine procedure-to-radiopharmaceutical edits in the I/OCE effective January 2008 that required a diagnostic radiopharmaceutical to be present on the same claim as a nuclear medicine procedure for payment under the OPPS to be made.

As is the standard process for edit lists under the OPPS, CMS reviews the appropriateness of the edits and considers modifying the edits quarterly as issues are brought to their attention. In April 2008, in response to several descriptions of specific clinical scenarios provided to CMS by members of the public, CMS added HCPCS code A9517 (Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie) to the list of radiopharmaceuticals that would be accepted for a nuclear medicine procedure claim to process. In addition, in July 2008, in response to additional comments and clinical scenarios provided to CMS by members of the public, CMS expanded the list of radiolabeled products that are accepted for nuclear medicine procedure claims to process to include all therapeutic radiopharmaceuticals and brachytherapy sources, in additional to all diagnostic radiopharmaceuticals.

Since these changes to the edit list were adopted for the July update, CMS has received additional reports of a clinical scenario where a radiolabeled product is provided to a patient by a hospital during an inpatient stay, and a nuclear medicine procedure follows after the patient has been discharged from the inpatient setting (typically days or weeks after the provision of the radiolabeled product). No additional radiolabeled product is administered to the patient for purposes of the nuclear medicine procedure. Payment for the radiolabeled product is bundled into payment for the inpatient admission, so the hospital is unable to report a HCPCS code for a radiolabeled product on the OPPS claim for the nuclear medicine procedure in order to meet the edit requirements.

Similar to other clinical scenarios CMS previously addressed through changes to the edit list, members of the public bringing this situation to CMS attention has indicated that situations where these radiolabeled products would be provided to a hospital inpatient, with follow-up diagnostic imaging performed in the hospital outpatient setting days or weeks later, would be rare, but are sufficiently common that hospitals require a methodology to appropriately bill and be paid for the associated nuclear medicine procedures. As a result of these requests, for the October 2008 update CMS has created HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay. This HCPCS code is assigned status indicator “N” because no separate payment is made for the code under the OPPS. The effective date of the code is January 1, 2008, the date the procedure-to-radiopharmaceutical edits were initially implemented. Because the Medicare claims processing system requires that

October 2008 update of the hospital outpatient prospective payment system (continued)

there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than $1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898.

With the specific exception described above for HCPCS code C9898, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

CMS expects that the majority of hospital outpatient claims for diagnostic nuclear medicine procedures will include reporting of a diagnostic radiopharmaceutical because both the radiopharmaceutical and the nuclear medicine procedure are provided in the hospital outpatient department, and that it will be only in uncommon circumstances that hospitals will provide a radiolabeled product during a hospital inpatient stay, followed by a diagnostic nuclear medicine procedure after the patient has been discharged. CMS will be monitoring claims to ensure that this is the case.

Therefore, beginning in October 2008, claims for diagnostic nuclear medicine procedures in which the radiolabeled product that provides the radioactivity for the study was furnished during a hospital inpatient stay will not be returned to the provider as long as the nuclear medicine procedure and HCPCS code C9898 are included on the same claim, with a token charge for HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits. Hospitals may submit claims reporting HCPCS code C9898 for dates of service beginning January 1, 2008.

The complete list of updated nuclear medicine procedure-to-radiolabeled product edits may be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp*.

j. Payment for therapeutic radiopharmaceuticals

The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to the costs. Therefore, the prospective payment rates for the HCPCS codes listed in Table 5 below, which were listed in Addendum B to the CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as CMS indicated in Transmittal 1536 (CR 6094 dated June 19, 2008; see *http://www.cms.hhs.gov/Transmittals/Downloads/R1536CP.pdf* on the CMS Web site).

Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at charges adjusted to cost will remain "H" effective July 1, 2008, through December 31, 2009, to indicate payment will be made for therapeutic radiopharmaceuticals at hospitals' charges adjusted to their costs.

Table 5 – Therapeutic radiopharmaceuticals paid at charges adjusted to cost from July 1, 2008, through December 31, 2009

HCPCS Code	Long Descriptor	SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H

7. Payment for brachytherapy sources

The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for brachytherapy sources for the period of July 1, 2008, through December 31, 2009, at hospitals' charges adjusted to the costs (with the exception of C2637, which is nonpayable, as noted in the table below). Therefore, the prospective payment rates for each source, which are listed in Addendum B to the CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as CMS indicated in Transmittal 1536, dated June 19, 2008, (see on the CMS Web site *http://www.cms.hhs.gov/Transmittals/Downloads/R1536CP.pdf*).

October 2008 update of the hospital outpatient prospective payment system (continued)

Instead, the status indicators of brachytherapy source HCPCS codes (except C2637) which were previously paid at charges adjusted to cost will remain "H" effective July 1, 2008 through December 31, 2008, for payment of brachytherapy sources at hospitals' charges adjusted to their costs. In addition, because of their cost-based payment methodology through CY 2009, brachytherapy sources will not be eligible for outlier payments or for the rural sole community hospital (SCH) adjustment during that time period. CMS will provide new instructions at a later date for brachytherapy source payment effective January 1, 2010. The codes for separately paid brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 6, the comprehensive brachytherapy source table below.

Note: When billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/Downloads/R1259CP.pdf*, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007.

Table 6 – Comprehensive list of brachytherapy sources payable as of July 1, 2008

HCPCS Code	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

8. Mental health codes on partial hospitalization program claims

If a hospital-based partial hospitalization program (PHP) bills with condition code 41 for mental health codes that are not on the PHP code list (List B) housed in the I/OCE, the I/OCE will return the claim to the provider (edit 80) with the claim message, "Mental health (MH) code not approved for partial hospitalization program." Examples of current mental health *CPT* codes that are not used in PHP processing are *90804, 90805, 90810, 90811, 96110,* and *96111*. These codes may be billed by the hospital but cannot be counted toward the three minimum services required to qualify for partial hospitalization.

9. Coverage determinations

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

October 2008 update of the hospital outpatient prospective payment system (continued)

Additional information

The official instruction, CR 6196, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1599CP.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6196
Related Change Request (CR) Number: 6196
Related CR Release Date: September 19, 2008
Related CR Transmittal Number: R1599CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1599, CR 6196

Medicare hospital outpatient prospective payment system PRICER file updated

The fourth quarter 2008 hospital outpatient prospective payment system (OPPS) PRICER downloads have been posted on the CMS Web site. You may go *to http://www.cms.hhs.gov/PCPricer/08_OPPS.asp#TopOfPage* to view the latest update in the Downloads section. ❖

Source: CMS PERL 200810-17

ELECTRONIC DATA INTERCHANGE

Nonacceptance of legacy provider numbers on incoming Medicare claims

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

Provider types affected

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

Provider action needed

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

- For 837 institutional claims, the employer identification number (EIN)/federal tax ID, qualified by "EI" or "TJ," will be accepted.
- For 837 professional claims, the provider's EIN/Tax ID, qualified by "EI" or "TJ," or social security number, as qualified by "SY," will be accepted.

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

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

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

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

Background

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

Additional information

If you have any questions, please contact your intermediary, carrier, A/B MAC, or DME MAC at its toll-free number 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 888-664-4112.

MLN Matters Number: SE0835
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 SE0835

Healthcare provider taxonomy code update effective October 1, 2008

Effective April 1 2008, the Healthcare Provider Taxonomy Codes (HPTC) were updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the *Washington Publishing Company Web site* at *http://www.wpc-edi.com/codes/taxonomy*.

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur.

To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor. ❖

Source: CMS Pub. 100-04, Transmittal 1614, CR 6190

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Provider, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

FRAUD AND ABUSE

CMS enhances program integrity efforts to fight fraud, waste and abuse in Medicare

The Centers for Medicare & Medicaid Services (CMS) today announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers; consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program.

"Because Medicare pays for medical services and items without looking behind every claim, the potential for waste, fraud and abuse is high," said CMS Acting Administrator Kerry Weems. "By enhancing our oversight efforts we can better ensure that Medicare dollars are being used to pay for equipment or services that beneficiaries actually received while protecting them and the Medicare trust fund from unscrupulous providers and suppliers."

As part of these enhanced efforts, CMS is consolidating its efforts with new program integrity contractors that will look at billing trends and patterns across Medicare. They will focus on companies and individuals whose billings for Medicare services are higher than the majority of providers and suppliers in the community. CMS is also shifting its traditional approach to fighting fraud by working directly with beneficiaries by ensuring they received the durable medical equipment or home health services for which Medicare was billed and that the items or services were medically necessary.

Furthermore, CMS will be taking additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in Florida, California, Texas, Illinois, Michigan, North Carolina and New York. Those additional steps include:

- Conducting more stringent reviews of new DMEPOS suppliers' applications including background checks to ensure that a principal, owner or managing owner has not been suspended by Medicare.
- Making unannounced site visits to double check that suppliers and home health agencies are actually in business.
- Implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and ordering or referring physicians.
- Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians.
- Verifying the relationship between physicians who order a large volume of DMEPOS equipment or supplies or home health visits and the beneficiaries for whom they ordered these services.
- Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the items and services for which Medicare is being billed.

The additional reviews that will be focused on DMEPOS equipment and supplies with high expenditures and high growth rates expect to identify items such as oxygen supplies and equipment, power mobility devices or power wheelchairs, and diabetic test strips.

For those claims not reviewed before payment is made, CMS is implementing further medical review of submitted DMEPOS claims by one of the new RACs. The RACs review paid claims for all Medicare Part A and B providers to ensure their claims meet Medicare statutory, regulatory and policy requirements and regulations. If the RACs find that any Medicare claim was paid improperly it will then request repayment from the provider if an overpayment was found or request that the provider is repaid if the claim was underpaid. The new national RACs can be found at www.cms.hhs.gov/RAC.

The new RACs were selected under a full and open competition and will begin to educate and inform providers later in October and November about the program. The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. The selection of these new contractors was based on a best value determination that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee. The three-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina and Arizona collected over $900 million in overpayments and nearly $38 million in underpayments returned to health care providers.

Finally, CMS is consolidating the work of Medicare's program safeguard contractors (PSCs), and the Medicare drug integrity contractors (MEDICs) with new zone program integrity contractors (ZPICs). The new contractors will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi). The first two ZPIC contracts were awarded to Health Integrity, LLC for Zone 4 which encompasses Texas, New Mexico, Colorado and Oklahoma and SafeGuard Services LLC for Zone 7 which encompasses Florida, Puerto Rico and US Virgin Islands.

"We are continuing to build on our fraud fighting and program integrity efforts by identifying high risk areas and trends to better focus our limited funds and resources," said Weems.

CMS enhances program integrity efforts to fight fraud, waste and abuse in Medicare (continued)

Medicare is required by law to pay claims to health care providers for services provided to beneficiaries within 30 days after the claim is submitted, as long as the claim meets Medicare's rules. After the claim is paid, CMS or its contractors can review the claim to ensure that the items or services were actually provided or the services were medically necessary. If the claim was not submitted under Medicare's rules, CMS checks to see if the claim was submitted in error or may be potentially fraudulent. Those claims that could be fraudulent are referred to law enforcement for further investigation.
For more information about CMS RAC Web site, please visit *http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf*.

To read the CMS Press release issued on October 6, 2008, access this link *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS Press Release, October 6, 2008

OIG publishes voluntary supplemental compliance program guidance for nursing facilities

New voluntary guidance will help nursing facilities develop compliance programs that address major Medicare and Medicaid fraud and abuse problems related to poor quality of care, billing Federal health care programs, and kickbacks. The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services announces that the supplemental compliance program guidance (CPG) for nursing facilities appears in the September 30 *Federal Register*.

The new CPG responds to developments in the nursing facility industry, including significant changes in the way nursing facilities deliver and receive reimbursement for health care services, evolving business practices, and changes in the federal enforcement environment.

"The new guidance reflects OIG's increased focus on quality of care for nursing home residents, as well as our longstanding commitment to safeguarding Medicare and Medicaid program funds and beneficiaries through fraud and abuse prevention efforts," said Inspector General Daniel R. Levinson. "The guidance should serve as a valuable resource for the long term care industry."

Since 1998, OIG has issued a series of CPGs directed at various health care industry sectors. Each provides comprehensive guidance to promote compliance with Medicare and other federal health care program rules and regulations. OIG originally published a CPG for nursing facilities in 2000. The new CPG reflects input from public comments received on a draft document published in the *Federal Register* in April 2008 and provides a roadmap for developing, implementing, and evaluating nursing facility compliance programs.

According to the new CPG, "A successful compliance program addresses the public and private sectors' common goals of reducing fraud and abuse, enhancing health care providers' operations, improving quality of health care services, and reducing their overall cost. Meeting these goals benefits the nursing facility industry, the Government, and residents alike."

A significant goal of the new CPG is fostering quality of care in nursing facilities. The new CPG will help compliance professionals address areas such as staffing, resident care plans, medication management, appropriate use of psychotropic medications, and resident safety. The new CPG emphasizes the importance of submitting accurate claims and discusses issues related to reporting resident case-mix data, therapy services, screening for excluded individuals and entities, and restorative and personal care services. The guidance also urges nursing facilities to consider the risks of improper kickback payments associated with their business arrangements including those involving free goods and services, as well as those with physicians and suppliers.

The guidance, "OIG Supplemental Compliance Program Guidance for Nursing Facilities," appears in the *Federal Register* on September 30, 2008. It is also available on the OIG Web site at *http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf*. ❖

Source: OIG News, September 30, 2008

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 e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Provider, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
November 2008 – January 2009

Hot topics – Medicare updates, coverage determinations, and tips to avoid claim denials and returns.

When: Wednesday, November 12, 2008

Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time

Type of Event: Webcast

Ask the contractor – Topic: Better business through better billing

When: Wednesday, December 10, 2008

Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time

Type of Event: Webcast

Hot topics – Medicare updates, coverage determinations, and tips to avoid claim denials and returns.

When: Wednesday, January 14, 2009

Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time

Type of Event: Webcast

Two easy ways to register

Online – Log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account using the instructions at *www.floridamedicare.com/Education/108651.asp* to register for a class and obtain materials.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.
Keep checking our Web site, *www.floridamedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Tips for using the FCSO provider training Web site

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

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

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.
If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to fcsohelp@geolearning.com.

Please Note:

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

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

More educational events (teleconferences, webcasts, etc.) are being planned to help providers with hot issues. Keep checking our Web site *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events. ❖

Order Form – Medicare 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: FCSO – account number 40-500-150.**

Number Ordered	Item	Account Number	Cost per Item
_____	***Medicare A Bulletin* Subscriptions –** The *Medicare A Bulletin* is available free of charge online at *http://www.fcso.com*. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers that meet the above criteria must register with our office (see May 2008 *Medicare A Bulletin* page 4) to receive the *Bulletin* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason is given indicating why the electronic publication available free-of-charge on the Internet cannot be used. Non-Medicare providers (e.g., billing agencies, consultants, software vendors, etc.) or providers that need additional copies at other office-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published in 2009 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription renewal or [ ] New subscription	40-500-150	$33.00 (Hardcopy) $55.00 (CD-ROM)

Subtotal $ _____

Tax **(add % for your area)** $ _____

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.

Medicare Publications

P.O. Box 406443

Atlanta, GA 30384-6443

Facility Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Attention:_____ Area Code/Telephone Number:_____

Please make check/money order payable to: FCSO Account #40-500-150

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT LEGIBLY

Note: *The Medicare A Bulletin is available* ***free of charge*** *online at* ***www.fcso.com***.

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-04 (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 Outreach and Education
P. O. Box 45157
Jacksonville, FL 32232-5157

Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

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 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)
Attn: FOIA PARD – 16T
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

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

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
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-888-664-4112
Speech and Hearing Impaired
1-877-660-1759

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

ELECTRONIC 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 Web sites

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦