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

Medicare annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider types affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DMACs], and fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs]).

Impact on providers

This article is based on change request (CR) 6107 and reminds the Medicare contractors and providers that the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm* in June of each year.

Background

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

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

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

Additional information

The official instruction (CR 6107) issued to your Medicare contractor is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf*.

As mentioned, you may find the new, revised, and discontinued ICD-9-CM diagnosis codes at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage* on the CMS Web site or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm*, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided on the CMS Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage*.

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found 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: MM6107
Related Change Request (CR) Number: 6107
Related CR Release Date: July 29, 2008
Related CR Transmittal Number: R1566CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1566, CR 6107

Revised form CMS-R-131 advance beneficiary notice of noncoverage

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

Provider types affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised advance beneficiary notice (ABN) of noncoverage; which combines the general advance beneficiary notice (ABN-G) and laboratory advance beneficiary notice (ABN-L) into a single form, with form number CMS-R-131 (03/08).

You should be aware that beginning March 3, 2008, and prior to March 1, 2009, your contractors will accept either the current ABN-G, and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN CMS-R-131 (03/08) as valid notification**.

Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious nonmedical health care institutions paid under Part A; were instructed to use the general ABN-G or ABN-L to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised ABN of noncoverage. This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number CMS-R-131 (03/08).

The *Medicare Claims Processing Manual Chapter* 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. A total of 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR 6136 is the updated Chapter 30 and the Web address for viewing CR 6136 is contained in the "*Additional Information*" section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare fee-for-service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious nonmedical health care institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and notice of exclusion from Medicare benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

   Note: Once the revised skilled nursing facility (SNF) ABN is implemented, SNFs must use the revised SNF ABN for all items and services billed to Part A and Part B.
3. The following situations require by statute that an ABN be issued:
   - Care is not reasonable and necessary
   - There was a violation of the prohibition on unsolicited telephone contacts
   - Medical equipment and supplies supplier number requirements not met
   - Medical equipment and/or supplies denied in advance
   - Custodial care
   - A hospice patient who is not terminally ill.
4. In the following situations ABN use is voluntary ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e., care that is never covered) or fails to meet a technical benefit requirement (i.e., lacks required certification). Additionally, the ABN may also be issued voluntarily in place of the NEMB for care that is never covered such as:
   - Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act.
   - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
     - Services for which there is no legal obligation to pay
     - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles)
     - Services required as a result of war
     - Personal comfort items
     - Routine physicals (except the initial preventive physical or "Welcome to Medicare" physical examination) and most screening tests
     - Routine eye care
     - Dental care
     - Routine foot care

Revised form CMS-R-131 advance beneficiary notice of noncoverage (continued)

5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as "**notifiers**". Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

   Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three "**triggering events**" during a course of treatment (initiation, reduction, and termination). Notifiers must give an ABN to "**recipients**" (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers' inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient's record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN preparation requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and comprehensive outpatient rehabilitation facility (CORF).

Additional information

You may find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf*.

There you will find the updated *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

Additional information on the revised ABN and other limitation of liability notices may be found on the Beneficiary Notice Initiatives Web site at *http://www.cms.hhs.gov/bni*. Questions regarding the revised ABN may be e-mailed to RevisedABN_ODF@cms.hhs.gov.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM6136
Related Change Request (CR) Number: 6136
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1587CP
Effective Date: March 3, 2008
Implementation Date: March 1, 2009

Source: CMS Pub. 100-04, Transmittal 1587, CR 6136

Reporting changes to Medicare enrollment information

Information for physicians, nonphysician practitioners (NPPs) and group practices

The Centers for Medicare & Medicaid Services (CMS) has posted three new fact sheets on the Medicare Provider Enrollment page, *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*, on the CMS Web site.

These fact sheets list the types of changes that enrolled physicians, NPPs, and group practices are required to report to Medicare within specific times of occurrence. Nonreporting of changes may adversely affect claims processing, claims payment amounts, and the eligibility of the physician, NPP, or group practice to participate in Medicare. The fact sheets indicate the Medicare provider enrollment forms that must be used to report the changes, and include information on where to go for assistance.

Links to each fact sheet are provided below:

Reporting Responsibilities for Individual Physicians Enrolled in the Medicare program *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/PhysicianReportingResponsibilities.pdf*.

Reporting Responsibilities for Individual Nonphysician Practitioners Enrolled in the Medicare Program *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/Non-PhysicianReportingResponsibilities.pdf*.

Reporting Responsibilities for Physician Group Practices Enrolled in the Medicare Program *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/GroupPracticeReportingResponsibilities.pdf*. ❖

Source: CMS Provider Education Resource 200809-32

Reporting withholding due to IRS federal payment levy program

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

Provider action needed

STOP – impact to you

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.

CAUTION – what you need to know

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of "WU" in the PLB03-1 data field.

GO – what you need to do

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

Background

In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP), which is authorized by the Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. **Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.**

Additional information

To view the official instruction (CR 6125) issued to your Medicare contractor on this issue, visit on the Centers for Medicare & Medicaid Services Web site *http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.pdf*.

MLN Matters Number: MM6125
Related Change Request (CR) Number: 6125
Related CR Release Date: August 15, 2008
Related CR Transmittal Number: R367OTN
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-20, Transmittal 367, CR 6125

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments

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

Provider types affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit claims to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, Medicare administrative contractors (A/B/MAC), or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided or supplied to Medicare beneficiaries.

What you need to know

Change request (CR) 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a qualified independent contractor (QIC).
- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.
- If the administrative law judge (ALJ) level process reverses the Medicare overpayment determination, Medicare will refund both principal and interest collected, and also pay Section 935 interest on any recouped funds that Medicare took from ongoing Medicare payments. (If a provider has any other outstanding overpayments, Medicare will apply the amount *collected* first to those overpayments and any excess monies will then be refunded back to the provider.)
- Payment of Section 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.
- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

This article provides more detail on these general points and clarifies which overpayments are subject to this limitation on recoupment and which types of overpayments are not subject to this limitation. Make sure that your billing staffs are aware of these changes as described below.

Background

Before the MMA was enacted, a provider electing to appeal an overpayment determination did not affect Medicare's prerogative to recover the debt. However, through an amendment of Title XVIII of the Social Security Act (the Act), MMA Section 935 changed this process, by adding a new paragraph (f) to Section 1893 of the Act.

This amendment requires the Centers for Medicare & Medicaid Services (CMS) to change: 1) the way it recoups certain overpayments to providers, physicians and suppliers; and 2) how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent ALJ or judicial levels of appeal.

CR 6183 describes these changes to the providers, physicians and suppliers overpayment recoupment process. Specifically, Section 1893 (f)(2)(a) of the Social Security Act protects providers, physicians, and suppliers during the initial stages of the appeal process (both first level appeal – contractor redetermination, and second level appeal – QIC reconsideration) by limiting the recoupment process for Medicare overpayments while the appeals process is underway.

It requires that when a valid first or second level appeal is received from a provider on an overpayment, subject to certain limitations (see below), CMS and its Medicare contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Overpayments that are subject to limitation on recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision).
- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued.
- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision), or
- MSP recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).
- The final claims associated with a home health agency (HHA) request for anticipated payment (RAP) under the home health prospective payment system (HH PPS), but not the RAP itself (see table 2).

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments (continued)

Overpayments that are not subject to limitation on recoupment

- All other MSP recoveries except those identified in the preceding section of this article.
- Beneficiary overpayments
- Overpayments that arise from a cost report determination.
- Overpayments that are appealed under the provider reimbursement payment (PRB) process of 42 CFR parts 405 subpart R-Provider/Reimbursement Determinations and Appeals.
- HHA requests for anticipated payment (RAP) under home health prospective payment system (HH PPS).

  Note: While a RAP is not considered a claim for purposes of Medicare appeal regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Sections 10.1.10 (Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment (RAP)), and 50 (Beneficiary-Driven Demand Billing Under HH PPS). This manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.**)**
- Hospice caps calculations
- Provider initiated adjustments
- Accelerated/advanced payments
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The rebuttal process

Here is how the rebuttal process with the limitation on recoupment works.

You are given an opportunity to **rebut** any proposed recoupment action submitting a statement within 15 days of the notice of an impending recoupment action. **These rebuttal procedures occur prior to the appeals process and are separate from the requirements of the limitation on recoupment.**

The rebuttal process gives you a vehicle to indicate why the proposed recoupment should not take place; but you should remember that, as opposed to the limitations that CR 6183 describes, your Medicare contractor may (based on the rebuttal statement) determine to either stop, or proceed with, recoupment.

Step one – overpayments

Part A

As a result of post-pay reviews or MSP recoveries and during the Part A claim adjustment process (including Part B of A claims), Medicare FIs, RHHIs, and/or MACs, will determine if the limitations apply to the claim and annotate the system of the MMA Section 935 adjustment. If the adjustment results in a refund to the provider, they will follow existing underpayment policies; however, if the adjustment is deemed an overpayment and the Section 935 rules apply, they will mark the claim as being available for the limitation on recoupment protections.

Part B

As a result of post-pay reviews or MSP recoveries and during the Part B claim adjustment process, Medicare carriers and MACs, including DME MACs, will adjust claims in the normal manner.

Step two – demand letter

These adjustments will trigger the creation of the first demand letter (unless previously issued), which (in addition to the requirements listed in the *Medicare Financial Management Manual*, Chapter 3 (Overpayments), and Chapter 4 (Debt Collection)) will:

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment).
- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter.
- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.
- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, **or** (when appropriate) why the provider was not found to be without fault in causing the overpayment.
- Explains that recoupment will begin on the 41st day from the date of the first demand letter if: 1) payment is not received in full, or 2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter. However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received and validated, but Medicare may not refund any recoupment already taken.

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments (continued)

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.
2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities may resume within the designated timeframes.
3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

Step three – how to stop recoupment
First level appeal (redetermination)

Recoupment can proceed on day 41 from the first demand letter unless you submit a request for a redetermination by the 30th day following the date of the first demand letter, in which case recoupment will stop.
Table 1 below displays the time frame for the recoupment process after the first demand letter.

Time frame	Medicare Contractor	Provider
Day 1	Date of demand letter (date demand letter mailed).	Provider receives notification by first class mail of overpayment determination.
Day 1-15	Day 15 deadline for rebuttal request. No recoupment occurs.	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs.	Provider can appeal and potentially limit recoupment from occurring.
Day 41	Recoupment begins.	Provider can appeal and potentially stop recoupment.

Redetermination or reconsideration (appeals) requests

Upon receiving your valid request for a redetermination of an overpayment, your Medicare contractor will take the following actions:

- Cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started.
- Retain any amounts recouped, if they had already recouped funds before receiving the request for redetermination, and apply them first to interest and then to principal.
- Will continue to collect any other debts that you might owe, but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A redetermination can have three possible outcomes:

1. Full reversal of the overpayment decision.
   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (they may apply these funds to any other debt that you might owe and then release any excess to you).
2. Partial reversal (partially favorable) of the overpayment decision.
   In this instance (in which the debt is reduced below the initial stated amount) Medicare contractors will recalculate the correct amounts of both the underpayment and the overpayment, make appropriate payments to you if due; or, if necessary, issue a revised demand letter for the newly calculated overpayment amount. This letter will state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination if they have not been notified by the QIC that you have requested a reconsideration. It will also state that in order to stop recoupment under the provisions of Section 935 of the MMA, you must request a valid appeal (reconsideration) of the overpayment within 60 days from the date of the notice. It will also remind you that you have an opportunity to rebut the proposed recoupment action (but keep in mind that a rebuttal does not mandate that recoupment will stop).
3. Full Affirmation of the overpayment decision.
   With this "unfavorable" decision that upholds the overpayment determination, the Medicare contractor will issue the second or third demand letter (as appropriate), which will state that they can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice, it they have not been notified by the QIC that you have requested a reconsideration.

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments (continued)

Table 2 below displays the time frame for the recoupment process after redetermination.

Time frame	Medicare Contractor	Provider
Day 60 following revised notice of overpayment following redetermination	Date reconsideration request is stamped in mailroom, or payment received from the revised overpayment notice	Provider must pay overpayment or must have submitted request for 2nd level appeal
Day 61 – 75	Recoupment could begin on the 61st day	Provider appeals or pays
Day 76	Recoupment begins or resumes	Provider can still appeal. Recoupment stops on date receipt of appeal

Second level appeal (reconsideration)

You can also stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the appropriate notice/letter.

When your Medicare contractor receives notification from the QIC of your valid and timely request for a reconsideration, they will:

- Cease recoupment of the overpayment, or not initiate recoupment if it has not yet begun.
- Retain the amount recouped, and apply it first to interest and then to principal (if the recoupment process had begun before the reconsideration request was received).
- Will continue to collect other debts that you might owe, if an overpayment is appealed and recoupment stopped; but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A QIC reconsideration can have three possible outcomes:

1. **Full reversal**
   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (the amount held may be applied to any other debt that you might owe and any excess refunded to you).
2. **Partial reversal**
   In this instance, this reduces the overpayment. Medicare contractors effectuate the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Medicare contractors may apply the excess to any other debt (including interest) that you might owe before releasing payment to you.
   They will issue you a notice of the revised overpayment amount, which will also state that they can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give you an opportunity to make payment arrangements or to rebut the recoupment as described above.
3. **Affirmation**
   If the QIC reconsideration results in an "unfavorable" overpayment decision, recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives you time to make payment or to request a repayment plan.

Note: Medicare contractors can initiate (or resume) recoupment immediately upon receipt the **QIC's** decision or dismissal notice of a physician's, provider's, or supplier's request for reconsideration, regardless of a subsequent appeal to the ALJ (third appeal level) and all further levels of appeal (see below).

Third level of appeal (administrative law judge)

Whether or not the provider, physician or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or federal court, the Medicare contractor will continue to recoup until the debt is satisfied in full.

Additional details of change request 6183

CR 6183 also provides some additional specific payment details, such as:

1. If you have been granted an extended repayment schedule (ERS) and have submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, you will not be considered in default if your payments were not made. The appeal would supersede the ERS agreement.
   Further, payments that you make under an ERS are **not** recoupment for the limitation provision and are not subject to Section 935 interest, if reversed at the ALJ appeal or above. However, if you default on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupment **are** subject to payment of interest under the Section 935 interest requirements.
2. Suspended funds involving providers who have been put on payment suspension are **not** a "recoupment" for purposes of the limitation on recoupment. Medicare is not restricted from applying suspended funds to reduce or dispose of an overpayment. However, if the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR, Section 405.379 "Limitation on Recoupment" provision under Section 1893(f)(2) of the Social Security Act, Section 935 of the MMA Act will be applicable to any remaining balance still owed to CMS.
3. Payments made by a provider in response to a demand are **not** recoupments. Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are **not** subject to Section 935 interest.

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments (continued)

4. Lastly, CR 6183 amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called Section 935 interest, which is payable on an underpayment when the reversal occurs at the ALJ level or subsequent levels of administrative appeal, when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds (based on the period that Medicare recouped the provider's or supplier's funds). Payment of Section 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions, and is only payable on the principal amount recouped. In these instances, Medicare will pay simple interest rather than compound interest, and ***will not pay interest on interest; (mirroring the manner in which interest against providers is assessed).*** Monies recouped and applied to interest would be refunded and **not** included in the "amount recouped" for purposes of calculating any interest due the provider.

The periods of recoupment will be calculated in full 30-day periods; and interest **will not** be payable for any periods of less than 30 days in which Medicare had possession of the recouped funds; and will be calculated for each 30-day period using the interest rate in effect on the ALJ decision date or the revised written final determination date.

Finally, please be aware that CR 6183 does not change the rebuttal process for this recovery, nor the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, or the decision making time frames.

Additional information

You may find the official instruction, CR 6183, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf*.

You will find the updated *Medicare Financial Management Manual*, Chapter 3 (Overpayments), as an attachment to CR 6183.

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: MM6183
Related Change Request (CR) Number: 6183
Related CR Release Date: September 12, 2008
Effective Date: September 29, 2008
Related CR Transmittal Number: R141FM
Implementation Date: September 29, 2008

Source: CMS Pub. 100-06, Transmittal 141, CR 6183

Inpatient psychiatric facility and skilled nursing facility PPS PRICER updates

The provider data distributed with the inpatient psychiatric facility (IPF) prospective payment system (PPS) PC PRICER has been updated as of July 2008. The RY2008 IPF PPS PC PRICER on the Web page *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp*, under "Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC PRICER," has been updated with the latest provider data. If you use the IPF PPS PC PRICER, please go to the page above and download the latest version of the IPF PPS PC PRICER posted on August 12, 2008.

Due to receiving updated quarterly provider data, the skilled nursing facility (SNF) prospective payment system (PPS) PC PRICER has been revised. See the FY 2008.2 SNF PPS PC PRICER on the Web page, http://www.cms.hhs.gov/PCPricer/04_SNF.asp, under the "Downloads" section. If you use the FY 2008.2 SNF PPS PC PRICER, please go to the page above and download the latest version of the PC PRICER. ❖

Source: CMS Provider Education Resource 200808-21

Note on payment for imaging services

The Deficit Reduction Act of 2005 capped the Medicare physician fee schedule (MPFS) payment for the technical component (TC) of most imaging services at the outpatient prospective payment system (OPPS) payment rate. The cap applies to both TC-only and the TC of global services. Where the payment is capped, the MPFS files may disclose only the capped payment amount. Several providers have requested disclosure of both the capped and uncapped amounts. Such information may be found at *http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp#TopOfPage*. ❖

Source: CMS Provider Education Resource 200809-38

Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines

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

Provider types affected

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

Impact on providers

This article is based on change request (CR) 6079 and notifies providers that the Centers for Medicare & Medicaid Services (CMS) revised Form CMS-1500 to accommodate the reporting of the national provider identifier (NPI). The current Form CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills. Therefore your Medicare contractor **should not return claims as unprocessable** to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of Form CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.

Key point of change request 6079

The requirement of an NPI for the rendering provider does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills.

Additional information

To see the official instruction (CR 6079) issued to your Medicare FI, carrier, or A/B MAC visit the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1586CP.pdf*.

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

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

MLN Matters Number: MM6079
Related Change Request (CR) Number: 6079
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1586CP
Effective Date: October 6, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1586, CR 6079

Flu shot reminder

Flu season is coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. 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 workers also need to protect themselves. **Get your flu shot – not the flu.**

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

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

To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing go to the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. ❖

Source: CMS PERL 200809-19

Supplier number required for federally qualified health clinics to bill DME

This is in response to a federally qualified health clinic (FQHC) question raised on the September 3, 2008, special open door forum: DMEPOS Accreditation – MIPPA 2008 Guidance. Durable medical equipment (DME) is not covered within the Medicare FQHC benefit.

All FQHCs would need to have a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier number in order to bill for those separately, and go through the same process as any other DME supplier. Thus, all FQHCs billing for the products covered under the DME quality standards would be subject to the accreditation deadline of September 30, 2009, in order to continue to bill for these supplies.

If you would like a list of those supplies, please go to the Web site at *http://www.cms.hhs.gov/medicareprovidersupenroll/*.

There is a link on the upper left-hand side of the page for DMEPOS accreditation. Once on that site, you will find the 10 accreditation organizations, the quality standards, and a fact sheet listing all of the covered items. ❖

Source: CMS Provider Education Resource 200809-22

Implementation of provider authentication requirements for contacting Medicare

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

Provider types affected

Change request (CR) 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to interactive voice response (IVR) systems.

What you need to know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a customer service representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide all three of the following data elements for authentication:

1. Your national provider identifier (NPI)
2. Your provider transaction access number (PTAN)
3. The last five digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last five digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last five digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last five digits of your TIN.

As a result of CR 6139, the Disclosure Desk Reference for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of providers with no NPI

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary authentication

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

1. last name
2. first name or initial, health insurance claim number (HICN)
3. either:
   - date of birth (eligibility, next eligible date) and Durable Medical Equipment Medicare Administrative Contractor Information Form [DIF] [pre-claim]
   - date of service (claim status, CMN/DIF [post-claim])

Written inquiries

In general, three data elements (NPI, PTAN, and last five digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on remittance advice (RAs) or Medicare summary notices [MSNs]).

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider.

Implementation of provider authentication requirements for contacting Medicare (continued)

(However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last five digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last five digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping claims

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last five digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional information

You may find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf*.

If you have any questions, please contact your Medicare contractor (carrier, FI, RHHI, 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: MM6139
Related Change Request (CR) Number: 6139
Related CR Release Date: August 8, 2008
Related CR Transmittal Number: R22COM
Effective Date: March 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-09, Transmittal 22, CR 6139

HHS proposes adoption of ICD-10 code sets and updated electronic transaction standards

Proposed changes would improve disease tracking and speed transition to an electronic health care environment

The Department of Health & Human Services (HHS) announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2011. In a separate proposed regulation, HHS has proposed adopting the updated X12 standard, version 5010, and the National Council for Prescription Drug Programs standard, version D.0, for electronic transactions, such as health care claims. Version 5010 is essential to use of the ICD-10 codes.

In 2000, under authority provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the ICD-9-CM code sets were adopted for use in the administrative transactions by both the public and private sectors to report diagnoses and inpatient hospital procedures. Covered entities required to use the ICD-9-CM code sets include health plans, health care clearinghouses, and health care providers who transmit any electronic health information in connection with a transaction for which a standard has been adopted by HHS.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help to enable the implementation of electronic health records because they will provide more detail in the electronic transactions.

Comments on both the ICD-10 code sets proposed rule and the updated transaction proposed standards are due by 5:00 p.m. Eastern Time on October 21, 2008.

Both regulations may be viewed at *www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage*.

To read the HHS press release issued please click here *http://www.hhs.gov/news/press/2008pres/2008.html*.

Fact sheets describing both proposed rules will be forthcoming at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

Visit the Medicare Learning Network – it's free. ❖

Source: CMS PERL 200808-23

Physician signature requirements for diagnostic tests

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) for diagnostic laboratory services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests (including X-ray, laboratory, and other diagnostic tests) that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional information

You may find more information about physician signature requirements for diagnostic tests by going to CR 6100, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf.*

You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR 6100.

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: MM6100
Related Change Request (CR) Number: 6100
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R94BP
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Source: CMS Pub. 100-02, Transmittal 94, CR 6100

Availability of interim study of alternative payment localities under the Medicare physician fee schedule

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 different localities, which have not been revised since 1997. In the calendar year (CY) 2009 physician fee schedule notice of proposed rulemaking, which was released on June 30, 2008, the Center for Medicare & Medicaid Services (CMS) indicated that they would post on their Web site a preliminary study of several options for revising the payment localities. The report entitled: "Review of Alternative GPCI Payment Locality Structures", which was produced by Acumen, LLC under contract to CMS, may currently be found at the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/ReviewOfAltGPCIs.pdf*.

CMS 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 encourages 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.

Electronic comments on the interim report may be submitted to *CMS MPFS@cms.hhs.gov* until October 20, 2008. ❖

Source: CMS PERL 200808-25, 200809-06

Nine-digit ZIP codes required for billing institutional claims

On November 23, 2007, the Centers for Medicare & Medicaid Services (CMS) instructed fiscal intermediaries (FIs) to turn off reason code 31999 (missing or invalid nine-digit ZIP code) until further notice. CMS has now instructed FIs to activate reason code 31999 and apply the missing or invalid nine-digit ZIP code criteria.

Effective for claims processed on or after September 1, 2008, FIs will **return to providers** any claim received with only a five-digit ZIP code or where the nine-digit ZIP code submitted on the claim does not match the nine-digit ZIP code in the Medicare provider master address file.

Action required by providers

Providers receiving claims returned to providers with reason code 31999 must submit a **CMS-855A Enrollment Application** (version 02/08) to update the provider master address file with a valid nine-digit ZIP code. The CMS-855A (02/08) enrollment application may be mailed to:

Medicare Provider Enrollment (Florida Part A)
P.O. Box 45169
Jacksonville, FL 32232-5169

Note: CMS issued revised CMS-855 Medicare enrollment applications in March 2008. Effective July 1, 2008, FIs will only accept the CMS-855A (02/08) version of the Medicare Enrollment Application for Institutional Providers. An electronic copy of the current CMS-855A (02/08) may be found at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp*. ❖

Source: CMS JSM 08442, August 21, 2008

Signature requirement clarification

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries, regional home health intermediaries, Part A/B Medicare administrative contractors, including durable medical equipment Medicare administrative contractors) for care provided to Medicare beneficiaries.

What you need to know

The purpose of this notice is to provide guidance to providers/suppliers and Medicare contractors on the use of stamped signatures. **Note that stamped signatures are not acceptable on any medical record.**

Background

The Centers for Medicare & Medicaid Services (CMS) has taken this step to ensure accurate application of Medicare's program requirements throughout the nation. CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systematic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents.

Change request (CR) 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. These requirements are intended to apply all providers/suppliers. **Stamped signatures are not acceptable on any medical record.** Medicare will accept hand written, electronic signature or facsimiles of original written or electronic signatures.

In addition, the Medicare conditions of participation (CoP) are requirements for ensuring health and safety. The CoPs define specific quality standards that providers must meet to participate in the Medicare program. A provider's compliance with the CoPs is ultimately determined by the CMS regional office based on the state survey agency recommendation (per the *Medicare Program Integrity Manual*, Publication 100-8, Chapter 3, Section 3.4.2.1, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf*). Compliance with the CoPs and any related policies does not necessarily ensure that certain requirements for payment are being met.

Additional information

The official instruction, CR 5971, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf*.

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

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

MLN Matters Number: SE0829
Related Change Request (CR) Number: 5971
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 SE0829

October 2008 average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

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 (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6175, from which this article is taken, instructs Medicare contractors to download and implement the October 2008 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2008, April 2008, January 2008, and October 2007 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

The ASP methodol*ogy* is based on quarterly data that drug manufacturers submit to CMS, which CMS then provides (quarterly) to Medicare contractors (carriers, *DME* MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs. Please note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under Section 1847A.

For the purpose of identifying "single source drugs" and "biological products" subject to payment under Section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The Food and Drug Administration (FDA) approval
- Therapeutic equivalents as determined by the FDA
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are **not** two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of not otherwise classified (NOC) HCPCS codes.

Average sales price methodology

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities)
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits are not being updated in 2008**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were

October 2008 average sales price Medicare Part B drug pricing files and revisions... (continued)

not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file.**

  Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.
- On or after September 16, 2008, the October 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after September 16, 2008, the October 2008 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR 6049 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
October 2008 ASP and NOC files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim makes these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

October 2008 average sales price Medicare Part B drug pricing files and revisions... (continued)

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Please be aware that your contractors will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

You may find the official instruction, CR 6175, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1595CP.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: MM6175
Related Change Request (CR) Number: 6175
Related CR Release Date: September 12, 2008
Related CR Transmittal Number: R1595CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1595, CR 6175

Reporting national provider identifier for secondary providers

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

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 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

Reporting national provider identifier for secondary providers (continued)

(ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that identifier must be an NPI.

- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) does not furnish its NPI at the time of the order/, referral, purchase, prescription, or time of service, **you** as the billing provider need to know that NPI in order to use it in your claim.
- You may use the NPI registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the implementation guides for the X12N claims transactions permit the reporting of the social security number (SSN) for some secondary providers if there is no NPI, the 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/R267PI.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
Related Change Request (CR) Number: 6093
Related CR Release Date: September 12, 2008
Related CR Transmittal Number: R267PI
Effective Date: May 23, 2008
Implementation Date: September 26, 2008

Source: CMS Pub. 100-08, Transmittal 267, CR 6093

October update to the 2008 Medicare physician fee schedule database

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

Provider types affected

Physicians and providers who submit claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services rendered to Medicare beneficiaries paid based on the Medicare physician fee schedule database (MPFSDB).

Key points of change request 6180

Changes in the October update to the 2008 MPFSDB are as follows:

CPT/HCPCS Codes	Action
15878 and 15879	Bilateral indicator = 1
92557 and 92567	PC/TC Indicator = 9
93660—26	Multiple Procedure Indicator = 2
G0398, G0399, and G0400	PC/TC Indicator = 1

- Attachment 1 of CR 6180 describes changes **effective March 13, 2008,** for:
  G0398–TC G0398–26 G0399-TC G0399-26 G0400-TC G0400-26
- An editorial change was made to the long descriptor of G0250 as noted in Attachment 1 of CR 6180.

Make certain your billing staffs are aware of these changes. Your Medicare contractor will retroactively adjust claims if you bring such claims to their attention.

October update to the 2008 Medicare physician fee schedule database (continued)

Background

This article is based on CR 6180, which states that payment files were issued to contractors based upon the 2008 MPFS final rule. CR 6180 amends those payment files.

Additional information

You may see the official instruction (CR 6180) issued to your Medicare carrier or A/B MAC, by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1580CP.pdf*.

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

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

MLN Matters Number: MM6180
Related Change Request (CR) Number: 6180
Related CR Release Date: August 22, 2008
Effective Date: January 1, 2008
Related CR Transmittal Number: R1580CP
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1580, CR 6180

FCSO selected to administer Medicare in Florida, Puerto Rico, and Virgin Islands

The Centers for Medicare & Medicaid Services (CMS) recently announced that First Coast Service Options Inc. (FCSO) has been awarded a contract of up to five years for the combined administration of Medicare Part A and Part B claim payment in Florida, Puerto Rico, and the U.S. Virgin Islands.

"With this award, CMS continues its progress in reengineering the way in which the government contracts for claim administration for the largest part of the Medicare program. CMS is seeking the best value, from a cost and technical perspective for this critical function," said acting CMS Administrator Kerry Weems. "This is another step toward improving services to beneficiaries and providers who are in the Medicare fee-for-service benefit plan."

FCSO will serve as the first point of contact for the processing and payment of Medicare fee-for-service claims from hospitals, skilled nursing facilities, physicians and other health care practitioners in Florida, Puerto Rico, and the U.S.Virgin Islands. The new Part A/Part B Medicare administrative contractor (A/B MAC) was selected using competitive procedures in accordance with federal procurement rules. The entire press release may be viewed at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS Provider Education Resource 200809-41

Medicare awards contracts for quality improvement organizations

Nationwide network of contractors to work with providers on improving quality and safety of health care for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) has awarded contracts for the 9th statement of work (SOW) for the 53 contractors participating in the Medicare quality improvement organization (QIO) program. The 9th SOW focuses on improving the quality and safety of health care services to Medicare beneficiaries. The QIO contracts extend from August 1, 2008, through July 31, 2011, and mark a new direction for the QIO program.

The QIO program 9th SOW aims to improve the quality of care and protect Medicare beneficiaries through three national themes, to be implemented by each of the 53 QIO contractors nationwide throughout the contract period:

- Beneficiary protection
- Patient safety (also known as the "CMS National Patient Safety Initiative")
- Prevention.

In addition to these national themes, QIOs in select states will focus on health disparities reduction, care transitions, and chronic kidney disease work.

For more information about the QIO 9th statement of work, including a list of all 53 QIOs and the states/jurisdictions selected for sub-national work, view the fact sheet at *http://www.cms.hhs.gov/QualityImprovementOrgs/downloads/9thSOWAnnouncement080508.pdf*.

For more information, please visit *http://www.cms.hhs.gov/QualityImprovementOrgs*. ❖

Source: CMS Provider Education Resource 200808-17

Implementation of new claim adjustment reason code 213

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], Medicare administrative contractors [A/B MAC], regional home health intermediaries [RHHI], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new claim adjustment reason code (CARC) 213 when denying claims based on non-compliance with the physician self-referral prohibition.

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

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound)
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Orthotics, prosthetics, and prosthetic devices
- Parenteral and enteral nutrients, equipment and supplies
- Physical therapy, occupational therapy, speech-language pathology services
- Outpatient prescription drugs
- Home health services and supplies
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC 213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition. Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You may read these exceptions in Section 1877 of the Social Security Act, which you may find on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf*; and in 42 C.F.R. Part 411, subpart J.) (42 U.S.C. Section 1395nn).

Additional information

You may find more information about CARC 213 by going to CR 6131, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf*.

You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR. If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, 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/CallCenter*.

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

MLN Matters Number: MM6131
Related Change Request (CR) Number: 6131
Related CR Release Date: August 15, 2008
Related CR Transmittal Number: R1578CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1578, CR 6131

CMS seeks cosponsors for conference on e-prescribing incentive payment program

The Centers for Medicare & Medicaid Services (CMS) held a conference to educate physicians and other stakeholders about a newly enacted federal program of incentive payments to encourage the use of electronic prescribing. CMS is requesting interested public and private sector organizations to join the agency as cosponsors of the conference, which will be held October 6–7, 2008, in Boston.

"The new incentive program will help spread adoption of e-prescribing throughout the health care community," said CMS acting Administrator Kerry Weems. "E-prescribing has many benefits for patients, providers, health plans, and pharmacies. Not only is e-prescribing more efficient than paper prescriptions, it is also safer. E-prescribing can help reduce the number of adverse drug events, which for Medicare beneficiaries alone is estimated at 530,000 (events) a year."

The many benefits of e-prescribing include:

- Physicians have electronic access to each patient's prescription history, helping him or her avoid prescribing drugs that may result in harmful drug interactions.
- E-prescribing eliminates the possibility of medication errors caused by illegible prescribing clinician handwriting.
- E-prescribing reduces confusion and miscommunication, resulting in fewer phone calls and faxes between the physician's office and the pharmacy.
- With access to a patient's insurance and formulary information at the point of care, physicians can prescribe a drug that is both covered and affordable, resulting in fewer trips to the pharmacy.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established a five-year program of incentive payments to eligible professionals who are "successful electronic prescribers." Successful prescribers are those who either report applicable electronic prescribing measures established under the Physician Quality Reporting Initiative (PQRI) or who electronically submit prescriptions under Medicare Part D at a level determined by CMS. The incentive payment program begins on January 1, 2009. The conference served to educate affected constituencies on the MIPPA program and CMS' plans for implementation.

The notice invites interested parties to submit proposals detailing how they could support CMS, in a nonfiduciary relationship, by developing conference content, identifying speakers, and implementing outreach activities to educate affected provider, business, and consumer stakeholders about this new program. Interested organizations may include:

- Physician and provider organizations (including those representing primary care, specialty care, surgical, and medicine-based specialties).
- Organizations representing health care professionals.
- Organizations representing pharmacy industry stakeholders, including retail and community pharmacies.
- Organizations representing state and local officials.
- Organizations representing a broad range of beneficiary interests.

The educational conference will:

- Equip health care professionals and other stakeholders with the knowledge and the tools to integrate e-prescribing into their business model.
- Educate health care professionals about the structure and implementation of the incentive payment structure with respect to e-prescribing and PQRI.
- Generate discussion about the use of e-prescribing and other e-health initiatives to increase patient compliance and overall health outcomes.
- Identify and promote opportunities to overcome barriers to adoption of this new technology
- Address constituent concerns about privacy, security, and risk management with respect to implementation of the e-prescribing incentive payment program

Selection criteria outlined in the notice included an applicant's:

- Identity as a non-profit, financially disinterested entity that represents constituencies affected by e-prescribing
- Demonstrated interest in e-prescribing technology and implementation and knowledge of current e-prescribing standards for Medicare Part D
- Presentation of activities and connections that likely will further the public health benefits of e-prescribing
- Willingness to work collaboratively with other public and private sector organizations to achieve the goals of e-prescribing and other e-health initiatives.

CMS invited selected organizations that meet the evaluation criteria to enter into formal, nonfiduciary cosponsor agreements to consult on the conference program content, speaker selection, and outreach strategies, in addition to other tasks as described in individual cosponsor agreements. Potential cosponsors must understand that cosponsor agreements will clearly indicate that there will be no federal endorsement of the cosponsor or endorsement of any policies, activities, products, or services resulting from cosponsorship of the conference

To read the entire CMS press release issued August 8, 2008, access this link in the CMS Web site *http://www.cms.hhs.gov/center/press.asp*. ❖

Source: CMS PERL 200808-08, 200808-12

HHS takes new steps to accelerate adoption of electronic prescribing

Medicare payments for successful electronic prescribers, reporting quality data are important steps toward a value-driven health care system

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value.

Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a two percent incentive payment in 2009 and 2010, a one percent incentive payment in 2011 and 2012, and a one half percent incentive payment in 2013.

Beginning in 2012, eligible professionals who are not successful electronic prescribers will receive a reduction in payment.

Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis, if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship.

To read more, see the HHS Fact Sheet at *http://www.hhs.gov/news/facts/eprescribing.html*. ❖

Source: PERL 200807-30

New CMS initiative helps to identify and assist Medicare beneficiary caregivers

Ask Medicare provides online information, tools, and materials for caregivers

The Centers for Medicare & Medicaid Services (CMS) recently launched **Ask Medicare**, a new initiative to help family caregivers – those who are family members or friends who help people with Medicare access and use valuable health care information, services, and resources.

According to a recent report by AARP, more than 44 million Americans (more than one in five adults), provide care valued in economic terms of $350 billion annually, to a loved one, friend, or neighbor.

The new initiative will provide a one-stop Web page for caregivers *http://www.medicare.gov/caregivers* that provides easy access to useful information about Medicare and other essential resources to help with caregiving. Most caregivers do not think of or identify themselves as caregivers; however, many of the resources available to them use that term.

The **Ask Medicare** Web site will provide links to key partner organizations that assist caregivers and beneficiaries, and present personal stories from caregivers in the community. Support information and tools to help caregivers address common problems will also be available. As part of the initiative, CMS will launch an e-newsletter for caregivers that will deliver information into the subscribers' e-mail boxes.

For more information about Medicare's new caregiver initiative, please visit *http://www.medicare.gov/caregivers*.

To read the CMS press release issued on September 18, 2008, click here *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200809-41

Beneficiary pilot program

The Centers for Medicare & Medicaid Services (CMS) today announced a pilot program to test options for beneficiaries with original Medicare to maintain their health records electronically. Under this pilot in Arizona and Utah, a beneficiary may choose one of the selected commercial personal health record (PHR) tools, and Medicare will transfer up to two years of the individual's claims data into the individual's PHR.

Beneficiaries who select one of the participating PHR vendors may also add other personal health information if they choose. Depending on the specific product, they may be able to authorize links to other personal electronic information such as pharmacy data. PHRs can offer links to tools that help consumers manage their health such as wellness programs for tracking diet and exercise, medical devices, health education information, and applications to detect potential medication interactions.

Beneficiaries can elect to allow family members to have access to their PHR. They can also provide access to the PHR to their health care providers.

If PHR vendors want more information about this pilot, they can visit *http://www.NoridianMedicare.com/phr/* or they can send an e-mail to *solicitation@medicarephr.org*.

To read the entire CMS press release issued August 8, 2008, access this CMS Web site: *http://www.cms.hhs.gov/center/press.asp*. ❖

Source: CMS PERL 200808-09

Lower Medicare Part D costs than expected in 2009

Beneficiary satisfaction remains high

The Centers for Medicare & Medicare Services (CMS) recently announced that as Medicare Part D prescription drug program enters its fourth year, beneficiary satisfaction rates remain high, program costs remain lower than originally expected, and Medicare prescription drug plan bids reflect nationwide drug price trends. Based on the bids submitted by Part D plans, CMS estimates that the average monthly premium beneficiaries will pay for standard Part D coverage in 2009 will be $28. This is about 37 percent lower than originally projected when the benefit was established in 2003.

The estimated average monthly premium for 2009 of roughly $28 for basic coverage is far below the original estimate for 2009 of $44.12, which was made at the time the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. The average expected premium for basic coverage in 2009 is about $3 higher than the actual average for 2008. The $3 premium increase is due to general trends in drug costs, the phase-out of a CMS demonstration project, and higher plan estimates for catastrophic coverage based on prior experience.

In addition to average premiums for 2009, CMS has announced the:

- 2009 national average monthly bid
- base beneficiary premium
- regional low-income subsidy premium amounts for 2009
- 2009 Medicare Advantage regional preferred provider organization benchmarks.

This data may be found at *http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp*.

To read the CMS Press release issued on August 14, 2008, access the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: CMS PERL 200808-22

Medicare issues new rules to enforce marketing requirements

The two regulations issued include prohibitions on telemarketing and other unsolicited sales contacts. The new rules also prohibit financial incentives that could encourage agents and brokers to maximize commissions by inappropriately moving, or churning, beneficiaries from one plan to another each year. Plans must be in compliance with these provisions when they begin their marketing activities on October 1, 2008.

The final rule implementing the Medicare Improvements for Patients and Providers Act (MIPPA) marketing requirements may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/2008-21674_PI.pdf*.

The interim final rule dealing with agent commissions and other MIPPA provisions may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/2008-21686_PI.pdf*.

Comments are due at 5:00 p.m. Eastern time on November 15, 2008.

Guidance for MA plans under Part C and PDPs under Part D plans may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/MIPPA_Imp_memo091208Final.pdf*.

Fact sheets with more information on each rule may be viewed at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

To read more of the CMS press release issued September 15, 2008, click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS Provider Education Resource 200809-41

August 2008 provider specific file update

Due to missing data, CMS had to reprocess the July 2008 quarterly provider specific files (PSF). Both the text, and the statistical analysis software (SAS) data have been revised and are now available on the CMS Web site at *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf.asp*, under the heading "Provider Specific Data for Public Use."

If you use the provider specific file data, please go to the page above and download the newer versions again of the PSF files.

Note: New this quarter. SAS data sets are now available for PSF data, in addition to the text files. Both sets of data have been revised. ❖

Source: CMS PERL 200808-02

Medicare providers remain satisfied with fee-for-service contractors

The Centers for Medicare & Medicaid Services (CMS) reports that Medicare health care providers continue to be satisfied with services provided by Medicare fee-for-service (FFS) contractors, showing a relatively smooth transition to the new Medicare administrative contractors (MACs). The average score based on a satisfaction survey across all contractors was 4.51 on a scale of 1 to 6. This year's average score was comparable to last year's average score of 4.56.

The Medicare contractor provider satisfaction survey (MCPSS), conducted by CMS for the third year, is designed to gather and report objective, quantifiable data on provider satisfaction with the FFS contractors who process and pay Medicare claims. In 2007, more than one billion claims were processed and paid to approximately one million health care providers who provided medically necessary items and services to 44 million beneficiaries.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 mandated the survey. Specifically, the law calls for CMS to develop contract performance requirements, including measuring provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to Medicare.

The summary report of the survey findings is available on the CMS Web site in the MCPSS section at *www.cms.hhs.gov/MCPSS*.

The CMS press release issued today may be viewed at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS Provider Education Resource 200808-30

Iowa and Indiana waivers expire

In June 2008, the Centers for Medicare & Medicaid Services (CMS) issued guidance that addressed Medicare skilled nursing facility (SNF) benefits' statutory requirement of a three-day prior hospital stay and the inability of beneficiaries who were evacuated or transferred because of the serious flooding in the states of Iowa and Indiana to meet this requirement. This guidance provided temporary emergency coverage of SNF services that are not post-hospital SNF services under our authority in section 1812(f) of the Social Security Act (the Act), for those beneficiaries who are evacuated, transferred, or otherwise dislocated as a result of the flooding.

In addition, for beneficiaries who, prior to the flooding, had been recently discharged from an SNF after utilizing some or all of their available SNF benefit days, guidance was issued to address the inability to meet the requirement to end an existing Medicare benefit period (or "spell of illness") before renewing SNF benefits. Under the authority of section 1812(f) of the Act, this policy enabled such beneficiaries to receive up to an additional 100 days of SNF Part A benefits for care needed as a result of the flooding, without first having to end a spell of illness by being discharged to custodial or non-institutional care for a 60-day period.

Unlike the general waivers issued in response to the Iowa and Indiana flooding under the authority of section 1135 of the Act, these two SNF-related policies were not limited to states designated as emergency areas. Rather, they would apply to all beneficiaries who were evacuated from an emergency area because of the flooding, regardless of where the "host" SNF providing post-flood care was located. In addition, these two SNF-related policies would remain in effect until CMS issued a notification that normal procedures would resume.

CMS has terminated these SNF-related policies concurrently with the general flood-related waivers issued under the section 1135 authority, which expire on September 12, 2008. Accordingly, effective with SNF admissions occurring on and after September 13, 2008, the Internet-only manual instructions for determining compliance with the SNF benefits' prior hospitalization and benefit period requirements shall apply.

Finally, beginning September 13, 2008, all program policies, questions, and answers that implemented modifications to program requirements under the section 1135 waiver authority for the Iowa/Indiana floods are no longer applicable. Therefore, claims with dates of service September 13, 2008, and later will follow all normal program requirements. ❖

Source: CMS Provider Education Resource 200809-26
CMS Provider Education Resource 200809-20

Delayed implementation of change request 5772

This information was previously published in the March 2008 Medicare A Bulletin (pages 7-10).

Change request 5772 – Medicare Clinical Laboratory Services Competitive Bidding Project, issued on February 1, 2008, was scheduled for implementation on July 7, 2008. However, due to a preliminary injunction issued in San Diego, implementation has been delayed. ❖

Source: JSM 08347, dated June 9, 2008

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:

- 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 'Reset 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 non-physician practitioners, 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 nonphysician practitioners, can 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.

Updating NPPES information

Health care providers, including physicians and nonphysician practitioners, 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 can 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*.

Need More 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 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 CMS Web page *https://www.cms.hhs.gov/NationalProvIdentStand*. ❖

Source: CMS Provider Education Resource 200809-16

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.

AMBULANCE SERVICES

July 2008 fee schedule for ground ambulance services under MIPPA

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. In accordance with Section 146(a) of MIPPA, ambulance fee schedule amounts for ground ambulance services have increased.

The fee increases are effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. First Coast Service Options Inc. will identify and, to the extent possible, automatically reprocess any claims that were paid under the previous fee schedule rates and complete that reprocessing no later than September 30, 2008.

HCPCS Code	Urban/Rural	Locality 01/02	Locality 03	Locality 04
A0425	Urban	$6.55	$6.55	$6.55
A0425	Rural	$6.61	$6.61	$6.61
A0426	Urban	$233.62	$245.08	$254.49
A0426	Rural	$235.91	$247.48	$256.98
A0427	Urban	$369.90	$388.04	$402.94
A0427	Rural	$373.52	$391.85	$406.89
A0428	Urban	$194.68	$204.23	$212.07
A0428	Rural	$196.59	$206.24	$214.15
A0429	Urban	$311.49	$326.77	$339.32
A0429	Rural	$314.54	$329.98	$342.65
A0432	Urban	$340.69	$357.41	$371.13
A0432	Rural	$344.03	$360.91	$347.77
A0433	Urban	$535.38	$561.64	$583.21
A0433	Rural	$540.62	$567.15	$588.92
A0434	Urban	$632.72	$663.76	$689.24
A0434	Rural	$$638.92	$670.27	$696.00

Source: CMS JSM 08429, July 24, 2008

Section 1011 Ask the Contractor teleconference — ambulance suppliers

The national contractor for the Section 1011 program, TrailBlazer Health Enterprises®, is hosting the third of three Ask the Contractor teleconferences (ACT) on Thursday, October 30, 2008, from 1:00 p.m. – 3:00 p.m. (CT).

This ACT is designed for Section 1011 ambulance suppliers and will examine a variety of program issues.

Conference call details

Ask the Contractor Teleconference – Ambulance Suppliers
Thursday, October 30, 2008
1-3:00 p.m. (CT)

You may register for the event on the calendar of events page of the Section 1011 Web site, *http://www.trailblazerhealth.com/Section_1011/Default.aspx?urlRD=708*.

A confirmation e-mail with the dial-in information will be sent to the e-mail address provided when your registration is approved.

A question-and-answer session concludes the teleconference and you may e-mail your questions in advance through the close of business Thursday, October 23, 2008, to *mailto:section.1011@trailblazerhealth.com* with Ask the Contractor in the subject line. ❖

Source: CMS PERL 200809-37

ACCESS TO CMS COMPUTER SERVICES

Individuals authorized access to CMS computer services—provider community

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

Note: CMS has revised this *MLN Matters* article on July 30, 2008, to reflect current processes and provide the Web address for the new individual authorized access to CMS (IACS) Web site, which contains user reference guides. Please note that CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This special edition *MLN Matters* article SE0747 was published in the December 2007 *Medicare A Bulletin* (pages 27-30).

The first in a series of articles

These articles will help providers to register for future access to CMS online computer services when directed to do so by CMS. This article contains:

- Eleven questions and answers to get you started
- Overview of the registration process for IACS-PC defined provider organization users.

Provider types affected

Medicare physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS-PC at this time. DMEPOS suppliers may want to review question number 11 below.

What providers need to know

The Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access in the CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC).

Provider action needed

CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. **Do not register until CMS or one of its contractors informs you and only do so if you meet the criteria in the notice.** This article and other articles in the IACS-PC series will help you navigate this process when directed to do so by CMS. The other articles currently available are:

- SE0753 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site
- SE0754 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Eleven questions and answers to get you started

1. **What is IACS-PC?**
   IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (see question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Through IACS, provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

   Note: This release of IACS-PC will not impact access to FI/carrier/MAC Internet applications or the DME competitive bidding system (DBidS) application.

2. **Who can use this system?**
   Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, DBidS has a dedicated version of IACS outside of IACS-PC. (See question # 11.)

3. **When should I register?**
   CMS will notify providers as Web-based applications become available and provide clear instructions that specify which providers should register in IACS. Do not register unless you fit the criteria in the CMS notice. For example, DMEPOS suppliers interested in becoming a contract supplier under the Medicare Competitive Bidding Program will receive explicit instructions on how and when to register for access to bid software.

4. **How long is my password valid?**
   Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

Individuals authorized access to CMS computer services—provider community (continued)

5. How do I register as an IACS-PC user?
IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: User guides for the IACS-PC community may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by e-mail at ***EUSSupport@cgi.com*** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?
An individual practitioner (IP) is defined by IACS-PC as a solo physician or nonphysician practitioner (NPP); who has not reassigned Medicare payments to a group practice. This designation is intended for practitioners who will be conducting transactions with online applications personally and have no staff who will be accessing the applications on their behalf. If you will have staff or other practitioners who will need to access CMS applications, you should register as a provider organization (not as an individual practitioner). (Please see #7.)
CMS will match your IACS registration with Medicare enrollment data before allowing you to access a CMS application. Those registering as individual practitioners who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to update their CMS-855.

Note: See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf* before submitting an enrollment application to a Medicare contractor.

If you enrolled in Medicare after November 2003, or have updated your enrollment since then, register as an individual practitioner following the steps in the Individual Practitioner Registration – Quick Reference Guide, which may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

7. When would I register as an IACS-PC provider organization?
The term "organization," as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the national provider identifier (NPI). For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.
It also includes individual physicians and nonphysician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.
IACS-PC provider organizations require security officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization security official.

8. What should I have in hand before I register as an individual practitioner?
An individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) will need to know his or her:

- Social security number
- Correspondence information.

9. What should I have in hand before I register as a security official of a provider organization?
For an IACS-PC provider organization, the SO of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- taxpayer identification number (TIN)
- legal business name
- corporate address
- Internal Revenue Service (IRS) issued CP-575 hard copy form.

If the SO does not have the CP-575, a copy of other official IRS documentation may be submitted. An official IRS document should have the following information:

Required:
- IRS letterhead
- legal business name (not handwritten)
- TIN/employee identification number (EIN) (not handwritten)

Examples of acceptable IRS documents include, but are not limited to:

- copy of IRS CP-575
- copy of IRS 147C letter
- copy of federal tax deposit coupon
- All documents received must be legible

10. How do I register my IACS-PC provider organization?
IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's IRS documentation, CMS will verify the SO's role in the organization, the TIN and the legal business name of the organization. This may take several weeks.

Individuals authorized access to CMS computer services—provider community (continued)

Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the *Overview* section, which follows question number 11.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration - Quick Reference Guide, which is available on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

The next *MLN Matters* article in this series of articles provides instructions for additional users to register in IACS-PC.

11. Why are you excluding DMEPOS suppliers from IACS-PC?

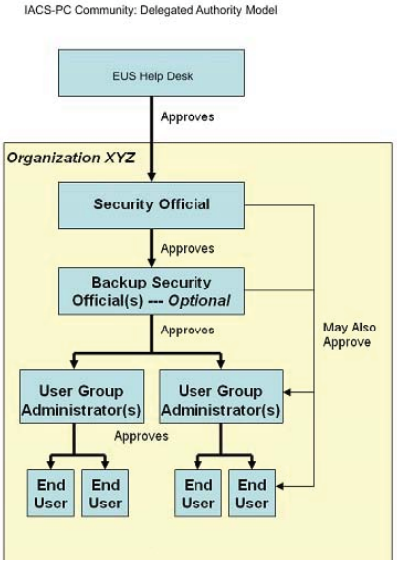
DMEPOS suppliers should not register in IACS-PC because we do not have new online applications at this time. DMEPOS suppliers interested in DMEPOS competitive bidding should follow CMS DMEPOS competitive bid instructions which would be released closer to the bid window.

Overview: registering in IACS-PC as a provider organization or a provider organization user

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and nonphysician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The registration process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access IACS-PC applications. The "delegated authority model" previously described is below. The EUS help desk will be responsible for approving the organization's security official. Then the security official may approve the backup security official(s) etc.



II. Registration roles

1. The first person to register must be the security official

The security official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There may be only one security official for an organization. The security official is trusted to approve the access request of backup security official(s) and can approve the access requests of user group administrators and end users. The security official will be approved by CMS through its EUS help desk. The security official is held accountable by CMS for the behavior of those approved in the organization, including the end users.

The *Security Official Registration – Quick Reference Guide* may be found on the CMS Web site at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf*.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS help desk.

2. An organization may choose to have one or more backup security officials (optional)

This is an optional role. You need not have a backup security official. The security official approves the backup security official. A backup security official performs the same functions as a security official in an organization, with the exception of approving

Individuals authorized access to CMS computer services—provider community (continued)

other backup security officials. There may be one or more backup security officials in an organization. The backup security official can approve the access requests of user group administrators and end users and may aid the security official with the administration of user groups and user group administrators' accounts.

3. **The next registrant must be a user group administrator**
   The security official or backup security official approves the user group administrator (UGA). The UGA is trusted to approve the access requests of end users for that user group.
   A UGA registers the user group within an organization in IACS-PC and updates the user group profile information in IACS-PC. There can be multiple UGAs for the same user group within an organization. If the UGA is a surrogate user (not part of the organization), they should select to create a "surrogate user group." See Section III.

4. **The next registrants are end users**
   An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

   Note: End user requests cannot be approved until after the user group administrator has been approved.

III. Surrogate user groups

This applies to provider organizations that want to delegate online work to individuals or a company **outside of the provider organization.** Under this scenario, those working on behalf of the provider organization register as a **surrogate user group**. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations.

1. The first contractor employee to register in a surrogate user group must be the UGA

If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS-PC. There can be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group.

The UGA of the surrogate user group must be approved by the security official or backup security official in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. **A contractor employee may also register as an end user**
   An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional help

The EUS help desk will support this process for IACS-PC. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

MLN Matters Number: SE0747 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0747

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.

Individuals authorized access to CMS computer services—provider community

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

Note: CMS has revised this *MLN Matters* article on July 30, 2008, to reflect current processes and provide the Web address for the new individual authorized access to CMS (IACS) Web site, which contains user reference guides. Please note that CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This special edition *MLN Matters* article SE0753 was published in the February 2008 *Medicare A Bulletin* (pages 15-18).

The second in a series of articles

This article contains:

- three questions and answers about the registration process for provider organizations (see Note).
- links to the quick reference guides for completing the registration process for provider organizations (see Note).

Note: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in this new series on IACS-PC, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider action needed

CMS will inform providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. **Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.** This article and other articles in the IACS-PC series will help you navigate this process when directed to do so by CMS.

What providers need to know

The CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

IACS protects and allows access to CMS enterprise applications. Communities (e.g., the IACS provider/supplier community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (for example, providers need access to provider-related CMS applications). The next community, which will become available is the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, Medicare providers should select the "Provider/Supplier Community".

The first *MLN Matters* article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) of provider organizations and individual practitioners using IACS-PC personally. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Three questions and answers about the provider organization registration process

1. **How can I get registered in IACS-PC? Can I just figure it out by myself?**

   We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC, go to *https://applications.cms.hhs.gov* and then click on Enter CMS Applications Portal.

2. **I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?**

   No, only register once. Each user will receive only one IACS-PC User ID and password. Once you receive approval and your user ID and password, you can add additional roles to your account.

   Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the *Additional Help* section.

3. **My organization is too small to fill all these roles. What should I do?**

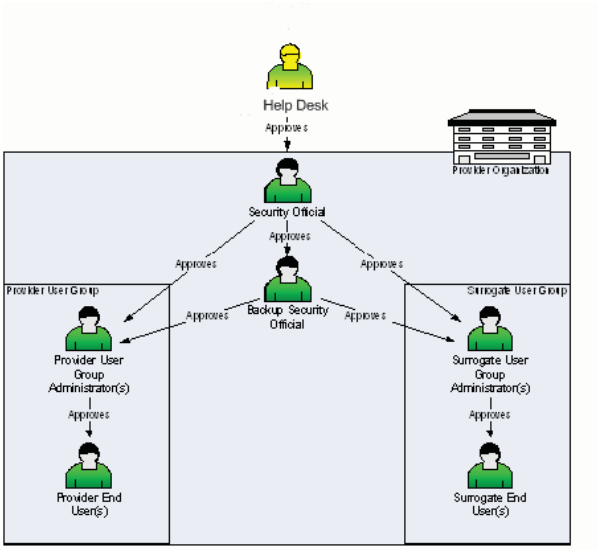
   As few as two staff may be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a SO, the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.

Individuals authorized access to CMS computer services—provider community (continued)

The backup security official (BSO) is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

If you are an individual professional who will be using IACS-PC personally, you may register for the single role of individual practitioner. Please refer to the first *MLN Matter* article, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Quick reference guides for completing the provider organization registration process



IACS-PC registration approval process

1. Backup Security Official Guide

Backup security officials (BSOs) will request access to an organization using the BSO *Registration Quick Reference Guide* on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

2. User group administration guide

User group administrators (UGAs) are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS-PC and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which he or she is responsible, so they should know everyone in their user group.

The UGA Registration Quick Reference Guide may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Special note for UGAs of surrogate user groups

A surrogate user group is established by individuals or a company outside of the provider organization that performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate-billing company ABC will work on behalf of provider organization XYZ. Once the provider organization XYZ is approved in IACS-PC, the surrogate-billing company ABC can register in IACS-PC and request to create a surrogate user group under the provider organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS-PC.

Individuals authorized access to CMS computer services—provider community (continued)

3. End user registration quick reference guide

An end user registration quick reference guide may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

4. Approver quick reference guide

The approver quick reference guide provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The approver quick reference guide may be found by selecting general user guides and resources on the left column on the CMS Web site of the following *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Next steps in accessing a CMS enterprise application

A third *MLN Matters* article discussing the final steps for using IACS to access CMS enterprise applications may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf*.

Additional help

CMS has established an external user services (EUS) help desk to assist with your access to IACS-PC. The EUS help desk may be reached by E-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for accessing CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0753

Individuals authorized access to CMS computer services—provider community

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

Note: CMS has revised this *MLN Matters* article on July 30, 2008, to reflect current processes and provide the Web address for the new individual authorized access to CMS (IACS) Web site, which contains user reference guides. Please note that CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This special edition *MLN Matters* article SE0754 was published in the February 2008 *Medicare A Bulletin* (pages 13-15).

The third in a series of articles

This article describes the three steps providers must take to access a CMS enterprise provider application including how to request a provider application role in IACS-PC (see step 2).

Provider types affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in a new series on IACS-PC which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider action needed

CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC). Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.

What providers need to know

The CMS will announce new online enterprise applications that will allow Medicare fee-for-service (FFS) providers to access, update, and submit information over the Internet.

Individuals authorized access to CMS computer services—provider community (continued)

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include Internet applications offered by FIs/carriers/MACs. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access through the CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC).

The first article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) and individual practitioners. This may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Note: Individual practitioners must register differently depending on whether they will have employees use IACS-PC and/or the CMS application on their behalf. Those using employees must register in IACS-PC as an "Organization". See the *MLN Matters* SE0747 for more information.

The second article in this series addressed common questions and gave remaining instructions for registering provider organizations including registration as backup security officials (BSOs), user group administrators (UGAs), and end users (EUs). It also provided instructions SOs, BSOs, and UGAs can use to approve user registration requests. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf*.

The three steps to access a CMS enterprise application

Provider IACS-PC users must take three steps to access a CMS enterprise application:

Step 1 Be approved for an IACS-PC role.

The first two *MLN Matters Articles* in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:

- Confirm the identity of the person requesting registration.
- Assure registrants have a legitimate business need to access CMS provider systems.
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or EU) that defines their responsibilities (if any) for approving the registration requests of others in their organization.
- Provide the registrant a user ID and password for IACS-PC.

Step 2 Be approved for an application role.

After receiving approval for an IACS-PC role, a registered user in a provider organization may then request access to CMS provider applications. This requires specifying a role for specific applications. For example, the role may be an "application approver" or an "application user." (**Note**: Because individual practitioners do work in the application themselves, they do not require "application approver" roles).

This role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization.
- What CMS enterprise applications (if any) they have a legitimate need to access.
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS-PC in Step 1 can then request access to specific CMS enterprise applications using their IACS-PC account.

This requires requesting either an "application approver" or an "application user" role for each application needed to perform Medicare-related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS.

Note: Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use. Roles will be specific to each application.

The "Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Application approvers

Organizations must have designated persons that approve each user's request for an application role. The person who performs this task is an "application approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate person to have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an EU may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application approver key points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SOs/BSOs is the application approver).
- Providers have flexibility in assigning the application approver role.

Individuals authorized access to CMS computer services—provider community (continued)

- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group).
- There may be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS-PC users are encouraged to have application approvers in each user group for each application (may be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in application approver roles will not have access to the application for which they are an approver. SOs and BSOs, by definition, can never access any applications as they serve as the default application approvers as noted above.

Instructions for approving application role requests are the same as for approving IACS-PC registration requests. The Approver Quick Reference Guide may be found by selecting General User Guides and Resources in the left column of the page on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications in accordance with approved application specific roles via the CMS or application Web site.

Additional CMS partner and customer communities will use IACS

IACS protects and allows access to CMS enterprise applications. IACS communities (e.g., the IACS – Provider/Supplier Community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications. For example, the next community will be the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider/Supplier Community."

Additional help

CMS has established the end user services (EUS) help desk to support access to IACS-PC. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for organizations to access CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

Coming soon

- CMS enterprise applications to be made available via the Web include those related to the Physician Quality Reporting Initiative (PQRI) and the Provider Statistical and Reimbursement Report (PS&R).
- Instructions for modifying your user profile.
- What to do if you forget your user ID or password.
- Tools for SOs, BSOs and UGAs to manage user accounts.

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0754

GENERAL COVERAGE

Prothrombin time monitoring for home anticoagulation management

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] or Part A/B Medicare administrative contractors [A/B MACs]) for home prothrombin time (PT) and international normalized ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6138, and alerts providers that effective for claims with dates of service on and after March 19, 2008 the Centers for Medicare & Medicaid Services (CMS) revised its national coverage determination (NCD) limits and will expand the population eligible for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. See the *Key points* section of this article for details.

Background

The PT test is an in-vitro test to assess coagulation. PT testing and its normalized correlate, the INR, are the standard measurements for therapeutic effectiveness of warfarin therapy. Warfarin, (Coumadin®) and others are self-administered, oral anticoagulant, or blood thinner, medications that affect a person's vitamin K-dependent clotting factors.

Currently, Medicare's NCD at 190.11 of the *NCD Manual* limits coverage of home PT/INR monitoring to anticoagulation management for patients with mechanical heart valves who are on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See the CMS Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf*.) and the following requirements must be met:

1. The patient must have been anticoagulated for at least three months prior to use of the home INR device.
2. The patient must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home.
3. Self-testing with the device should not occur more frequently than once a week.

CMS received a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. CR 6138 is a result of that request.

Key points of change request 6138

Effective for claims with dates of service on and after March 19, 2008, CMS revised its NCD to provide for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least three months prior to use of the home INR device.
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home.
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring.
4. Self-testing with the device should not occur more frequently than once a week.

Note: Applicable HCPCS codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 outpatient code editor (OCE) and Medicare physician fee schedule updates, the descriptors of these codes will change to reflect the revised coverage policy.

The following revised descriptors reflect the expanded NCD criteria and are effective for services on or after March 19, 2008, as follows:

- **Long descriptor G0248**: Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.

  Short descriptor G0248: Demonstrate use home INR mon

- **Long descriptor G0249**: Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week

  Short descriptor G0249: Provide INR test mater/ equipm

Prothrombin time monitoring for home anticoagulation management (continued)

- **Long descriptor G0250**: Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.

  Short descriptor G0250: MD INR test revie inter mgmt

Note: Test materials continue to include four tests. Frequency of reporting requirements shall remain the same.
Porcine valves are not included in this NCD, so Medicare will not make payment on home INR monitoring for patients with porcine valves unless covered by local Medicare contractors.
This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the *NCD Manual*.

The following are applicable diagnosis codes to be used when submitting claims to Medicare contractors:

- For services furnished on or after March 19, 2008, the applicable ICD-9-CM diagnosis codes for this benefit are:
  V43.3 (organ or tissue replaced by other means; heart valve)
  289.81 (primary hypercoagulable state)
  451.0-451.9 (phlebitis & thrombophlebitis)
  453.0-453.3 (other venous embolism & thrombosis)
  415.11-415.19 (pulmonary embolism & infarction)
  427.31 (atrial fibrillation [established] [paroxysmal])

Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with CR 6138. Denied claims are subject to appeal. When denying such claims, your Medicare carrier, FI or A/B MAC will use the following codes:

- Remittance advice remark code N386, "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp* on the CMS Web site. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Claim adjustment reason code 50 will be used: "These are noncovered services because this is not deemed a 'medical necessity' by the payer."

Providers should be aware that your Medicare contractor will assign liability for the denied charges to you unless documentation of an advance beneficiary notice (ABN) is present on the claim. Also, your contractor will not search for claims but will adjust inappropriately denied claims with dates of service March 19, 2008, through the implementation date of CR 6138, that are brought to their attention.

Additional information

CR 6138 was issued in two transmittals, one for the *National Coverage Determination Manual* and one for the *Medicare Claims Processing Manual*. These transmittals are available respectively, on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R90NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1562CP.pdf*.

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: MM6138
Related Change Request (CR) Number: 6138
Related CR Release Date: July 25, 2008
Effective Date: March 19, 2008
Related CR Transmittal Number: R1562CP and R90NCD
Implementation Date: August 25, 2008

Source: CMS Pub. 100-04, Transmittal 1562, CR 6138

Medicare travel allowance fees for collection of specimens under the clinical laboratory fee schedule

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

Provider types affected

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6195, which revises and clarifies payment of travel allowances that are based on either a per mileage basis (HCPCS code P9603) or on a flat rate basis (HCPCS code P9604) for calendar year (CY) 2008. The new rates are $1.035 per mile (HCPCS code P9603) and $9.55 per flat-rate trip (HCPCS code P9604).

Caution – what you need to know

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

Go – what you need to do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act and payment is made based on the clinical laboratory fee schedule. (See Section 1833(h)(3) of the Social Security Act at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet.) Furthermore, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover estimated travel costs of collecting the specimen (including the laboratory technician's salary and travel expenses), and Medicare contractors have the discretion to choose:

- Either a flat rate or a mileage basis.
- How to set each type of allowance.

The per flat rate trip basis travel allowance (P9604) is $9.55, and the per mile travel allowance (P9603) is $1.035 cents per mile and is used in situations where the average trip to the patients' homes is:

- Longer than 20 miles round trip.
- To be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

As of August 1, 2008, the per mile allowance rate of $1.035 cents per mile was computed using the federal mileage rate of $0.585 cents per mile for automobile expenses plus an additional $0.45 cents per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum of $1.035 cents per mile if local conditions warrant it.

Under either method (i.e., flat rate allowance or per mile travel allowance), when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip (for both Medicare and non-Medicare patients) either at the time the claim is submitted by the laboratory or when the flat rate is set by the Medicare contractor.

The following are examples to further clarify the new allowances:

Example 1: On August 2, 2008, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

Example 2: On August 2, 2008, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $41.40 (40 x 1.035), plus the specimen collection fee.

Note: Some Medicare contractors have established local policy to pay based on a flat rate basis only.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $9.55 for a total trip reimbursement of $19.10, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $9.55 = $57.30). Each of the claims submitted would be for $11.46 ($57.30 /5 = $11.46). Since one of the patients is non-Medicare, four claims would be submitted for $11.46 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from five patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $9.55 = $19.10) and then divided by five (1/5 of $19.10 = $3.82). Since one of the patients is non-Medicare, four claims would be submitted for $3.82

Medicare travel allowance fees for collection of specimens under the clinical laboratory fee schedule (continued)

each, plus the specimen collection fee.

At no time will a laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Additional information

To see the official instruction (CR 6195) issued to your Medicare A/B MACs and carriers visit on the Centers for Medicare & Medicaid Services (CMS) Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1584CP.pdf*.

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: MM6195
Related Change Request (CR) Number: 6195
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1584CP
Effective Date: July 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1584, CR 6195

2008 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza and pneumococcal vaccinations provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6121, which reminds the Medicare physician community of the requirements to correctly enroll in order to conduct mass immunization roster billing and centralized billing of Medicare for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for mass immunizer roster billers.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing CR 6121 as a reminder for mass immunization roster billing and centralized billing for influenza and pneumococcal vaccinations.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

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

Providers who only offer influenza services:

- May enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a centralized biller.
- Must meet the guidelines for being either a mass immunizer or centralized biller.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must:

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

2008 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations (continued)

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

Providers and suppliers must enroll using the appropriate CMS-855 provider enrollment form (See the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp*).

Applications are available from the local contractors. Refer to the *Medicare Claims Processing Manual*, Chapter 18, Section 10-10.5 at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* on the CMS Web site for more information on billing requirements.

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

Remember the following regarding the influenza vaccine:

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

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

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

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

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

Additional information

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

The official instruction, CR 6121, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R366OTN.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: MM6121
Related Change Request (CR) Number: 6121
Related CR Release Date: August 15, 2008
Related CR Transmittal Number: R366OTN
Effective Date: September 15, 2008
Implementation Date: September 15, 2008

Source: CMS Pub. 100-20, Transmittal 366, CR 6121

Fluorodeoxyglucose positron emission tomography imaging for infection and inflammation

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], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6099 instructing that the Centers for Medicare & Medicaid Services (CMS) is continuing its national noncoverage policy for the off-label indications of fluorodeoxyglucose (FDG) positron emission tomography (PET) imaging for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Background

CMS was asked to reconsider the current, de facto noncoverage for FDG PET imaging in the *Medicare National Coverage Determinations (NCD) Manual* (Section 220.6), for the following off-label uses (instead of bone, leukocyte, and/or gallium scintigraphy):

1. Suspected chronic osteomyelitis in patients with:
   - previously documented osteomyelitis with suspected recurrence, or
   - symptoms of osteomyelitis for more than 6 weeks (including diabetic foot ulcers)
2. Investigation of patients with suspected infection of hip prosthesis
3. Fever of unknown origin in patients with:
   - a febrile illness of >3 weeks duration,
   - a temperature of >38.3 degrees centigrade on at least two occasions, and
   - uncertain diagnosis after a thorough history, physical examination, and 1 week of proper investigation.

Based upon its review, CMS determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore is not reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A). (See that provision on the Internet at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*.)

Additionally, CMS determined that this request for coverage is not appropriate for the Coverage with Evidence Development (CED) paradigm.

Additional information

The official instruction, CR 6099, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R84NCD.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free numbers, 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: MM6099
Related Change Request (CR) Number: 6099
Related CR Release Date: June 27, 2008
Related CR Transmittal Number R84NCD
Effective Date: March 19, 2008
Implementation Date: July 28, 2008

Source: CMS Pub. 100-03, Transmittal 84, CR 6099

Medicare coverage of artificial hearts

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

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for cardiac-related services and supplies to Medicare fee-for-service (FFS) beneficiaries and Medicare managed care plan beneficiaries.

What you need to know

Change request (CR) 6185, from which this article is taken, announces that Medicare has issued a national coverage determination (NCD) (effective on May 1, 2008), that establishes limited coverage for artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies meeting all of the coverage with evidence development (CED) criteria.

Make sure that your billing staffs are aware of these artificial heart coverage and billing instructions in CR 6185. Details are presented in the *Background* section below.

Background

As determined by the May 19, 1986, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD), Medicare did not cover the use of artificial hearts prior to May 1, 2008. CR 6185 announces that Medicare has issued an NCD that establishes limited coverage for artificial hearts as a **bridge-to-transplantation** and as **destination therapy** under CED.

This means that Medicare will cover artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies that meet all of the CED criteria listed below.

For your reference, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies, which CMS has determined meet the standards, and address the research questions listed below. Clinical studies CMS has determined meet these requirements will be listed on the CMS Web site at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp*.

Coverage under CED will only apply to artificial hearts that are implanted in the context of one of these approved clinical studies.

To be approved, a clinical study must:

1. Address at least one of the following questions:
   - Were there unique circumstances (such as expertise available in a particular facility or an unusual combination of conditions in particular patients) that affected their outcomes?
   - What will be the average time to device failure when the device is made available to larger numbers of patients?
   - Do results adequately give a reasonable indication of the full range of outcomes (both positive and negative) that might be expected from more widespread use?

and

2. The clinical study must meet all of the following criteria:
   - It must be reviewed and approved by the Food and Drug Administration (FDA).
   - Its principal purpose is to test whether a particular intervention potentially improves the participants' health outcomes.
   - It is well supported by available scientific and medical information, or is intended to clarify or establish the health outcomes of interventions already in common clinical use.
   - It does not unjustifiably duplicate existing studies.
   - Its design is appropriate to answer the research question being asked in the study.
   - It is sponsored by an organization, or individual, capable of executing the proposed study successfully.
   - It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 CFR Part 46 (if a study is FDA-regulated it also must be in compliance with 21 CFR Parts 50 and 56).
   - All aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org* on the Internet).
   - It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with study participation (CSP) or CED coverage.
   - It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. (Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options).
   - It is registered at *http://clinicaltrials.gov/* on the clinical trials Web site by the principal sponsor/investigator as demonstrated by having a national clinical trial control number.
   - The research protocol must:
     - Specify the method and timing of public release of all pre-specified outcomes to be measured, including release of outcomes if outcomes are negative or study is terminated early. (The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors, which can be found at *http://www.icmje.org* on the Internet. However a full

Medicare coverage of artificial hearts (continued)

report of the outcomes must be made public no later than three years after the end of data collection.)

- Explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of these populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, it must discuss why these criteria are necessary.
- Explicitly discuss how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Billing requirements

Claims related to the routine costs, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in the trial, and claims for managed care beneficiaries receiving services in an approved-clinical study for artificial hearts, should be sent to the appropriate FFS contractor and include the appropriate codes to ensure proper payment.

Institutional and physician/supplier claims for routine services provided in approved artificial heart studies should be billed and processed according to previously issued instructions for clinical trials.

Your Medicare contractor will hold your claims until CR 6185 is implemented and the claims can be correctly processed. Upon successful implementation of CR 6185, Medicare contractors will process the claims and pay interest (as appropriate) on held claims.

CMS has also determined that since coverage is only available under clinical studies, the billing and coding requirements will be the same as those currently used for other Medicare covered clinical trials as included in the NCD effective September 2000. This means that Medicare Advantage (MA) organizations will not be responsible for payment for the artificial heart, or for routine services related to the study, until a plan's capitated rate has been appropriately adjusted to include them.

Coding requirements

The following addresses the institutional and physician/supplier coding requirements for coverage of artificial hearts in clinical trials:

1. Institutional claims

Effective for discharges on or after May 1, 2008, institutional claims for International Classification of Diseases, 9th edition (ICD-9) procedure code 37.52 are only payable when you include ICD-9 diagnosis code V70.7 (examination of participant in clinical research) and condition code 30 (qualifying clinical trial). In addition, value code D4, with an 8-digit national clinical trial number that matches an approved clinical trial on the CMS Web site provided above is also required.

If your FI or A/B MAC rejects your claim with ICD-9 procedure code 37.52, because it does not meet all of these necessary billing criteria, they will use:

- **Claim adjustment reason code (CARC) 16 – *Claim/service lacks information, which is needed for adjudication*, when ICD-9 procedure code 37.52 is present on a claim without all the required ele*ments.***
- The following remittance advice remark codes (RARCs), when applicable:

  MA97 – *Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number*, for a missing/incomplete/invalid clinical trial number when ICD-9 procedure code 37.52 is billed.

  M64 – *Missing/incomplete/invalid other diagnosis*, for a missing V70.7 diagnosis code when ICD-9 procedure code 37.52 is billed

  M44 – *Missing/incomplete/invalid condition code*, for a missing condition code 30 when ICD-9 procedure code 37.52 is billed.

2. Physician/supplier claims

Effective for dates of service on or after May 1, 2008, physician/supplier claims for *Common Procedural Terminology (CPT)* code *0051T* must include ICD-9 diagnosis code V70.7 and Healthcare Common Procedure Coding System (HCPCS) modifier Q0 on the same claim line as *CPT* code *0051T*, and must also include the eight-digit clinical trial number that matches an approved clinical trial on the CMS Web site provided above.

If your carrier or A/B MAC returns your claim with *CPT* code *0051T* as unprocessable because it does not meet all of these necessary billing criteria, they will use:

CARC 16 – *Claim/service lacks information, which is needed for adjudication*, when CPT code 0051T is present on a claim without the required diagnosis code or 8-digit clinical trial number.

CARC 4 – *The procedure code is inconsistent with the modifier used or a required modifier is missing*, when there is no HCPCS modifier Q0 appended to *CPT* code *0051T*.

RARC MA 130 – (Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information), when there is no HCPCS modifier Q0 appended to *CPT* code *0051T*.

The following RARCs when applicable:

MA97 – *Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number*, for a missing/incomplete/invalid clinical trial number when *CPT* code *0051T* is billed without the eight-digit clinical trial number.

Medicare coverage of artificial hearts (continued)

M64 – *Missing/incomplete/invalid other diagnosis*, for a missing V70.7 diagnosis code when *CPT* code *0051T* is billed without the V70.7 diagnosis code.

3. Additional inpatient and outpatient claims instructions related to clinical trial patients

Inpatient Claims

Institutional providers billing clinical trial service(s) must report a diagnosis code V70.7 and a condition code 30 regardless of whether all services are related to the clinical trial or not.

Note: HCPCS codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

Outpatient claims

Institutional providers billing clinical trial claims that contain only clinical trial line item services do not have to report the routine modifiers QV or Q1. The presence of condition code 30, along with the absence of modifier QV or Q1 r, is the provider's attestation that **all** line item services on the claim are routine clinical trial services (with the exception of any investigational item on the claim that would be identified with modifier Q0 on or after January 1, 2008, or modifier QA before January 1, 2008.

Institutional providers billing clinical trial claims that contain both clinical trial line item services *and* nonclinical trial line item services, must bill the following elements:

Claims with dates of service **before** January 1, 2008:

- HCPCS modifier QV **only** on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the *secondary* diagnosis
- Condition code 30

Claims with dates of service **on or after** January 1, 2008:

- HCPCS modifier Q1 **only** on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the **secondary** diagnosis
- Condition Code 30

Message to principal investigator

Finally, if you are the principal investigator (PI) of an artificial heart clinical study seeking Medicare payment, you should submit the following documentation to CMS (who will notify you when the review is complete):

- The complete study protocol (must be dated or identified with a version number)
- The protocol summary
- A statement that the submitted protocol version has been agreed upon by the FDA
- A statement that the above study standards are met
- A statement that the study addresses at least one of the above questions related to artificial hearts
- Complete contact information (phone number, e-mail address, and mailing address)
- The Clinicaltrials.gov registration number.

The PI should send this information to:
Director, Coverage and Analysis Group
Centers for Medicare & Medicaid Services
Re: Artificial Heart – Mailstop C1-09-06
7500 Security Boulevard
Baltimore, MD 21244-1850

Additional information

CR 6185 was issued in two separate transmittals, one for conveying changes to the *Medicare National Coverage Determination Manual* and one for changes to the *Medicare Claims Processing Manual*. These transmittals are available respectively, on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R95NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1592CP.pdf*.

The revised portions of each manual are attached to the respective transmittals.

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: MM6185
Related Change Request (CR) Number: 6185
Related CR Release Date: September 10, 2008
Related CR Transmittal Number: R95BP and R1593CP
Effective Date: May 1, 2008
Implementation Date: December 1, 2008

Source: CMS Pub. 100-04, Transmittal 1592, CR 6185

Screening DNA stool test for colorectal cancer

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 A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

CAUTION – what you need to know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA (deoxyribonucleic acid) stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA-approval is obtained.

GO – what you need to do

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

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the *Code of Federal Regulations* (42 CFR 410.37(a)(1)(v)) at *http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html* and the Social Security Act (section 1861(pp)(1)(D)) *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the *Medicare National Coverage Determination Manual* for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer-screening test at this time.

Additional information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the *Medicare Benefit Policy Manual* and one for the *National Coverage Determinations Manual*. These two transmittals are at *http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf*, respectively, on the CMS Web site.

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: MM6145
Related Change Request (CR) Number: 6145
Related CR Release Date: July 25, 2008
Related CR Transmittal Number: R93BP and R92NCD
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Source: CMS Pub. 100-03, Transmittal 92, CR 6145

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 September 2, 2008, to reflect revisions to change request (CR) 6048, which CMS revised on August 28, 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 *MLN Matters* article MM6048 was published in the August 2008 *Medicare A Bulletin* (pages 18-19).

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 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 National Coverage Determination 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 with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

   Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring**.**

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.

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

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 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *Medicare 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/R94NCD.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
Related Change Request (CR) Number: 6048
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R94NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Source: CMS Pub. 100-03, Transmittal 91, CR 6048

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

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

AJ7187: Hemophilia Clotting Factors—Revision to the LCD

LCD ID: L1323

The local coverage determination (LCD) for hemophilia clotting factors was last revised January 1, 2008. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued instructions to treat draft change request 6006 (New Hemophilia Clotting Factor and HCPCS Code) as final. Therefore, HCPCS code Q4096 (Injection, von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO VWF complex, NOS) was added to the "CPT/HCPCS Codes" section of the LCD.

Effective date

This revision to the LCD is effective for services provided **on or after April 1, 2008.**

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

AJ9041: Bortezomib (Velcade®)—Revision to the LCD

LCD ID: L21631

The local coverage determination (LCD) for bortezomib (Velcade®) was last updated on October 1, 2007. Since that time, a revision was made based on the new Food and Drug Administration (FDA)-approved indication for multiple myeloma without prior therapy for bortezomib – J9041.

A revision for the above FDA-approved indication was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD deleting the requirement for at least one prior therapy for treatment of patients with multiple myeloma.

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

Effective date

This revision to the LCD is effective for services provided **on or after June 20, 2008**.

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

ATHERSVCS: Therapy and Rehabilitation Services—Revision to the LCD and Coding Guidelines

LCD ID: L1125

The therapy and rehabilitation services local coverage determination (LCD) was last revised on January 1, 2008. Since that time, it has been revised. Change Request 5871, dated January 10, 2008, imposed a limitation on the therapy cap exception process which instructed providers that they could bill for services that qualified for the therapy cap exception process through June 30, 2008. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted with a provision that extended the therapy cap exception process through December 31, 2009. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and the "coding guidelines" attachment have been revised to reflect this new date for therapy cap exceptions.

Effective date

This revision to the LCD and the "coding guidelines" attachment is effective for services provided **on or after July 1, 2008.**

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

2009 ICD-9-CM changes

The 2009 update to the ICD-9-CM diagnosis coding structure is effective October 1, 2008. Providers are required to use the 2009-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring on or after October 1, 2008.

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

Florida Medicare has revised the LCDs, for procedure codes with specific diagnosis criteria that are affected by the 2009 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2009 ICD-9-CM update.

LCD title	2009 changes
A0145T – Computed Tomographic Angiography of the Chest, Heart, and Coronary Arteries	• Added diagnosis 414.3 for procedure codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T*, and *0151T*.
A11000 – Debridement Services	• Changed descriptor for diagnosis range 998.31-998.32 for procedure codes *11000, 11001, 11040, 11041, 11042, 11043, 11044, 97597*, and *97598*. • Added diagnoses 998.30 and 998.33 for procedure codes *11000, 11001, 11040, 11041, 11042, 11043, 11044, 97597*, and *97598*.
A29540 – Strapping	• Changed descriptor for diagnosis range 707.10-707.19 for procedure code *29580*.
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Added diagnoses 535.70, 535.71, and 571.42 for procedure codes *43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258.*
A44388 – Diagnostic Colonoscopy	• Added diagnoses 199.2 and 569.44 for procedure *codes 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391*, and *45392*.
A73218 – Magnetic Resonance Imaging of Upper Extremity	• Changed descriptor for diagnosis 208.90 for procedure codes *73218, 73219, 73220, 73221, 73222*, and *73223*. • Added diagnoses 203.82 and 208.92 for procedure codes *73218, 73219, 73220, 73221, 73222*, and *73223*.
A78459 – Myocardial Imaging, Positron Emission Tomography (PET) Scan	• Added diagnosis 414.3 for procedure codes *78459, 78491*, and *78492*.
A82310 – Total Calcium	• Added diagnoses 208.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, and 209.30 for procedure code *82310*.
A82330 – Ionized Calcium	• Removed diagnoses 780.6 and V45.1 for procedure code 82330. • Added diagnoses 780.60, 780.61, 780.62, 780.63, and V45.11 for procedure code *82330*.
A84100 – Serum Phosphorus	• Added diagnosis 203.02 for procedure code *84100*.
A86706 – Hepatitis B Surface Antibody and Surface Antigen	• Removed diagnoses 780.6 and V45.1 for procedure code *87340*. • Removed diagnosis V45.1 for procedure code 86706. • Added diagnoses 780.60, 780.61, and 780.63 for procedure code *87340*. • Added diagnosis V45.11 for procedure codes *86706* and *87340*.
A87181 – Susceptibility Studies **(Coding Guidelines only)**	• Removed diagnoses 599.7, 780.6, and 788.9 for procedure codes *87181, 87184, 87185, 87186, 87187, 87188*, and *87190*. • Added diagnoses 599.70, 599.71, 599.72, 780.60, 780.61, 788.91, and 788.99 for procedure codes *87181, 87184, 87185, 87186, 87187, 87188*, and *87190*.

2009 ICD-9-CM changes (continued)

LCD title	2009 changes
A93000 – Electrocardiography	• Removed diagnoses 337.0 and 997.3 for procedure codes *93000*, *93005*, and *93010*. • Added diagnoses 337.00, 337.01, 337.09, and 997.39 for procedure codes *93000*, *93005*, and *93010*.
A93303 – Transthoracic Echocardiography (TTE)	• Changed descriptor for diagnosis 038.11 for procedure codes *93307*, *93308*, C8923, and C8924. • Removed diagnosis 780.6 for procedure codes *93307*, *93308*, C8923, and C8924. • Added diagnoses 038.12, 780.60, 780.61, and 780.62 for procedure codes *93307*, *93308*, C8923, and C8924.
A93922 – Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	• Changed descriptor for diagnosis range 707.10-707.19 for procedure code *93922*, *93923*, and *93924*.
A93975 – Duplex Scanning	• Removed diagnosis 599.7 for procedure codes *93975* and *93976*. • Added diagnoses 599.70, 599.71, and 599.72 for procedure codes *93975* and *93976*.
A95860 – Electromyography and Nerve Conduction Studies	• Removed diagnosis 337.0 for procedure codes *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95872*, *95900*, *95903*, *95904*, *95934*, *95936*, and *95937*. • Added diagnoses 337.00, 337.01, and 337.09 for procedure codes *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95872*, *95900*, *95903*, *95904*, *95934*, *95936*, and *95937*.
AJ0640 – Leucovorin (Wellcovorin®)	• Added diagnosis 199.2 for procedure code J0640.
AJ0881 – Erythropoiesis Stimulating Agents	• Added diagnosis 199.2, 203.82, 204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, and 209.30 for procedure code J0881 and J0885.
AJ1440 – G-CSF (Filgrastim, Neupogen®)	• Added diagnosis 238.77 for procedure codes J1440 and J1441.
AJ1561 – Intravenous Immune Globulin	• Changed descriptor for diagnosis 204.10 for procedure codes J1561, J1566, J1568, J1569, J1572, and Q4097. • Added diagnosis 204.12 for procedure codes J1561, J1566, J1568, J1569, J1572, and Q4097.
AJ2430 – Pamidronate (Aredia®, APD)	• Added diagnosis 203.02 for procedure code J2430.
AJ2505 – Pegfilgrastim (Neulasta™)	• Added diagnoses 199.2, 203.82, 204.02, 204.12, 204.22, and 204.82 for procedure code J2505.
AJ9000 – Doxorubicin HCl	• Added diagnoses 203.02, 204.02, 204.12, 205.92, 206.02, and 207.02 for procedure code J9000.
AJ9001 – Doxorubicin, Liposomal (Doxil)	• Added diagnosis 203.02 for procedure code J9001.
AJ9010 – Alemtuzumab (Campath®)	• Added diagnosis 204.12 for procedure code J9010.
AJ9015 – Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)	• Added diagnoses 205.02 and 205.12 for procedure code J9015.
AJ9041 – Bortezomib (Velcade®)	• Changed descriptor for diagnosis 203.00 for procedure code J9041.
AJ9045 – Carboplatin (Paraplatin®, Paraplatin-AQ®)	• Added diagnosis 199.2 for procedure code J9045.
AJ9181 – Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)	• Added diagnoses 199.2, 203.02, 204.02, 205.02, 205.12, 206.02, and 207.02 for procedure codes J9181 and J9182. • Removed new diagnosis 238.77 from diagnosis range 238.71-238.79 for procedure codes J9181 and J9182, as it is not appropriate.

2009 ICD-9-CM changes (continued)

LCD title	2009 changes
AJ9185 – Fludarabine (Fludara®)	• Added diagnoses 204.12, 204.92, 205.02, 206.02, and 207.02 for procedure code J9185.
AJ9213 – Interferon, alfa-2a (Roferon®-A)	• Changed descriptor for diagnosis 205.10 for procedure code J9213. • Added diagnosis 205.12 for procedure code J9213.
AJ9265 – Paclitaxel (Taxol®)	• Added diagnosis 199.2 for procedure code J9265.
AJ9280 – Mitomycin (Mutamycin®, Mitomycin-C)	• Added diagnosis 205.12 for procedure code J9280, J9290, and J9291.
AJ9293 – Mitoxantrone Hydrochloride	• Added diagnosis 204.02, 205.02, 206.02, and 207.02 for procedure code J9293.
AJ9300 – Gemtuzumab Ozogamicin (Mylotarg™)	• Added diagnosis 205.02 for procedure code J9300.
AJ9310 – Rituximab (Rituxan®)	• Added diagnosis 204.12 for procedure code J9310.
AJ9350 – Topotecan Hydrochloride (Hycamtin®)	• Added diagnosis 205.12 for procedure code J9350. • Removed new diagnosis 238.77 from diagnosis range 238.71-238.79 for procedure code J9350, as it is not appropriate.
ATHERSVCS – Therapy and Rehabilitation Services	• Changed descriptor for diagnosis range 998.31-998.32 for procedure code *97026*.

Source: CMS Pub. 100-04, Transmittal 1566, CR 6107

ADDITIONAL MEDICAL INFORMATION

0192T: Aqueous Drainage Device for the Treatment of Glaucoma

Glaucoma filtering surgery is indicated when glaucomatous damage progresses despite pharmacological and/or surgical treatment. Trabeculectomy is the most widely used form of filtering surgical treatment for primary open-angle glaucoma. Glaucoma drainage implants designed to shunt the aqueous fluid posteriorly represent an alternative method for lowering intraocular pressure in glaucomatous patients and are commonly used in refractory glaucoma or after failure of filtration surgery.

Since the Food and Drug Administration (FDA) approved the first mini shunt device for marketing in March 2002, over 14,000 implantations have been performed. However, there has been disagreement in the ophthalmology community regarding the correct coding for this procedure. The majority of ophthalmologists billed *Current Procedural Terminology (CPT)* code *66180 (Aqueous shunt to extraocular reservoir [eg, Molteno, Schocket, Denver-Krupin])*, with some using *CPT* code *66172 (Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma [includes injection of antifibrotic agents])* or *CPT* code *66999 (Unlisted procedure, anterior segment of eye)*. Because of this disagreement, the American Medical Association (AMA) CPT Panel developed a new Category III CPT code, *0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach)*, **effective for services provided on or after July 1, 2008**. The appropriate ICD-9-CM codes are 365.10 - 365.15 (Open-angle glaucoma). The device used must be FDA-approved, such as the Ex-PRESS™ mini shunt (Optonol). ❖

HOSPITAL SERVICES

Transition of responsibility for medical review from quality improvement organizations

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

Provider types affected

Hospitals paid under the inpatient prospective payment system (IPPS) and long-term care hospitals (LTCH).

What you need to know

CMS has shifted the majority of utilization review of inpatient hospital claims (including acute inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) claims) from the quality improvement organizations (QIOs) to Medicare fiscal intermediaries (FIs) and Part A and B Medicare administrative contractors (A/B MACs). FIs and MACs will begin performing reviews on IPPS hospital and LTCH claims for improper payment reduction purposes in August 2008. FIs and MACs will be allowed to review claims submitted January 1, 2008 forward.

Responsibility for IPPS hospital and LTCH error rate measurement has been shifted from the QIOs to the comprehensive error rate-testing (CERT) contractor. The CERT contractor began reviewing acute care hospital claims for improper payment measurement beginning April 1, 2008.

Background

This article is based on change request (CR) 5849. CR 5849 makes modifications to the *Medicare Program Integrity Manual*. The key points are**:**

- FIs or MACs may still make referrals to the QIO for quality of care issues of claims when their review of outpatient claims or inpatient claims data reveal a problem provider.
- FIs and MACs will perform most utilization reviews, for improper payment reduction purposes, of acute care inpatient hospital claims, and the CERT contractor will measure the inpatient hospital paid claims error rate.
- QIOs will no longer conduct the HPMP program and will instead focus their efforts on quality improvement, continuing to perform quality reviews, expedited determinations, and certain utilization reviews, such as provider-requested higher-weighted diagnosis related group (DRG) reviews and referrals.

Note: Like with all other Medicare claims, providers and beneficiaries have appeal rights after the payment denial of a claim is issued. Providers are advised on the issuance of a hospital issued notice of noncoverage (HINN) as they do for all other claim types.

Additional information

The official instruction (CR 5849) was issued to your Medicare FI or A/B MAC in two transmittals, one related to the *Medicare Program Integrity Manual* and one for the *Medicare Claims Processing Manual*. These transmittals are available respectively on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R264PI.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1571CP.pdf*.

CMS has posted a fact sheet and power point slides to the CMS Web site. These documents may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/InpatientReviewFactSheet.pdf* and *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/Inpatient_Hospital_Review_Transition.zip*.

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

MLN Matters Number: MM5849
Related Change Request (CR) Number: 5849
Related CR Release Date: August 7, 2008
Related CR Transmittal Number: R264PI and R1571CP
Effective Date: August 1, 2008
Implementation Date: No later than August 15, 2008

Source: CMS Pub. 100-08, Transmittal 264, CR 5849

Inpatient prospective payment system personal computer PRICER update

The provider data distributed with the *Inpatient PPS PC PRICER* has been updated as of July 2008. The inpatient prospective payment system (PPS) personal computer (PC) PRICER on the CMS page *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, in the Downloads section has been updated with the latest provider data. If you use the *Inpatient PPS PC PRICER*, please go to the page above and download the latest version of the PC PRICER posted on August 8, 2008. ❖

Source: CMS Provider Education Resource 200808-07

Payment for implanted prosthetic devices for Medicare Part B inpatients

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 implanted prosthetic devices provided to Medicare beneficiaries under Part B.

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6050, which clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.

CAUTION – what you need to know

CR 6050 revises the *Medicare Claims Processing Manual* (Chapter 4, Section 240) to provide instructions regarding how contractors are to establish the payment to be made under the outpatient prospective payment system (OPPS) for implanted prosthetic devices that are furnished to Medicare beneficiaries who, on the date that the device is implanted, are hospital inpatients without Part A coverage of services, but with Part B coverage.

GO – what you need to do

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

Background

The Centers for Medicare & Medicaid Services (CMS) can designate medical and other health services (that are payable under the Medicare OPPS) for beneficiaries who are hospital inpatients with Medicare Part B benefits, but who do not have Part A benefits. See the Social Security Act (Section 1833(t)(2)(A)) on the Internet at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*.

The *Medicare Benefits Policy Manual* (Chapter 2, Section 10) includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but who do have Part B coverage, on the day that they receive an implanted prosthetic device. The processing of claims for these services is discussed in the *Medicare Claims Processing Manual* (Chapter 4, Section 240). Under Medicare PPS, reimbursement for these items is packaged into payment for the procedure in which they are implanted.

CR 6050 revises the *Medicare Claims Processing Manual*, [Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 240 (Inpatient Part B Hospital Services)] to provide instructions regarding how Medicare contractors are to establish payment for providers subject to the OPPS for implanted prosthetic devices that are furnished to Medicare beneficiaries who are hospital inpatients not having Part A coverage of services on the date that the device is implanted.

Specifically, the manual is revised to specify that **providers must submit these services on a type of bill 12x, reporting a new HCPCS C-code** that will be effective for services furnished on and after January 1, 2009, **when they furnish an implanted prosthetic device** to a Medicare beneficiary:

- Who is a hospital inpatient, but
- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

By reporting the new HCPCS C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

The manual is also revised to specify that Medicare contractors will:

- Determine if the device meets the definition for an implanted prosthetic device.
- Establish the payment to be made for the device.

Medicare contractors will first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in Chapter 6, Section 10, of the *Medicare Benefits Policy Manual*. If the item does not meet the criteria for coverage as an implantable prosthetic device, the Medicare contractor will deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

Once the Medicare contractor determines that the device is covered, it will then determine the appropriate payment amount for the device.

The contractor shall begin this process by determining if the device has pass through status under the OPPS. If so, the contractor will establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio.

Where the device does not have pass through status under the OPPS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the DMEPOS fee schedule, where there is such an amount or the actual charge for the device. Where there is no amount for the device in the durable medical equipment prosthetic orthotics supply (DMEPOS) fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. Payment would be made at the lesser of the contractor established payment rate for the specific device or the actual charge for the device.

In setting a Medicare contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable ambulatory payment classification (APC) payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

Payment for implanted prosthetic devices for Medicare Part B inpatients (continued)

See *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp* for the amount of reduction to the APC payment that would apply in these cases. From this OPPS Web page, select "Device, Radiopharmaceutical and Procedure Edits" from the list on the left side of the page. Open the file "Procedure to Device edits" to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS Web page and open the file "APC Adjustments in Cases of Full Credit/No Cost or Partial Credit for Replaced Devices." Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new HCPCS C code. It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient.

For example, if the HCPCS new C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in "remarks") the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for calendar year 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is $4881.77. It would therefore be reasonable for the FI or MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to $4881.77. In this case the coinsurance would be $936.75 (20 percent of $4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount or the contractor established amount, or the actual charge where applicable), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Note that Medicare contractors will deny payment for an item reported with the new HCPCS C-code if they determine that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily. On such denials, the remittance advice remark code will show N180 (This item or service does not meet the criteria for the category under which it was billed.) with a group code or PR (Patient responsibility) and a claim adjustment reason code of 96 (Noncovered charges).

Medicare contractors will also deny payment if they or Medicare systems determine that the beneficiary was in a covered Part A stay on the date of service of the item reported with the new HCPCS C-code. Such denials will contain a remittance advice remark code of M2 (Not paid separately when the patient is an inpatient), a group code of CO (Contract obligation) and a claim adjustment reason code of 96 (Noncovered charges).

Note: The revised *Medicare Claims Processing Manual*, (Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 240 (Inpatient Part B Hospital Services)) is included as an attachment to CR 6050.

Additional information

The official instruction, CR 6050, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1597CP.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.

MLN Matters Number: MM6050
Related Change Request (CR) Number: 6050
Related CR Release Date: September 12, 2008
Related CR Transmittal Number: R1597CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1597, CR 6050

Hospital-acquired conditions and present-on-admission indicator updates

The Centers for Medicare & Medicaid Services (CMS) has recently updated all sections of the hospital-acquired conditions (HACs) and the present-on-admission (POA) indicator reporting Web site to describe the changes published in the CMS inpatient prospective payment system (IPPS) fiscal year (FY) 2009 final rule. The HAC and POA indicator information is available on the CMS Web site at *http://www.cms.hhs.gov/HospitalAcqCond/*. ❖

Source: CMS Provider Education Resource 200809-33, 200809-41

Medicare enhances consumer information on hospital care

The Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS), has announced important additions to the *Hospital Compare* consumer Web site (*http://www.hospitalcompare.hhs.gov/*) that will give consumers even better insight into the quality of care provided by their local hospitals.

The improvements include the addition of a mortality measure for pneumonia and, for the first time on *Hospital Compare*, publicly reported measures for hospital care of children. Previously *Hospital Compare*, had provided only quality information based on hospitalizations of adult patients.

Since its inception in March 2005, *Hospital Compare* has become a popular tool for consumers and their caregivers in making health care decisions. The addition of patient experience data and Medicare payment and volume information in March 2008 caused the number of page views to jump from an average of 600,000 per month to more than 2.5 million per month. Page views for this year to date have totaled more than 20 million.

"Reporting quality data on the care provided hospital patients is a key to our continuing effort to provide better, value-based health care for all Americans," HHS Secretary Mike Leavitt said. "Expanding the scope of measures is making *Hospital Compare* a more valuable tool for all health care consumers." Earlier this year, Medicare added patient satisfaction information to the Web site. Today's additions bring the total to 26 process of care measures, three outcome of care measures, two children's asthma care measures, and 10 patient experience of care measures. *Hospital Compare* also contains information about the number of certain elective hospital procedures provided to patients and what Medicare pays for those services."

"CMS' goal for updating and enhancing the *Hospital Compare* Web site is to provide usable and accurate information about hospital performance to providers and communities that will encourage hospitals to excel in the quality of care they provide," said CMS acting Administrator Kerry Weems. "With these new enhancements, consumers and health care providers will be able to look at individual hospital mortality scores. We hope that this new information will cement the Web site's role as a key driver in improving the quality and reliability of care in the nation's hospitals."

"The 30-day Medicare mortality data will strengthen quality improvement partnerships in hospitals by encouraging better handoffs and communication," said Carolyn M. Clancy, M.D., AHRQ's director. The addition of pediatric quality measures also is an important step in ensuring that our nation's hospitals provide high quality health care."

The measure on pneumonia 30-day mortality joins existing 30-day mortality measures heart failure (HF) and heart attack (AMI), which CMS began reporting last summer. Since last summer, CMS has seen improvement nationally on mortality rates for heart attack. The rate of 30-day heart attack mortality dropped from 16.3 percent reported in 2007 to 16.1 percent reported in 2008.

Hospitals varied less in their rates: for example, there are no longer any hospitals whose heart attack mortality rates were low enough to classify them as "worse than the U.S. national rate" under CMS' mortality rate classification system. In other words, CMS' calculations predicted that while some hospitals' rates are lower than the U.S. national rate, they are not low enough to consider them "worse" than the U.S. national rate with a great degree of certainty (or "statistical significance").

The pneumonia mortality measure, like its predecessors, has been endorsed by the National Quality Forum (NQF) and is supported by the Hospital Quality Alliance (HQA). The mortality outcome measures are risk-adjusted and take into account previous health problems to "level the playing field" among hospitals. The measures are also intended to help ensure accuracy in performance reporting.

In addition to new information about pneumonia mortality, CMS is releasing new information to the *Hospital Compare* Web site that will allow consumers and hospitals to drill down beyond the categorical information of the mortality measures for each hospital – whether the hospital's mortality rate is "better than," "no different from," or "worse than" the U.S. national rate.

This new data information includes each hospital's risk-standardized mortality rate (RSMR), an estimate of the rate's certainty (also known as the interval estimate), and the number of eligible cases for each hospital. By posting hospital RSMRs, interval estimates, and number of eligible cases, CMS is giving consumers and communities additional insight into the performance of their local hospitals in hopes that this will prompt all hospitals to work toward achieving the level of the top-performing hospitals in the country.

This information will also serve as a benchmark where Medicare beneficiaries and other consumers can determine – on a year-by-year basis – whether their hospital is improving for these important outcome measures.

The children's asthma care measures added today are relievers for inpatient asthma, and systemic corticosteroids for inpatient asthma. By including these measures, CMS and HQA begin providing the public with information about the quality of children's care in hospitals, including in pediatric hospitals, for the first time.

Through the *Hospital Compare* Web site, CMS is working to implement the principles of a value-based system in the Medicare program. The enhancements to the site further empower consumer choice and create incentives by motivating providers to provide better care for less money. An Executive Order issued in 2006 by President Bush directed that federal agencies that sponsor or subsidize health care commit to the four cornerstones of value-driven health care: ensuring transparent quality and price information, interoperable health information technology and incentives for high-quality, efficient health care delivery (*http://www.hhs.gov/valuedriven*).

HQA is instrumental in facilitating CMS' communication with hospitals and helping to motivate those hospitals to continually analyze and improve the quality

Medicare enhances consumer information on hospital care (continued)

of their care. Collaboration by the members of the HQA continues to ensure that public reporting efforts for hospitals are supported by a broad cross-section of the health care community.

Public reporting of these and other measures is intended to empower patients and their families with information with which to engage their local hospitals and physicians in active discussions about quality of care.

To help hospitals use the 30-day mortality data as a quality improvement tool, CMS provided detailed reports to each hospital listed on the Web site. CMS believes that all hospitals, regardless of their mortality rates, should use the data available in these free, detailed reports to find ways to continually improve the care they deliver.

CMS urges consumers to not view any one process or outcome measure on *Hospital Compare* as a tool to "shop" for a hospital. The information contained on *Hospital Compare* is one additional tool for consumers to use in making health care decisions, although consumers should gather information from multiple sources when choosing a hospital. For example, patients and caregivers could use the Web site to help them discuss plans of care with their trusted health care providers. In an emergency situation, patients should always go to the nearest, most easily accessible facility. ❖

Source: CMS Provider Education Resource 200808-32

Fiscal year 2006 supplemental security income data

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

Provider types affected

Hospitals submitting cost reports to a Medicare administrative contractor (A/B MAC) or fiscal intermediary (FI).

Impact on providers

This article is based on change request (CR) 6126, which states that, as of May 5, 2008, hospitals (this includes acute care hospitals paid under the inpatient prospective payment system and inpatient rehabilitation facilities [IRFs]) may elect to use either its fiscal year (FY) 2005 or FY 2006 supplemental security income (SSI) ratio from the files published on the Centers for Medicare & Medicaid Services (CMS) Web site to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.

- Until the FY 2007 SSI ratios are published, a hospital, as defined above, may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS Web site to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.
- Until the FY 2007 SSI ratios are published, if a hospital (as defined above) submitted its cost report using the FY 2006 ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit a written request, signed by an official of the hospital, to its FI or MAC. After receiving such a written request, the FI/MAC shall issue (or reissue to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Background

A hospital may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS Web site to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio. Once the FY 2007 SSI ratios are published on the CMS Web site, hospitals will no longer have the option of submitting cost reports using the published FY 2005 or FY 2006 SSI ratio.

If a hospital has already submitted its cost report using the FY 2006 SSI ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit its written request, signed by an official of the hospital, to its Fiscal Intermediary (FI) or Medicare administrative contractor (MAC). After receiving such a written request, the FI/MAC will issue (or re-issue, to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Additional information

For complete details regarding this CR please see the official instruction (CR 6126) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R363OTN.pdf*.

CMS has published IRF SSI ratios on the CMS Web site in the "Downloads" section of *http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage*.

Other SSI ratios are published on the CMS site in the "Downloads" section of *http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage*.

If you have questions, please contact your Medicare 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: MM6126
Related Change Request (CR) Number: 6126
Related CR Release Date: August 8, 2008
Effective Date: May 5, 2008
Related CR Transmittal Number: R363OTN
Implementation Date: September 8, 2008

Source: CMS Pub. 100-20, Transmittal 363, CR 6126

Inpatient rehabilitation facility annual update to the prospective payment system PRICER for fiscal year 2009

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6166, which provides updated rates used to correctly pay IRF PPS claims for fiscal year (FY) 2009. Be sure billing staff are aware of these changes.

Background

The fiscal year (FY) 2009 inpatient rehabilitation facility (IRF) prospective payment system (PPS) final rule published on August 1, 2008, sets forth the prospective payment rates applicable for IRFs for FY 2009. A new IRF PRICER software package will be released prior to October 1, 2008, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2008, through September 30, 2009. Medicare systems will install the new revised PRICER program in a timely manner to ensure accurate payments for the IRF PPS claims with discharges occurring on or after October 1, 2008, through September 30, 2009.

PRICER updates

For IRF PPS FY 2009, (October 1, 2008 – September 30, 2009):

- The standard federal rate is $12,958.
- The fixed loss amount is $10,250
- The labor-related share is 75.464 percent.
- The non-labor related share is 24.536 percent.
- Urban national average CCR is 0.490.
- Rural national average CCR is 0.619.

Additional information

The official instruction, CR 6166, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1585CP.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.

MLN Matters Number: MM6166
Related Change Request (CR) Number: 6166
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1585CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1585, CR 6166

CMS announces more accurate payments for inpatient rehabilitation services in FY 2009

The Center for Medicare & Medicaid Services (CMS) issued a final rule to improve the accuracy of payment for services furnished to people with Medicare who need the intensive rehabilitation services provided by inpatient rehabilitation facilities (IRFs). These include patients who are recovering from serious illnesses or injuries, such as stroke, spinal cord injuries, severe burns, amputations and a number of other conditions. There are currently more than 1,200 facilities that are paid as IRFs. CMS projects that Medicare payments to IRFs under this final rule will be approximately $5.6 billion in fiscal year (FY) 2009.

To view a copy of the entire press release, please visit *www.cms.hhs.gov/apps/media/press_releases.asp*.

For more information, please visit the following Web site resources:

The fact sheet is available at *www.cms.hhs.gov/apps/media/fact_sheets.asp*.

CMS Inpatient Rehabilitation Facility Web page at *http://www.cms.hhs.gov/InpatientRehabFacPPS/*.

The copy of the final regulation is available at *http://www.cms.hhs.gov/InpatientRehabFacPPS/LIRFF/list.asp#TopOfPage*. ❖

Source: CMS PERL 200807-33

Inpatient rehabilitation facility prospective payment system PRICER update

The provider data distributed with the inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC PRICER has been updated as of July 2008. The fiscal year (FY) 2007 and FY 2008 IRF PC PRICER on the CMS Web site page *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*, under "*Inpatient Rehabilitation Facility PPS PC PRICER*" have been updated with the latest provider data. If you use the IRF PPS PC PRICER, please go to the page above and download the latest version of the IRF PPS PC PRICER posted on August 4, 2008. ❖

Source: CMS Provider Education Resource 200808-09

CRITICAL ACCESS HOSPITAL SERVICES

2009 annual update for the health professional shortage area bonus payments

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

Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries in health professional shortage areas (HPSA).

What you need to know

Change request (CR) 6150, from which this article is taken provides your carriers, FIs, and A/B MACs with the names of the test and final files for the health professional shortage area (HPSA) bonus payments for 2009 and alerts providers that the 2009 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Web site when it is available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors in early December of each year. CR 6150, from which this article is taken, provides them the names of the test and final 2009 HPSA bonus payment files which contractors will use for the automated bonus payment for claims with dates of service on or after January 1, 2009, through December 31, 2009.

You will find the annual HPSA bonus payment file (as it becomes available) and other important HPSA information on the CMS Web site at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*.

You should also review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You may determine if you are eligible for the automated payment by going to the CMS Web site *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf* and following the instructions on the page.

Additional information

You may find the official instruction, CR 6150, issued to your carrier, FI, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1582CP.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: MM6150
Related Change Request (CR) Number: 6150
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R1582CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1582, CR 6150

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Update of the intern-to-bed ratio for method II teaching critical access hospitals

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

Provider types affected

Method II teaching critical access hospitals (CAHs) 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.

What you need to know

This article is based on change request (CR) 6176, which notifies Medicare contractors that they should update the intern-to-bed ratio on the provider specific file for method II teaching CAHs when the field contains zeroes. Your Medicare contractor will contact you to obtain your intern-to-bed ratio. An intern-to-bed ratio greater than zero is used to determine if the method II CAH is a teaching hospital, and the Centers for Medicare & Medicaid Services (CMS) identifies teaching hospitals by an intern-to-bed ratio greater than zero.

Background

Physicians and nonphysician practitioners billing on type of bill (TOB) 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the method II CAH, payment is then made to the CAH for professional services (revenue codes [RC] 96x, 97x or 98x).

Medicare makes payment for an assistant-at-surgery when:

- The procedure is authorized for an assistant
- The person performing the service is a:
  - Physician
  - Physician assistant (PA)
  - Nurse practitioner (NP)
  - Clinical nurse specialist (CNS).

The Social Security Act (Section 1842(b)(7)(D); see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the Internet) stipulates that no payment shall be made for the services of assistant-at-surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified individual on the staff of the hospital is available to provide such services. Payment may be made for assistant-at-surgery services that are required due to exceptional medical circumstances.

Payment may be made for the services of assistants-at-surgery in teaching hospitals not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries, etc.), which require immediate treatment, or there may be situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant-at-surgery even though a qualified resident is available.

Payment may also be made for the services of assistants-at-surgery in teaching hospitals if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

An intern-to-bed ratio greater than zero is used to determine if the method II CAH is a teaching hospital, and CMS identifies teaching hospitals by an intern-to-bed ratio greater than zero. It has been brought to the attention of the CMS that the intern-to-bed ratio located on the provider specific file is not being updated for method II teaching CAHs. Therefore, CR 6176 advises Medicare contractors to contact method II teaching CAHs to obtain their intern to bed ratio and update the intern-to-bed ratio on their provider specific file for method II teaching CAHs when it contains zeroes so that teaching CAHs are properly identified for claims processing purposes.

Additional information

The official instruction, CR 6176, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R372OTN.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.

MLN Matters Number: MM6176
Related Change Request (CR) Number: 6176
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R372OTN
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 378, CR 6176

ESRD Services

Sunset of end-stage renal disease final rule rollout mailbox

The Centers for Medicare & Medicaid Services (CMS) is thanking all the colleagues in the renal care community who submitted questions to CMS about the recently released end-stage renal disease (ESRD) conditions for coverage final rule. CMS received a good number of interesting and important questions from you to their ESRD final rule rollout mailbox. In response to these inquiries, CMS has already provided many of you with individual responses to your questions; however, to share the benefit of these questions with the entire community, CMS is working on a "Frequently Asked Questions" document that will condense many of the questions they received through the mailbox. That document will be posted online in the coming weeks—a notification will be issued once it is available for public download.

With the imminent publication of the "Frequently Asked Questions" document, CMS has decided to sunset the ESRD final rule rollout mailbox. As of September 1, 2008, CMS will no longer monitor the mailbox for new questions.

For more information about the new rule, please visit the CMS Web site at *http://www.cms.hhs.gov/CFCsAndCoPs/13_ESRD.asp*.

If you have an immediate inquiry, please contact Lauren Oviatt at *Lauren.Oviatt@cms.hhs.gov*. ❖

Source: CMS Provider Education Resource 200809-03

Updated end-stage renal disease PC-PRICER software now available

The Centers for Medicare & Medicaid Services (CMS) has updated the PC-PRICER Web page at *http://www.cms.hhs.gov/PCPricer/02e_ESRD_Pricer.asp* to include an end-stage renal disease (ESRD) PC-PRICER that uses the same pricing logic as the Medicare claim processing system. This version of the software will replace the current version (referred to as the ESRD calculator) in January 2009. Both pricing tools will continue to be available through the end of this calendar year. CMS is encouraging renal dialysis facilities to download the updated version of the ESRD PC-PRICER and begin familiarizing themselves with it as soon as possible.

Feedback on the latest version of this PC-PRICER software should be directed to *Wendy.Tucker@cms.hhs.gov*. ❖

Source: CMS Provider Education Resource 200809-03

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CMS end-stage renal disease network external stakeholder meetings

The Centers for Medicare & Medicaid Services (CMS) has hosted a series of end-stage-renal-disease (ESRD) stakeholder meetings to discuss the ESRD network (NW) program. The purpose of these meetings is to provide an opportunity for interested stakeholders to provide vital input and recommendations on the program moving forward.

The Office of Clinical Standards and Quality (OCSQ), is currently conducting an evaluation of the ESRD NW program. The results and recommendations developed from the evaluation will provide the steps to improving the program. OCSQ recognizes this assessment is essential to moving the program forward to meet the present needs and demands of Medicare beneficiaries in the rapidly growing field of ESRD. As well as, transitioning the program to achieve even greater strength in the following areas:

- Value
- Attribution
- Oversight
- Improved outcomes
  - o

Since 2006, OCSQ has been engaged in redesigning the quality improvement organization (QIO) program. The redesign efforts have been essential in developing the framework for the new contract period. These changes are captured in the recently released 9th statement of work (SOW) request for proposal (RFP). The changes are not limited to only the RFP documents. Change extends to several other areas as well, including the principles under which the scope of work is developed, fundamental methods of contracting, (including methods of contract awards), and, especially, contract evaluation and monitoring. CMS goal is to apply these concepts to the ESRD NW program. CMS welcomes your feedback during the stakeholder meetings to discuss how these changes can be applied to the program.

These meetings occurred during the months of August and September 2008. CMS conducted five separate meetings targeted for the following groups:

Stakeholder	Date	Location
CMS ESRD NW Contractors	August 28, 2008	CMS Quality-Net Conference
ESRD Advocates / Patients	September 4, 2008	CMS
CMS ESRD NW Contractors	September 16, 2008	Web-Ex Conference
ESRD Providers / Facilities	September 11, 2008	CMS
ESRD Researchers • Manufactures • Pharmaceutical companies • Academic Institutions	September 19, 2008	CMS

Each meeting was a participatory dialogue focused on key questions; we encourage you to review the materials in advance of each meeting and come prepared to share your feedback and recommendations during the dialogue session at the meeting.

You may access up-to-date information on these meetings at *http://esrdncc.org*, under the section titled "Events."

CMS looks forward to these meetings and how they can work collectively in improving the quality of care for Medicare beneficiaries. If you have questions regarding these meetings, please contact Cheryl Bodden at (410) 786-6875, *Cheryl.Bodden@cms.hhs.gov*. ❖

Source: CMS PERL 200808-24

SKILLED NURSING FACILITY SERVICES

Nursing home rates increased, recalibration of RUGs to be studied further

Medicare payment rates to nursing homes will increase by $780 million next year, the Centers for Medicare & Medicaid Services (CMS) announced in a press release.

The boost in payments is the result of a 3.4 percent increase in the annual market basket calculation of the cost of goods and services included in a skilled nursing facility stay. The price of the items in the basket is measured every year and Medicare payments are adjusted accordingly.

A recalibration of the payment categories (resource utilization groups or RUGs), intended to correct a previous error that had been proposed for fiscal year 2009 has been delayed while CMS continues to evaluate the data. The proposed rule announcing the planned recalibration was published in the *Federal Register* on May 4, 2008.

The copy of the final regulation is available at the CMS Web site.

The entire press release is available on the CMS Web site. ❖

Source: CMS PERL 200807-34

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CORF/ORF SERVICES

Billing update on smoking and tobacco use cessation counseling

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

Provider types affected

Comprehensive outpatient rehabilitation facilities (CORFs) and outpatient physical therapy providers (OPTs) who bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6163, from which this article is taken, updates CR 5878 (Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare), released February 1, 2008, to remove outpatient physical therapy provider (OPT) bill type 74x and comprehensive outpatient rehabilitation facility (CORF) bill type 75x from the list of applicable bill types for smoking and tobacco cessation counseling (effective July 1, 2008).

In addition, CR 6163 also announces that the applicable revenue codes for CORF billing are being updated to remove 029x (Durable Medical Equipment) because CORFs do not bill durable medical equipment (DME); and lists the revenue codes for which CORFs can bill on 75X bill types.

Make sure that your billing staffs are aware (effective July 1, 2008) that smoking and tobacco use cessation counseling is not billable by OPT or CORF providers, and are also aware of the current, applicable CORF revenue codes for 75x bill types.

Background

OPT and CORF providers cannot bill for smoking and tobacco use cessation counseling. CR 6163, from which this article is taken, updates: 1) CR 5878 (Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare), released February 1, 2008; and 2) The *Medicare Claims Processing Manual* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 100.1.1 (Allowable Revenue Codes on CORF 75X Bill Types) and 100.8 (Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings), and Chapter 32 (Billing Requirements for Special Services), Section 12.3 (FI Billing Requirements) to reflect that these bill types are not applicable for smoking and tobacco cessation counseling.

In addition, CR 6163 also announces that the applicable revenue codes for CORF billing are being updated to remove 029x (Durable Medical Equipment) because CORFs do not bill DME.

You should note that effective July 1, 2008, only those revenue codes displayed in table 1, below, are allowable for reporting CORF services on 75x bill types.

Revenue codes billable by CORFs on 75x bill types

Effective July1, 2008, only the following revenue codes are allowable for reporting CORF services on a bill type 75x:

0270	0274	0279	0410	0412	0419	042x
043x	044x	0550				
0559	0560	0569	0636	0771	0900	0911
0914	0919.					

Additional information

You may find more information about the billing of OPT and CORF smoking and tobacco use cessation counseling services, and about revenue codes billable by CORFs on 75x bill types by going to CR 6163, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1593CP.pdf*.

You will find the revised *Medicare Claims Processing Manual* Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 100.1.1 (Allowable Revenue Codes on CORF 75X Bill Types) and 100.8 (Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings), and Chapter 32 (Billing Requirements for Special Services), Section 12.3 (FI Billing Requirements) as an attachment to CR 6163.

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.

MLN Matters Number: MM6163
Related Change Request (CR) Number: 6163
Related CR Release Date: September 12, 2008
Related CR Transmittal Number: R1593CP
Effective Date: July 1, 2008
Implementation Date: December 12, 2008

Source: CMS Pub. 100-04, Transmittal 1593, CR 6163

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2008 integrated outpatient code editor specifications version 9.3

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6186 which notifies FIs, RHHIs, and A/B MACs of changes, additions, and deletions of ambulatory payment classification (APC) codes, Health Care Common Procedure System Codes (HCPCS) and diagnosis codes to ensure correct billing and processing of claims that are routed through the integrated/outpatient code editor (I/OCE). See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

CR 6186 informs Medicare contractors and providers that the integrated OCR (I/OCE) will be updated for October 1, 2008. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. Claims with dates of service prior to July 1, 2007, are routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

The integration did not change the logic that is applied to outpatient bill types that previously passed through the OPPS OCE software. It merely expanded the software usage to include non-OPPS hospitals.

CR 6186 provides the integrated OCE instructions and specifications for the I/OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system or to a hospice patient for the treatment of a nonterminal illness. The I/OCE instructions are attached to CR 6186 and will also be posted to the Centers for Medicare & Medicaid Services (CMS) Web site *http://www.cms.hhs.gov/OutpatientCodeEdit/*.

There are numerous changes/additions/deletions to diagnosis codes, APC codes, and HCPCS codes in October 2008. All of the changes will not be detailed in this article. Instead, please see CR 6186 for those details. CR 6186 is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1590CP.pdf*.

The key changes for the October 2008 I/OCE (V9.3) are summarized as follows:

Effective Date	Modification
August 1, 2000	Modify the software to restore all (four) previously purged versions of programs and codes in each release. The earliest version date included in the October 2008 release will be 8/1/2000. [Removal of older versions will be restarted in 2009].
October 1, 2008	New edit 79 – Incorrect billing of revenue code with HCPCS code **(RTP)**. **Criteria:** Revenue code 381 with HCPCS other than packed red cells (P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9057, P9058). Or revenue code 382 with HCPCS other than whole blood (P9010, P9051, P9054, P9056).
October 1, 2008	Change the disposition for edit 21 to claim returned to provider (**RTP**). **Note:** The IOCE change to RTP means this claim will no longer trigger an initial determination. The provider should validate the medical documentation and correct the bill as appropriate.
October 1, 2008	Change the disposition for edits 67, 68 and 69 to line item denial (**LID**). **Note:** The I/OCE change to LID is for no medical necessity and the provider is held liable if billed as covered. If the notice of noncoverage was provided to the patient prior to the service being rendered, then the provider should bill the services as noncovered and affix liability with the GA or GZ modifier as appropriate.

October 2008 integrated outpatient code editor specifications version 9.3 (continued)

Effective Date	Modification
October 1, 2008	Modify appendix D to apply bilateral procedure discounting with modifier 50 only to type "T" procedures that are on the conditional bilateral list.
January 1, 2008	New edit 80 – Mental health code not approved for partial hospitalization (**RTP**). **Criteria:** Mental health HCPCS codes that are not approved for partial hospital program submitted on type of bill 13x and condition code 41 (list of codes).
	Make HCPCS/APC/SI changes as specified by CMS in CR 6186.
	Implement version **14.2** of the NCCI file, removing all code pairs, which include anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
October 1, 2008	Update the valid diagnosis code list with ICD-9-CM changes.
October 1, 2008	Update diagnosis/age and diagnosis/sex conflict edits with the Medicare code editor changes.
January 1, 2008	Change bilateral indicator for *CPT* code *76645* to '3' (Independent bilateral).
January 1, 2008	Update radiopharmaceutical edits requirements.
	Create a 508 compliant version of the document for publication on the CMS Web site.

Affected providers should also read through the specifications attached to CR 6186 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.

Additional information

The official instruction, CR 6186, issued to your FI, RHHI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1590CP.pdf*.

If you have any questions, please contact your FI, RHHI, 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: MM6186
Related Change Request (CR) Number: 6186
Related CR Release Date: September 8, 2008
Related CR Transmittal Number: R1590CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1590, CR 6186

Holding of certain screening Pap smear claims billed by OPPS providers

Due to systems issues related to an incorrect deductible and coinsurance assignment of screening Pap smear claims containing Healthcare Common Procedure Coding (HCPCS) code Q0091, (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) on outpatient prospective payment system (OPPS) claims, effective immediately, CMS will be instructing their contractors to hold all claims containing HCPCS code Q0091 submitted by OPPS facilities. Contractors will hold these claims until the successful implementation of the outpatient code editor (OCE), scheduled for January 5, 2009. In the interim, OPPS facilities may choose not to submit HCPCS code Q0091 until the successful implementation of the OCE, in order to avoid a delay in reimbursement for other services submitted on the claim. Interest will be paid on clean claims held longer than 30 days after the date of receipt. ❖

Source: CMS Provider Education Resource 200809-03

Outpatient prospective payment system PRICER Web page update

The outpatient prospective payment system (OPPS) PRICER Web page has recently been updated to include the July 2008 provider specific file. You may go to *http://www.cms.hhs.gov/PCPricer/08_OPPS.asp* to view the latest update. ❖

Source: CMS PER 200807-30

PROVIDER AUDIT ISSUES

Requirement to educate providers regarding the use of Medicare cost report data

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

Provider types affected

Providers required to submit cost reports to Medicare contractors (carriers, fiscal intermediaries [FIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6132 which requires Medicare contractors to educate Medicare providers regarding the specific way that the Centers for Medicare & Medicaid Services (CMS) uses Medicare cost report (MCR) data. Medicare providers are statutorily required to submit cost reports annually.

CAUTION – what you need to know

MCR data play a central role in the development of the input price indexes (market baskets) used to update prospective payment systems (PPSs). Similarly, they are essential in evaluating Medicare payment adequacy. It is crucial that Medicare providers fill out these reports with complete and valid data.

GO – what you need to do

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

Background

Most Medicare providers are statutorily required to submit annual Medicare cost reports. The rules governing the submission of MCRs are set forth in the *Code of Federal Regulations* (CFR) (42 CFR 413.20(b) and 413.24(f)), which require providers to submit cost reports annually, with the reporting period based on the provider's accounting year. Additionally, under 42 CFR 412.52, all hospitals participating in the PPS must meet cost reporting requirements set forth in 42 CFR 413.20 and 413.24. See on the Internet *http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html*.

In reviewing the MCR data submitted by providers, CMS has found that many are failing to completely fill out their MCR with valid data likely due to the misconception that the data submitted on the MCR do not impact their payments.

To correct that misconception and to educate Medicare providers, CR 6132 is intended to provide information regarding how CMS uses the MCR data to update future PPSs. It is crucial that Medicare providers know how CMS uses the MCR data and understand the importance of filling out these reports with complete and valid data.

The MCRs play a central role in CMS' development of the input price indexes (or market baskets) used to update PPS payments. Similarly, MCR data are essential in evaluating Medicare payment adequacy in aggregate and for subclasses of providers. Following are key uses of the MCR data:

- MCR data are used to develop the major cost weights that are used in the market baskets. Market baskets are used by CMS to annually update payments for the various providers paid via a PPS. They are designed to measure the input price inflation that providers face in the provision of the medical care services they deliver.
- MCR data are also used to determine the labor-related share of a given market basket, that is, the proportion of costs that are related to, influenced by, or vary with the local labor markets. The labor-related share is used in conjunction with the area wage index to determine the geographic adjustment to Medicare payments. This adjustment can vary widely, thus individual hospitals' payment levels can be very sensitive to the changes, and errors, in measuring the labor-related share. For more information on Medicare's market baskets, visit on the CMS Web site *http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasketData.asp*.
- CMS, as well as the Medicare Payment Advisory Commission (MedPAC), rely heavily on complete, valid, and up-to-date MCR data to evaluate the adequacy of PPS payments, i.e., determining whether Medicare is paying its "fair share" to providers in aggregate and in a variety of subclasses (urban/rural, hospital-based/freestanding, etc.). In addition, periodically, CMS is approached by Congress or other payment rate stakeholders and asked to evaluate revenues and costs for specific providers and compare and contrast those estimates to those of their peers in the immediate market area. Having complete and valid data is essential to address such inquiries.
- Policymakers and program administrators, as stewards of the public trust, require the ability to validly quantify whether Medicare is paying a fair amount for the health services it purchases for its beneficiaries. The information submitted on the MCRs represents the only nationally available data on which these statutorily required payment updates in aggregate and by subclass can be appropriately based.

Requirement to educate providers regarding the use of Medicare cost report data (continued)

To carry out the tasks described above, CMS typically uses cost data from worksheets A, B, D, and G of the cost report, provider characteristics and salary data from the S worksheets, and payment data from worksheet E and other cost report worksheets (the location of which varies by provider-type). Be sure to be thorough and accurate in completing these worksheets.

Additional Information

The official instruction, CR 6132, 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/R362OTN.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: MM6132
Related Change Request (CR) Number: 6132
Related CR Release Date: August 1, 2008
Related CR Transmittal Number: R362OTN
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 362, CR 6132

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ELECTRONIC DATA INTERCHANGE

Remittance advice remark code and claim adjustment reason code update

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

Provider types affected

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

Impact on providers

Change request (CR) 6109, from which this article is taken, announces the latest update of remittance advice remark codes (RARC) used in electronic and paper remittance advice, and claim adjustment reason codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in COB transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) Web site *at http://www.wpc-edi.com/Codes* on the Internet. The tables at the end of this article (right after the *Additional Information* section) summarize the latest changes to these lists, as announced in CR 6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this Web site does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional information

To see the official instruction (CR 6109) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf* on the CMS Web site.

For additional information about remittance advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/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.

The changes that are effective on October 1, 2008 are as follows:

Remittance advice remark code changes

New codes

Code	Current narrative	Medicare initiated
N433	Resubmit this claim using only your national provider identifier (NPI)	Y

Modified codes

Code	Current modified narrative	Last modified
MA97	Missing/incomplete/invalid Medicare managed care demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08

Remittance advice remark code and claim adjustment reason code update (continued)

Code	**Current modifier narrative**	**Last modified**
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated codes

None

Health care claim adjustment reason codes

New codes

Code	**Current narrative**	**Effective date (per WPC Web site)**
213	Noncompliance with the physician self-referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as noncompensable. This Payer not liable for claim or service/treatment. **Note**: To be used for Workers' Compensation only.	1/27/2008
215	Based on subrogation of a third party settlement.	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. **Note**: To be used for Workers' Compensation only.	1/27/2008
218	Based on entitlement to benefits. **Note**: To be used for Workers' Compensation only.	1/27/2008
219	Based on extent of injury. **Note**: To be used for Workers' Compensation only.	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. **Note**: To be used for Workers' Compensation only.	1/27/2008
221	Workers' Compensation claim is under investigation. **Note**: To be used for Workers' Compensation only. Claim pending final resolution.	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. **Note**: To be used for Workers' Compensation only. Temporary code to be added for timeframe only until 1/01/2009. Another code to be established and/or for 6/2008 meeting for a revised code to replace or strategy to use another existing code.	1/27/2008

Modified codes

Code	**Modified Narrative**	**Effective Date (per WPC Web site.**
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Remittance advice remark code and claim adjustment reason code update (continued)

Deactivated codes

Code	Current Narrative	Effective Date (per WPC Web site)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. **Note**: To be used for Workers' Compensation only. Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 6/2008 meeting for a revised code to replace or strategy to use another existing code.	1/1/2009

MLN Matters Number: MM6109
Related Change Request (CR) #: 6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1563, CR 6109

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FRAUD AND ABUSE

OIG reports more than $2 billion in recoveries from fighting fraud, waste, and abuse for first-half fiscal year 2008

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) "Semiannual Report to Congress" announced expected recoveries of $2.2 billion for the first half of fiscal year (FY) 2008 from efforts to reduce fraud, waste, and abuse in HHS programs.

Specifically, OIG's $2.2 billion in expected recoveries encompasses $1.1 billion in audit-related recoveries and another $1.1 billion in investigative-related recoveries. Additional savings from implemented recommendations are calculated annually and will be reported in the final FY 2008 Semiannual Report.

"OIG's accomplishments reflect a robust oversight agenda implemented through audits, evaluations, and compliance and enforcement activities," said Inspector General Daniel R. Levinson. "It is through a combination of vigilant oversight, outreach to the health care community, and partnership with government agencies at all levels that we are able to fulfill our mission to protect the integrity of HHS programs and beneficiaries."

Also for this period, OIG reported exclusions of 1,291 individuals and organizations for fraud or abuse of federal health care programs; 293 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 142 civil actions, which include False Claims Act (FCA) and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

OIG accomplishments for this first-half of FY 2008 include:

Medicare Part D sponsors: estimated reconciliation amounts for 2006

In our analysis of the Centers for Medicare & Medicaid Services' (CMS) Medicare Part D preliminary reconciliation data estimates (as of August 2007) and data from 16 sponsors with high enrollments, we estimated that Part D sponsors owed Medicare a net total of $4.4 billion for the 2006 program year. Eighty percent of the sponsors owed CMS money and 20 percent were due money. We also found that CMS had no mechanism to collect funds or adjust prospective payments prior to the reconciliation that is conducted after the close of the plan year. As a result, sponsors had the use of billions of dollars for a significant length of time. In response to our recommendations, CMS agreed to use data collected from 2006 and subsequent plan years in reviewing future bids, acknowledged its authority to change certain payment methodologies, and agreed to examine related options. CMS did not agree to implement an interim process or to seek legislation delaying changes to risk corridors.

Bristol-Myers Squibb Co. pays more than $499 million to resolve allegations of illegal drug marketing and pricing

As part of a civil settlement, the Bristol-Myers Squibb Co. (BMS) and its wholly owned subsidiary, Apothecon, Inc., agreed to pay $499 million plus interest to resolve allegations relating to a variety of federal and state claims. The Government alleged that BMS fraudulently set and maintained inflated prices for a wide assortment of oncology and generic drug products, paid various forms of illegal kickbacks to physicians and pharmacies, promoted off-label uses of the antipsychotic drug Abilify, and knowingly misreported its best price for the antidepression drug Serzone. BMS entered into a 5-year corporate integrity agreement (CIA) with OIG as part of the resolution of this FCA case.

National Institutes of Health: conflicts of interest in extramural research

In our review of financial conflicts of interest reported by grantee institutions to the National Institutes of Health (NIH), we found that the agency needed to improve its oversight of such conflicts. For FYs 2004-2006, NIH could not provide an accurate count of the financial conflict-of-interest reports that it received from grantees; of 438 financial conflict-of-interest reports received from grantee institutions in 2006, at least 89 percent did not state the nature of the conflicts or the way in which they would be managed; regarding oversight, NIH's institutes most often relied on grantees' assurances that financial conflict-of-interest regulations were being followed. NIH agreed with our recommendations to increase oversight of grantee compliance with regulations, require Institutes to forward grantee conflict-of-interest reports, and ensure that all of the reports are included in its database. NIH did not agree with our recommendation to require grantees to provide details about financial conflicts of interest.

Artificial-joint makers pay $310 million to settle kickback case

Medical device makers Zimmer Holdings, Inc.; DePuy Orthopaedics, Inc. (a unit of Johnson & Johnson); Smith & Nephew, Inc.; and Biomet, Inc., agreed to pay a total of approximately $310 million to resolve allegations of anti-kickback statute and FCA violations.

The four companies allegedly used consulting deals with orthopedic surgeons to induce the purchase of their respective artificial hip and knee products. As part of the settlement, the companies entered into five-year CIAs with OIG.

OIG reports more than $2 billion in recoveries from fighting fraud, waste... (continued)

Medicare Part D payments to local community pharmacies

In our review of the relationship between Medicare Part D payments to local community pharmacies and the pharmacies' drug acquisition costs, we found that in September 2006 pharmacies almost always (97 percent of the time) acquired drugs for less than the reimbursement amounts. We performed this review at the request of 33 senators who raised concerns about the sufficiency of reimbursement to local community pharmacies. We estimated that, excluding dispensing fees and including rebates that drug wholesalers paid to pharmacies, Medicare Part D payments to local, community pharmacies exceeded the pharmacies' drug acquisition costs by 18.1 percent. We recommended that Congress and CMS consider the results of the review in deliberations regarding Medicare Part D reimbursement, and CMS agreed.

Dermatologist sentenced for upcoding surgical procedures

A Michigan dermatologist was sentenced to 10 years and 6 months in prison and ordered to pay approximately $1.3 million in restitution and a $175,000 fine for upcoding surgical procedures, billing for medically unnecessary procedures, and improperly billing for follow-up office visits. The dermatologist falsely informed patients that they had cancer when, in fact, laboratory results indicated that their tissue specimens were benign. He then performed surgeries based on these false diagnoses.

Temporary assistance for needy families improper payment pilot reviews

In our pilot reviews of Temporary Assistance for Needy Families (TANF) basic assistance payments during a six-month period in 2005, we found that three States—Michigan, New York, and Pennsylvania—collectively claimed an estimated $95 million in improper payments. The estimated error rates ranged from 11.5 percent to 40 percent of the federal dollars expended. Our recommendations focused on state compliance with requirements, enrollee eligibility, and recalculating improperly paid benefits. Michigan disagreed, New York did not address the recommendations, and Pennsylvania agreed.

Payments for outpatient services in skilled nursing facility stays

We found that Medicare Part B made a total of $106.9 million in potential overpayments to suppliers of outpatient services on behalf of beneficiaries in Part A-covered skilled nursing facilities (SNF) during calendar years (CYs) 2001 and 2002. These potential overpayments occurred because CMS did not have system edits in place during most of this period. For CY 2003, when the edits were fully implemented, potential overpayments were reduced to $22.7 million. CMS agreed with our recommendations about reviewing overpayments, testing and refining edits, and establishing recovery controls.

To read the full semiannual report go to *http://oig.hhs.gov/publications/docs/semiannual/2008/semiannual_spring2008.pdf*. ❖

Source: OIG semiannual report to Congress, June 12, 2008

OIG policy regarding providers waiving retroactive beneficiary cost-sharing amounts attributable to increased payment rates under the Medicare Improvements for Patients and Providers Act of 2008

The purpose of this policy statement is to assure providers, practitioners, and suppliers (collectively, "Providers")[1] affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[2] that they will not be subject to Office of Inspector General (OIG) administrative sanctions if they waive retroactive beneficiary liability (as defined below), subject to the conditions noted in this policy statement.

MIPPA, enacted by Congress on July 15, 2008,[3] includes increased payment rates for certain items and services related to:

- the physician fee schedule[4]
- durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (in the ten competitive bidding areas for the specific items for which competitive bidding was temporarily implemented)[5]
- brachytherapy sources and therapeutic radiopharmaceuticals under the outpatient prospective payment system[6]
- the ambulance fee schedule.[7]

Under MIPPA, these payment rate increases apply retroactively to July 1, 2008. We have been informed by the Centers for Medicare & Medicaid Services (CMS) that, as a result, beneficiary liability for cost-sharing amounts for the affected items and services also increased on a retroactive basis. Thus, beneficiaries who already paid, or were billed for, cost-sharing amounts based on lower payment rates temporarily in effect since July I, 2008, are liable for additional cost-sharing amounts under the increased MIPPA payment rates (the "retroactive beneficiary liability").[8]

We have been asked whether providers affected by the MIFPA payment rate increases are required to bill for or collect the retroactive beneficiary liability in order to comply with the OIG's fraud and abuse authorities. Ordinarily, routine waivers of Medicare cost-sharing amounts potentially implicate the federal anti-kickback statute,[9] the civil monetary penalty and exclusion laws related to kickbacks,[10] and the civil monetary penalty law prohibiting inducements to beneficiaries.[11] Notwithstanding, in these limited circumstances, providers will not be subject to OIG administrative sanctions if they waive retroactive

OIG policy regarding providers waiving retroactive beneficiary cost-sharing amounts attributable... (continued)

beneficiary liability, subject to the conditions noted below.

- This policy statement applies to waivers of retroactive beneficiary liability owed by beneficiaries only for the period from July 1, 2008, until the date on which CMS (or the relevant carrier or intermediary) implements the increased payment rates applicable to the particular provider.[12] Once new payment rates are implemented, providers are expected to calculate cost-sharing amounts based on the new payment rates.
- This policy statement applies only to retroactive beneficiary liability, which is the increase in the beneficiary's cost-sharing obligation attributable to the increase in payment rates under MIFPA. This policy does not apply to waivers of beneficiary cost-sharing amounts that were calculated using the lower payment rates temporarily in effect since July 1, 2008.
- This policy statement does not apply to waivers of retroactive beneficiary liability if the waivers are conditioned in any manner on the provision of future items, supplies, or services.

Nothing in this policy statement requires providers to waive retroactive beneficiary liability.

Importantly, nothing in this policy statement affects the ability of a provider to waive any cost-sharing amounts on the basis of a good faith, individualized determination of a beneficiary's financial need.[13] ❖

Source: Daniel R. Levinson, Inspector General, July 23, 2008

[1] This policy statement applies only to providers that are impacted by the increased MIPPA payment rates. Specifically, with respect to DMEPOS suppliers, this policy statement only applies to those DMEPOS suppliers in the ten regions that were designated for competitive bidding, and then only to beneficiary liability related to the specific items to which competitive bidding would have applied.
[2] M1PPA, P.L. No. 110-275.
[3] Id.
[4] See id. at § 131(a).
[5] See id. at § 154.
[6] See id. at § 142.
[7] See id. at § 146.
[8] Generally speaking, the retroactive beneficiary liability will be 20 percent of the payment rate increase.
[9] Section 1128B(b) of the Social Security Act (the "Act"), 42 U.S.C. § 1320a-7b(b).
[10] Sections 1128(b)(7), 1128A(a)(7) of the Act, 42 U.S.C. §§ 1320a-7(b)(7), 1320a-7a(a)(7).
[11] Section 1128A(a)(5) ofthe Act, 42 U.S.c. § 1320a-7a(a)(5).
[12] Although MIPPA was enacted on July 15, 2008, as a practical matter, the revised payment rates will take time to be implemented by CMS (or the relevant contractors and intermediaries). We are informed by CMS that the exact implementation dates may vary by benefit, contractor, and intermediary. Until such time as the new payment rates are implemented, some providers may continue to calculate beneficiary cost-sharing obligations based on the prior, temporary payment rates, and the beneficiaries may pay, or be billed for, a lower amount than they actually owe under MIPPA.
[13] There is an important exception to the general prohibition against waiving Medicare cost-sharing amounts for financial hardship situations. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived as long as: (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the party offering the waiver does not routinely waive cost-sharing amounts; and (iii) the party waives the cost-sharing amounts after determining in good faith that the beneficiary is in financial need or reasonable

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EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
October 2008 – December 2008

Ask the contractor – Topic: Inpatient cost outlier claims – intermediary level

When: Wednesday, October 15, 2008

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

Type of Event: Teleconference/Webcast

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: Teleconference

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: Teleconference/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. ❖

PREVENTIVE SERVICES

August is national immunization awareness month

The goal of the National Immunization Awareness Month (NIAM) is to increase awareness about immunizations across the life span, from infants to the elderly. Getting immunized is a lifelong effort regardless of age, sex, race, ethnic background or country of origin. As parents prepare their children for school, students enter college and health care workers prepare for the upcoming flu season, the month of August and NIAM present an excellent opportunity to remind individuals that they can help protect themselves, their families, friends and their communities from serious, life-threatening infections by staying up-to-date with their immunizations.

Medicare helps beneficiaries with the cost of adult immunizations by providing coverage for pneumococcal, influenza and hepatitis B vaccines. Medicare covers the cost of pneumococcal and influenza vaccines and their administration by recognized providers. No beneficiary co-insurance or copayment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or copayment applies for hepatitis B vaccination after the yearly deductible has been met.

How can you help?

As a health care professional, you play an important role in helping your Medicare patients and others understand the importance of disease prevention through immunizations. Your recommendation is one the most important factors in increasing immunization rates among people with Medicare. Be aware of the recommended vaccines for adults of all ages and particularly seniors. Encourage your Medicare patients to stay up-to-date on recommended vaccines including those adult immunizations covered by Medicare (an annual influenza vaccination, a pneumococcal vaccination and the hepatitis B vaccination (for beneficiaries at high to intermediate risk) by encouraging utilization of these benefits as appropriate.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of provider education and outreach resources to help providers and suppliers to learn more about Medicare coverage, coding, billing and reimbursement of influenza, pneumococcal, and hepatitis B immunizations. Resources include:

- The *Guide to Preventive Services for Providers, Physicians, Suppliers and Other Health Care Professionals* *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- Quick reference information: *Medicare Part B Immunization Billing Chart* *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- Adult immunizations brochure *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- The *MLN* Preventive Services Educational Products Web Page *www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

For information to share with your Medicare patients, please visit on the Web *www.medicare.gov*.

To learn more about National Immunization Awareness Month, please visit on the Web *http://www.cdc.gov/vaccines/events/niam/default.htm#add*.

Thank you for supporting the effort to increase awareness and promote utilization of vaccines that can prevent infectious disease and save lives.

Visit the Medicare Learning Network – it's free! ❖

Source: CMS Provider Education Resource 200808-03

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.

September 21-27, 2008, is national adult immunization awareness week

This annual health observance is a great opportunity to promote the importance of adult immunizations. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers who accept the Medicare-approved payment amount for influenza, pneumococcal, and hepatitis B vaccines and their administration. All adults 65 and older should get influenza and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for hepatitis B should get hepatitis B shots. CMS needs your help to ensure that people with Medicare take full advantage of these vital preventive benefits. You can help by talking with your Medicare patients about their risk for these vaccine-preventable diseases covered by Medicare and the steps they can take to help reduce their risk of contracting these diseases, including getting vaccinated. With flu season approaching, remember to start vaccinating as soon as you receive the vaccine. And remember to continue to vaccinate as long as you have vaccine available, even after the new year. And finally, don't forget, health care workers also need to protect themselves.

September 21-27, 2008, is national adult immunization awareness week (continued)

Get your flu shot – not the flu.

For more information about Medicare's coverage of adult immunizations and a list of related educational resources, please visit CMS' *Medicare Learning Network* Preventive Services Educational Products on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

For information about the national adult immunization awareness week, please visit the National Foundation for Infectious Diseases at *http://www.nfid.org/* on the Web. ❖

Source: CMS Provider Education Resource 200809-40

OTHER EDUCATIONAL RESOURCES

New educational materials from the Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) reminds providers that the following fact sheets are now available in print format from the *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "*MLN* Product Ordering Page."

- ***Federally Qualified Health Center Fact Sheet*** (revised April 2008) which provides information about federally qualified health center (FQHC) designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC payments; and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- ***Medicare Disproportionate Share Hospital Fact Sheet*** (revised April 2008) which provides information about methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.
- ***Inpatient Psychiatric Facility Prospective Payment System Fact Sheet*** (revised May 2008) which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2009 update to the IPF PPS. ❖

Source: CMS PERL 200808-09, 200807-31

Inpatient psychiatric facility prospective payment system fact sheet

The Inpatient Psychiatric Facility Prospective Payment System fact sheet (revised May 2008) is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "*MLN* Product Ordering Page."

The Inpatient Psychiatric Facility Prospective Payment System fact sheet provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2009 update to the IPF PPS. ❖

Source: CMS PERL 200808-01

Guidelines for teaching physicians, interns, and residents

The revised *Guidelines for Teaching Physicians, Interns, and Residents* (July 2008), which provides information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*. ❖

Source: CMS Provider Education Resource 200809-42

Medicare guide to rural health services CD-ROM version now available

The CD-ROM version of the revised *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* (April 2008) is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005.

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

Visit the *Medicare Learning Network* – it's free! ❖

Source: CMS Provider Education Resource 200808-06

April 2008 rural health clinic fact sheet now available

The April 2008 version of the *Rural Health Clinic Fact Sheet*, which provides information about rural health clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "*MLN* Product Ordering Page."

To download a copy, visit the "*MLN* Publications" page at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*, and search for the booklet title. ❖

Source: CMS Provider Education Resource 200808-09

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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

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